The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors (held remotely due to COVID-19)

Date and time: Thursday 7 April 2022 at 9.30 – 13.00
Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	9
	1.4	Matters arising and action log	Review	All	22
09.35	Patient story: 'Connection Wins'				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	24
10.10	2.2	CEO's report including: • COVID-19 update	Inform	Chief executive	35
03 Risk					
10.30	3.1	Significant risk register	Review	Medical director	41
10.40	3.2	Board assurance framework 2021-22	Review/ Approve	Head of corporate affairs	47
04 Patients					
10.45	4.1	Report from Quality and Safety Committee 25.03.22	Note	Committee Chair	61 64
10.50	4.2	Learning from deaths (Mortality)	Discuss	Medical director	65
11.00	4.3	Maternity SI report	Assure	Director of nursing and midwifery	74
11.05	4.4	Nursing, midwifery and care staff levels including nurse recruitment	Discuss	Director of nursing and midwifery	76
11.10	4.5	Ockenden update	Assure	Director of nursing and midwifery	95
05 People					
11.20	5.1	Report from Workforce Committee 28.03.22	Note	Committee Chair	108
11.25	5.2	Staff Survey results	Discuss	Director of people and OD	110
11.35	5.3	Equality, Diversity and Inclusion Board Champion	Note	Director of people and OD	129

		BREAK			
06 Performance/pounds					
11.50	6.1	Report from Performance and Finance Committee 31.03.22	Note	Chair of Committee	132
11.55	6.2	Integrated performance report	Discuss	Chief Information Officer	134
12.10	6.3	Amendment to Standing Financial Instructions	Approve	Director of Finance	202
07 Strategy/Governance					
12.15	7.1	Report from Strategic Transformation Committee 28.03.22 including: • Terms of Reference 2022/23	Inform/ Approve	Chair of Committee	203
12.20	7.2	Digital Transformation Strategy	Approve	Chief Information Officer	208
12.25	7.3	Report from Audit Committee 07.03.22	Inform	Chair of Committee	266
12.30	7.4	Report from Senior Management Team Meetings	Inform	Chair of Committee	268
12.35	7.5	Corporate Trustee: • Report from CFC.11.03.22	Inform	Chair of Committee	270
12.40	7.6	Report on use of Trust Seal	Note	Head of Corporate Affairs	272
08 Questions from the public					
12.45	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	
13.00	9.4	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	

The Princess Alexandra Hospital NHS Trust

Purpose:
The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.
Quoracy:
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.
Ground Rules for Meetings:
1. The purpose of the meeting should be defined on the day (set the contract). 2. Papers should be taken as read. 3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified. 4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter. 5. Challenge should be constructive and a way of testing the robustness of information. 6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time. 7. The use of mobile phones during meetings should be avoided; phones must be set to silent. 8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

Board Membership and Attendance 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	Director of Finance	Saba Sadiq
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Non-Executive Director	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 3 February 2022 from 09:30 to 13:15

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Dr Amik Aneja (late)	General Practitioner (GP-AA), Board Advisor
Darshana Bawa	Associate Non-Executive Director (ANED-DB)
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Ogechi Emeadi (non-voting)	Director of People (DoP)
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)
Stephanie Lawton	Chief Operating Officer (COO)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Lance McCarthy	Chief Executive Officer (CEO)
Colin McCready	Non-Executive Director (NED-CM)
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:	
Giuseppe Labriola	Director of Midwifery
Amy Skellett	Clinical Practice Facilitator, Midwife
Laura Warren	Associate Director - Communications
Members of the Public	
Alan Leverett	Member of the Public
Shruti Sheth Trivedi	Reporter – Health Service Journal
Apologies:	
None	
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. She particularly welcomed new Non-Executive Director Colin McCready (NED-CM), new Associate NED Liz Baker (ANED-LB) and also informed members that NExT NED Darshana Bawa had now been appointed as an Associate NED (ANED-DB). General Practice and Board Advisor Amik Aneja (GP-AA) would be late in joining the meeting and would not attend the afternoon sessions.
1.1 Apologies	
1.2	There were no apologies.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of the Meeting held on 02.12.21	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	The action log was noted.
Staff Story	

1.6	The Director of People (DoP) welcomed the Clinical Practice Facilitator, Midwife (CPF) and the Director of Midwifery (DoM) to the meeting. The CPF then took members through the Midwifery and Registered Midwifery Shortened Programme.
1.7	She informed Board members that this was a shortened course for qualified nurses (adult) who wanted to become midwives. The programme lasted between 18– 21 months depending on experience and the Trust worked in partnership with Hertfordshire University and currently had four candidates in the process of completing the programme. She informed colleagues that the programme cost candidates £9250 per academic year and that student funding could be applied for to support that. For the duration of the programme candidates would receive a Band 5 salary.
1.8	The CPF continued that the programme consisted of 86 weeks in total - eight study block weeks, practice development time and placement experience. Eight modules would be completed including Newborn and Infant Physical Examination. Key elements were also experiential learning within the clinical area through the supervisor-student partnership, learning through simulation, self-directed work and reflection sessions. In terms of assessments there were placement assessments, practical exams, online theory assessments and essay formats.
1.9	Non-Executive Director John Hogan (NED-JH) thanked the CPF for her presentation. In response to a number of questions the CPF confirmed that the number of spaces on the course were different each year. The Trust worked with ARU and the University of Hertfordshire and at present there were approximately 77 student midwives and in addition some paramedics with maternity experience. Normally capacity was for four short course midwives each year and in terms of retention for each of those four places, the Trust would on average retain three.
1.10	In response to questions from NED Helen Glenister (NED-HG) the CPF confirmed that the shortened course was not open to paramedics and there was no requirement currently for students to remain with the Trust after qualifying. Students were given plenty of study/protected time which could include undertaking audits and theory work.
1.11	In response to the presentation Associate NED John Keddie (ANED-JK) asked why the Trust was not funding its own people to complete the course. In response it was confirmed that up until two years ago, course fees had been funded by Health Education England. An internal candidate (from Penn Ward) was currently on the course and the CPF agreed it would be beneficial for internal staff to be funded and thereby developed. In addition the DoM added that the midwifery apprenticeship was currently being explored which could draw on the apprenticeship levy in terms of funding. NED Helen Howe (NED-HH) added that from discussions as the Workforce Committee (WFC) she believed there would be capacity within the apprenticeship levy to support that.
1.12	The Director of Quality Improvement (DoQI) enquired as to whether any of the course modules covered quality improvement. In response the CPF confirmed one module covered advanced midwifery practice which included an improvement work-stream with the potential to be involved in audits.
1.13	At this point the DoP asked what would make the course even better. In response the CPF commented it would be having more candidates to take more advantage of the existing skill mix of the students.
1.14	The DoM then took members through his career journey from nursing diploma, qualified nurse in trauma and haematology and oncology, to student midwife to matron, to head of midwifery to director of midwifery. He felt his nursing and midwifery qualifications had supported and catapulted his career progression.
1.15	In response to the above the Medical Director (MD) commented that the story was a wonderful example of role modelling and opportunity. She asked how the organisation was currently inspiring its workforce and the wider community with stories such as that. In response the DoM stated that was something that needed further discussion. He had done talks in local schools in terms of career pathways and in particular those roles not necessarily associated with a particular gender.

1.16	The DoP agreed with the above and that the story could be used as part of the organisation's wider recruitment strategy. She would be taking a paper back to WFC in terms of international recruitment: Costs versus 'grow our own' and supporting the midwifery team to utilise the apprenticeship levy to fill internal places on the shortened course.
1.17	The TC thanked colleagues for their presentation and agreed with the importance of supporting the organisation's people in terms of development. That required a rethink which would now be undertaken by the DoP and reported back via Workforce Committee.
1.18	In response to a prompt from the MD in terms of closing the loop on Board stories, the Director of Nursing & Midwifery (DoN&M) was able to update from December's Patient Story that in response to some simple requests, she could confirm that some new (and larger) mugs were about to be delivered into the organisation to support hydration for patients.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC presented her report the key highlights of which she commented were the recent recruitment of new NEDs. She opened the item to questions.
2.2	NED Helen Glenister (NED-HG) asked when it was likely that the Board-to-Ward walkabouts would recommence. In response the TC stated she was hoping visits may recommence in three weeks' time (to Paediatric ED) but she cautioned with the current pandemic, visits may be subject to cancellation at short notice. The DoN&M added that Infection Prevention & Control (IPC) colleagues would be reviewing COVID prevalence rates in the local community continuously in order to inform decision-making.
2.3	NED-HH commented that she would like to thank the Director of Finance (DoF) for a recent and very informative training session on finance. The TC thanked her for her comments and stated she would be keen moving forward to keep up the pressure on Board Development.
2.2 CEO's Report	
2.4	The CEO presented his update. He informed colleagues that the first section of his report detailed the pressures the organisation had been facing in terms of COVID. He was pleased to report that prevalence rates in the local community had been reducing over the previous three to four weeks, however, it remained a moving feast with continual peaks and troughs so the utmost caution was still required.
2.5	The CEO continued that COVID numbers in Harlow for the previous seven days had been 889 new infections per 100k of the population, so still extremely high and the highest in Essex, however much reduced on 1800 per 100k of the population at the beginning of January. The impact of the prevalence of cases was being evidenced by attendances/admissions via the Emergency Department (ED). However the number of positive inpatients was falling – from 52 in the previous week to 45 earlier that week.
2.6	He emphasised the need to continue with stringent IPC practices in all areas including the wearing of fluid resistant masks and social distancing. His thanks went to everyone in the organisation for all their work around COVID, in terms of recovery of services, reducing 104 week waiters and elective and diagnostic activity which had required a huge amount of effort to keep everyone as safe as possible.
2.7	The CEO continued that as of that week, the organisation had become part of the national discharge programme, helping to support patients through the hospital and discharge them out to allow greater capacity for inpatient/elective work and also for urgent and emergency care demand. He cautioned that COVID had not yet gone away causing fluctuations in sickness absence and pressures on staff. The organisation's people remained under strain but were being supported by colleagues and a robust health and wellbeing package.
2.8	In terms of Vaccination as a Condition of Deployment (VCOD) the CEO confirmed his update was now out of date due to the recent changes in guidance and the discussion would be picked up later in the meeting.
2.9	The CEO continued that in terms of the new hospital, the Trust continued to develop its outline business case (OBC) and to work closely with the national new hospital programme (NHP) whilst the business case for the national programme was under approval. The

	Government's 'levelling up' paper had included the redevelopment of PAHT into a 'high tech' healthcare campus'. He congratulated colleagues on the huge amount of work undertaken in terms of getting the OBC for a new electronic health record (EHR) approved by national colleagues recently and funding agreed. If the process for procurement was approved at the Board's private session later that day then the organisation planned to go out to procurement the following week. He emphasised the significant benefits for both patients and colleagues in a new system.
2.10	In terms of planning guidance, the headlines were provided in the paper along with a number of key changes to personnel at a national, regional and ICS level.
2.11	The CEO then drew members' attention to a new section in the paper 'Recent Achievements/Significant Improvements for Out-Patients'. The key elements to highlight were: • Kirstie Savege (Midwifery Matron) had been awarded a prestigious Cavell Nurses Star award for her contribution to midwifery practice. • The Trust had been reassessed by the UNICEF Baby Friendly Initiative and re-accredited as a Baby Friendly Hospital. The assessors commended the organisation on achieving that during the pandemic, maintaining training; and they found that a high percentage of mothers were happy with the care at PAHT– valuing the kindness from staff.
2.12	As a final point members noted that following an AAC panel on 27.01.22 two offers of appointment as consultant at PAHT had been made to colleagues in diabetes and endocrinology department - Dr Eleftheria Panteliou and Dr Anneke Graf. That was fantastic news for the department and the Board was asked to ratify the offer of those appointments, made through delegated authority to the AAC panel. In line with the recommendation the Board approved both appointments.
2.13	In response to the above NED-HG highlighted that the planning update indicated that financial guidance would be issued at the end of January. She asked if that had happened. In response the CEO confirmed that some snippets had come through, but not all required to undertake local planning. The DoF added that the detailed planning guidance had just been received and colleagues were working through that. The elements awaited were revenue and CIP programme and she would update on the position the following month.
2.14	NED-CM asked how the recent position in terms of VCOD had been received by staff. In response the CEO stated the response had been mixed. Those who did not want to be vaccinated were pleased, others were now frustrated that they had been vaccinated in recent weeks which may possibly not now have been required. The DoP added there were three camps, those who had been vaccinated, those who were hesitant for various reasons (including fertility concerns) and those who did not want to be vaccinated. She would cover the detail later. The TC requested that colleagues in Staff Health & Wellbeing who had been supporting the vaccination programme be thanked for their efforts. The DoP agreed to do that.
ACTION **TB1.03.02.22/15**	**Board thanks to be conveyed to Staff Health & Wellbeing colleagues for their efforts during COVID.** **Lead: Director of People**
2.15	At this point Associate NED Anne Wafula-Strike (ANED-AWS) asked if there was more that could be done in terms of messaging to the community in terms of bringing down transmission rates. In response the CEO stated that national guidance changed rapidly. It was important to remember that 85% of staff lived within a five mile radius of the hospital so the stringent guidance in the hospital itself should support that out in the community. There were a number of ongoing discussions with local councillors and Local Authority CEOs who were supporting with messaging so that the public heard the same information. With the high rates currently in Harlow, Essex County Council were working with Harlow District Council on a range of focuses but much would be word of mouth or how the hospital communicated with outpatients and those attending the site.
2.16	In terms of the planning guidance, NED-HH updated colleagues that WFC had requested an update on working differently/new roles. She commented it would be useful to understand

	the strategic direction in that area across the ICS, particularly in terms of Anaesthetic Associates.
2.17	In response the CEO reminded members that new roles had been added over recent years and the clinical strategies that had been developed in terms of service provision over coming years included some good ideas on how to work in different ways. The focus needed to be not necessarily on new roles, but on extending the scope of current staff to provide greater career opportunities and packages of care.
2.18	In response to a question from ANED-LB, the CEO confirmed that the organisation was in constant dialogue with the national NHP and indeed one PAHT team member was part of the national team. The design convergence review was part of the national NHP business case to be approved by the Department of Health/Treasury in the spring.
2.19	At this point the TC extended her thanks to NED-HG for supporting in her place with interviews for the ICS Board members.
03 RISK/STRATEGY	
3.1 Significant Risk Register	
3.1	This paper was presented by the MD and was taken as read. The key highlights were: **Delays to assessment in Same Day Emergency Care unit (SDEC) -** Patients were having lengthy delays waiting for a medical review in Same Day Emergency Care (SDEC). There were two doctors to review 40-45 patients (SDEC-120721, raised in April 21 with score increased in August due to increasing waiting times of 4-5 hours). That risk score had now reduced from 20 to 9. **Patients receiving ward care on the Post Anaesthetic Care Unit (PACU - Recovery) -** Due to lack of in-patient beds patients were remaining on the Post-Anaesthetic Care Unit (PACU) rather than being placed on a ward, leading to delays in sending for patients as PACU was full, resulting in cancellations and breaching of the mixed sex accommodation guidance (PACU001/2018 with score increasing due increased frequency of occurrences). That risk had now been downgraded to 8. **Bed pressures for elective care -** Risk that at times, extreme pressure for non-elective beds had an impact on bed availability for elective care as those beds may be reassigned for emergency medical capacity, including outliers. That would reduce elective admissions and operating capacity, (S&CC002/2021 raised November 2021). That was a new risk that had been added.
3.2	NED-JH asked about risks such as 3.3.2 (Cancer Access Standard) which had been on the register since 2016. In response the MD stated that in terms of those risks that had been on the risk register a long time, the focus did not change, the focus was already high. Cancer access was a conversation that took place at performance review meetings and Senior Management Team (SMT), so was very much a focus. The Chief Operating Officer (COO) added that there was a recovery trajectory in place with cancer being a key focus of the Access Board. She acknowledged the issue would remain a risk to the organisation until the national standard was achieved again but she provided assurance the position was monitored monthly.
3.3	In response to the above NED-JH acknowledged the comments but asked therefore for the point of the risk register if risks remained on there for significant periods of time. In response the CEO stated that it linked to the work around tolerance and recognition of the risk. Just because a risk remained on the register for a long time did not mean that nothing was being done about it. No organisation had achieved the national four hour ED standard in the previous couple of years but that did not mean the organisation (and others) wasn't working hard in the background with internal and external colleagues to ensure it continued to provide safe and high quality care. The very nature of the cancer access risk meant it would always score a 5 in terms of consequence.
3.4	In response to a question from NED-CM, the MD confirmed that she would be happy to provide further information on the Trust's risk management processes. She noted that the risk management team were currently updating the risk strategy and revising the risk appetite statement. This work would be discussed with the Board in April. NED-HG noted that there

	was a need to differentiate between risks and issues. It was agreed that the MD would lead a Board workshop on risk.
ACTION TB1.03.02.22/16	**Lead a Board workshop on risk. Lead: Medical Director**
3.5	NED-HH asked if the Trust was actually in breach of the Ockenden requirements for consultant cover in obstetrics (risk 3.2.1). The report stated that the unit was achieving 87 hours but was only required to achieve 60 hours. The CEO confirmed that the risk related to the stretch target that the Trust had set itself to achieve better outcomes for mothers. The risk score was high (20) but this did not relate to the delivery of care. The MD noted that the number of high risk deliveries was increasing so the stretch target was about managing the future risk.
3.6	The TC summarised the discussion and agreed that a Board workshop on risk would be beneficial. The workshop would include risk appetite, how aspirational targets were flagged as risks and the length of time that risks were on the register.
3.2 Board Assurance Framework 2021/22	
3.7	The HoCA presented the paper and it was noted that the risks had been discussed at Committees during the month and whilst the risks had been updated there were no changes to any of the risk scores. Members noted the update.
04 PATIENTS	
4.1 Report from Quality & Safety Committee (QSC)	
4.1	The report was presented by NED-HG as Chair of QSC. The report was taken as read and it was noted that review lists/ASI were being monitored by PAF. The Committee was content with the report from the Quality PMO (QPMO) and was keen to ensure that the rigour was not lost when the QPMO transitioned to the central PMO.
4.2	NED-HG stated it was pleasing to note that PPH rates had come down and were lower that month than the national average.
4.2 Learning from Deaths Update	
4.3	This update was presented by the MD and the paper was taken as read. She informed members that the latest report was using what was known as 'flex' data. That was a dataset that was incomplete. There was another dataset using 'freeze' data which was complete and accurate. The Trust had discussed with Telstra which dataset to use going forward and in summary the freeze data was significantly more accurate. The impact of that was that there was a delay for freeze data so the organisation would receive data that was a month older to work from (i.e. end of September data was analysed for January – a four month lag).
4.4	In terms of SHMI, HSMR and diagnostic outliers, the MD continued that accurate 12 month rolling HSMR remained as expected (101.1) and the September in-month HSMR was as expected (104). SHMI remained as expected at 0.9749. An SMR diagnostic outlier was fractured neck of femur (#NoF). However the team was working hard to make improvements in the pathway. The current analysis was that crowding in ED, lack of beds on Tye Green, COVID positive #NOF patients and full trauma lists were all causing significant delays to the treatment of those patients.
4.5	In terms of the Medical Examiner Service, in December 93.9% of MCCDs (medical certificates of cause of death) had been completed (national target 95%). Timely medical examiner scrutiny (seven deaths) was prevented by lack of availability of the ward doctors and Christmas Bank Holidays (a four day weekend).
4.6	In response to the above the CIO stated he agreed with the decision to use freeze rather than flex data. The delays to the data were a national (not Trust) issue.
4.7	As a final point NED-HG added that QSC had been provided with reassurance in terms of the work underway around #NoF and next steps.
4.3 Maternity SI Report	

4.8	This update was presented by the DoN&M and she was pleased to report there had been no serious incidents (SIs) in-month. Page 54 detailed the themes extracted from patient pathways and she was pleased to report that a Maternity Improvement Board had recently been established. She also drew members' attention to the recent reduction in the post-partum haemorrhage (PPH) rate.
4.9	Members had no questions.
4.4 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.10	This update was presented by the DoN&M who updated that the overall staffing risk rating in-month was amber for ED and red for paediatric and maternity staffing. The fill rate for overall RN/RM in month had been 94.7% but the fill rate for healthcare support workers (HCSWs) had dropped from 96.6% in November to 85.7% in December. That was due to a combination of continued vacancies, staff unavailability due to apprenticeship study days and increase in demand of patients identified as requiring enhanced care.
4.11	Data should be viewed in the context of the changing landscape of COVID admissions over the month with associated moving of wards and staff absences in the final ten days of the month. That added difficulty in analysing ward level data and in reflecting changing safest staffing picture over the course of the month. The overall vacancy rate for RNs was 0% and Band 5 -9.4%. HCSW vacancy was 15.5%. The HCSW recruitment pipeline of RN and HCSW remained green.
4.12	The DoN&M informed colleagues that the Resources section of Diligent they would find a paper which had been submitted to WFC in relation to the organisation's view of safer staffing and how it had maintained its staffing base.
4.13	In terms of the CQC section 31 notice for ED, she informed members that the organisation continued to submit its staffing figures to the CQC on a weekly basis (planned versus actual) and there was currently a good level of nursing fill. HCSWs was less so but significant progress had been made with 40 recently appointed including an additional 20 the previous weekend.
4.14	The TC thanked the DoN&M for her update.
4.5 Maternity Establishment Review	
4.15	This update was presented by the DoN&M. She informed members that the Director of Midwifery (DoM) had led the work and the paper had been supported by Senior Management Team (SMT), WFC and Performance & Finance Committee (PAF).
4.16	The DoN&M continued that Birthrate Plus® (BR+) had been commissioned to review the workforce at PAHT and make recommendations on the midwife to birth ratio, based upon the acuity and activity of the service. A midwifery workforce review had also been undertaken by the DoM to ascertain staffing needed in clinical areas. Both reviews had determined that there was a deficit of clinical midwives, maternity support workers and specialist/managerial midwifery posts. Phased over the remainder of the year and 2022/23, it was recommended that £1,049,180 be invested within maternity to maintain safe staffing with external funding received (Ockenden) or expected (MIS) of £1,055,822 against the investment cost.
4.17	NED-HH and NED-GW stated as chairs of WFC and PAF respectively, both Committees had endorsed the paper for Board approval.
4.18	In line with the request, the Board approved the uplift to the midwifery establishment to maintain safe staffing and achieve midwife to birth ratios.
05 PEOPLE	
5.1 Report from Workforce Committee	
5.1	This update was presented by NED-HH and key headlines were as follows: **Guardian of Safe Working:** WFC recognised the issues behind the exception reports were not solved but was confident there were actions in place to address the issues, particularly staffing levels and senior clinical support. **Medical Staffing Workforce Planning:** WFC received assurance on the medical recruitment strategy and local processes to manage the medical establishment within the

	Trust. Further updates would be received on the job planning process and the overall operating plan would be received at PAF. **Voluntary Services:** WFC was assured in terms of the activity of the voluntary services team. Further assurance was required in regards to the progress against the patient experience strategy. **Workforce Report:** It was agreed subsequent reviews/reports on the following topics would be brought back to the WFC; exit interviews, outcome of review of finance vacancy rates, reasons for direct agency bookings and the support framework for redeployment. The Board would be updated on the latest information on VCOD. **Health and Wellbeing:** The Committee had been pleased to note the appointment of a back consultant for MSK conditions.
5.2	In response to a question from NED-HG in relation to any current volunteer vacancies, NED-HH confirmed there was currently no suggestion the organisation was short of volunteers.
5.2 Vaccination as Condition of Deployment (VCOD) for all Healthcare Workers	
5.3	This update was presented by the DoP. As indicated earlier by the CEO, current legislation was going through a period of consultation which would be followed by a vote back in Parliament. During that time the organisation had been advised not to serve notice on any staff. In line with that, work around VCOD had been paused in order to take stock and deal with some specific elements, for example those staff who had already handed in their notice and also in supporting managers who had had to have difficult conversations with staff.
5.4	The DoP continued that more guidance was awaited but the Trust had been clear that it would communicate further with its people once the full guidance had been received and it was working with the ICS to ensure communications were consistent across the system. In terms of current compliance, 96% of staff had received their first vaccination and 92.3% had received their second.
5.5	The TC thanked the DoP for her update and stated it would be important to keep on top of the guidance because the issue was having an impact on staff morale.
5.6	In response to the above Associate NED John Keddie (ANED-JK) acknowledged the current position but stated it would be important at a future meeting to discuss whether the pressure should be maintained on staff to have the vaccination in order to reach 100% compliance. In response the DoP stated her view would be to await the outcome of the consultation and take stock then. The current focus would be on supporting individuals.
5.7	The TC stated that the organisation would need to commit to its obligation to keep staff and patients as safe as possible. The debate would be how to maintain that position moving forward. The CEO agreed and that the SHaW team would continue to support those who were not vaccinated to understand the benefits and support their concerns so that an informed decision could be made.
5.8	ANED-AWS asked whether the organisation should start to consider the scenario where a patient did not want to be treated by an unvaccinated staff member. In response the CEO stated that the focus was on trying to minimise the spread of infection so to maintain a stance on IPC policies. Staff would still be encouraged to work from home where possible and to wear fluid resistant masks on site. There were a number of elements to work through.
5.9	In response to the above the TC stated it would be helpful to have a report (via QSC) on how to maintain patient safety moving forward. NED-JH stated that report should be presented by the DIPC. 100% vaccination would not prevent the spread of COVID. In response the DoN&M reminded colleagues that QSC had received an update from the DIPC on the Trust's position against the ten key actions from national learning. That would continue to be presented and fundamentally came back to the basics of 'hands, face, space, ventilation and testing' so QSC would continue to be updated on that.
ACTION **TB1.03.02.22/17**	**QSC to continue to be updated on how patient safety was being maintained in terms of COVID.** **Lead: Director of Nursing & Midwifery**

5.10	The TC thanked colleagues for their update, noted the current position in terms of VCOD and that an update/progress on keeping patients safe (in relation to COVID) would continue to be presented to QSC.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee	
6.1	This update was presented by NED George Wood (NED-GW). Key highlights were as follows: **Cost Improvement Plan (CIP):** A more detailed plan would be presented in February to provide assurance that robust plans were in place for the coming year. **104 week waiting list:** The organisation was on track to clear those patients by the end of the financial year. **Surgery Deep Dive**: Despite recent challenges, the team was committed to achieving more efficiencies in theatres and to reducing the backlog of cases. He would encourage colleagues to read the team's presentation which was in the Board Resources area of Diligent.
6.2 Integrated Performance Report	
6.2	This update was presented by the Chief Information Officer (CIO). Key headlines under the organisation's 5Ps were as follows: **Patients:** Three bacteraemias had been reported in the last rolling 12 month period. A root cause analysis (RCA) was underway for the December case with the expected focus to be on the management and documentation of intravenous devices. Planned Caesarean sections had been above the mean for seven months and in special cause variation (SCV). Work to improve the pathway was underway and included the plan to appoint a midwife consultant.
6.3	In response to the above the DoN&M commented that MRSA bacteraemias were unusual in the organisation and may link to the recent complexities of PPE/COVID. Work would continue in terms of the RCA.
6.4	**Pounds:** At M9 the organisation had achieved year to date break-even but only £1.92m of CIP savings against a plan of £4.65m. Capital spend was on trajectory and the Trust anticipated achieving its capital resource limit (CRL). Cash balances continued to remain healthy. The DoF added that additional capital had been received in the sum of £4.5m to be spent by the end of March. She was confident that plans in place would deliver on that.
6.5	**Places:** Catering food waste remained below the national target and the team were looking at developing KPIs in terms of the Green Plan.
6.6	**People:** Appraisal performance had been constant up to October but progression had regressed since November, most likely down to COVID and staff sickness. Statutory/mandatory training compliance remained at 87%, below the target of 90%. There had been a small reduction in sickness absence in December, compared to the previous two months.
6.7	**Performance:** **RTT/52 week waits:** Given the current conditions in terms of COVID, a further deterioration was expected in terms of performance. Patients were being treated in clinical priority. **Cancer:** There had been an upturn in two week wait performance and significant media coverage had led to an increase in referrals. Performance was however still in SCV. **ED 4 Hour Standard:** There had been some improvement in some of the KPIs (triage and decision to admit) and some minor improvements in terms of ambulance handovers. Bed occupancy still remained high and the focus remained on discharge. **Diagnostics:** Performance was consistent with a focus on booking the longest waiting patients.
6.8	In response to the above the COO added that in terms of the cancer two week wait, there was some additional support for Dermatology so the team was on track. There was also some support for Urology from the Intensive Support Team. In terms of 104 week waiters,

	PAF had been advised that as of that day there were now only 46 to be seen before the end of the March, reduced from 94.
6.9	The COO continued that in terms of elective bed capacity the team was working hard to be as flexible as possible. Elective beds were now back up to 17 and the Surgery division was on track to have their Orthopaedic 'clean ward' back by the end of February.
6.10	In terms of discharge, the organisation was one of 14 organisations selected to work with the national team around discharge opportunities. There would be a site visit by the national team on 18.02.22 to support that work.
6.11	The CIO said he would be happy to walk new colleagues through the IPR outside the meeting.
6.12	In response to a question from NED-CM, the CIO was able to confirm that in terms of the Green Plan, some KPIs would be developed to understand what to measure and what success looked like.
6.13	NED-HG then drew members' attention to Appendix B – Quality Improvement Plan, and asked whether the updates should have the same colour coding as the system (red, amber, green). She felt that would link with the updates to QSC. In response the CIO agreed and to provide that for the next iteration.
ACTION TB1.03.02.22/18	**Update on the Quality Improvement Plan in the IPR to use the same rating as the system (red, amber, green). Lead: Chief Information Officer**
6.14	The CIO then informed colleagues that Appendix C was an Urgent Care deep dive which he would take colleagues through.
6.15	In terms of the current position the organisation had not been able to meet the four hour standard for a significant period of time, and since May 2021 there had been a gradual reduction in performance against the standard. That was driven by a number of factors: Delays in ambulance offloads, increased delays in time to triage, increased delays in waits for specialty review from time of referral and more than a doubling of patients waiting more than 12 hours from arrival over last six months. The end of lockdown had precipitated a significant increase in attendances, higher than at any time over the last five years, impacting on the organisation's performance against the standard. A similar correlation to overall performance for the four hour standard was mirrored in non-admitted performance.
6.16	Unsurprisingly, as the proportion of patients offloaded within 15 minutes reduced, that had been mirrored in the proportion of patients waiting over an hour to be offloaded. In terms of the breakdown of patient by time period, the gradual reduction of patients in the department less than four hours was understandably consistent. However, it meant a significant increase in patients waiting over 12 hours in the department (nearly double in four months), and those waiting between four and six hours).
6.17	In terms of bed occupancy there had been a gradual increase in length of stay, stranded and super stranded patients. However, none of those increases had been significant, and none were in SCV. Whilst overall occupancy was in SCV it was consistent with occupancy levels generally experienced prior to the first COVID wave in March 2020. If bed occupancy was a key driver to delivery of the four hour standard, the expectation would have been to see more of a direct correlation, i.e. the consistent downward trend of four hour standard performance set against a consistent upward trend of bed occupancy. That correlation was not evidenced
6.18	In terms of benchmarking with peers, attendances and admissions had followed a consistent trend with peers over the last 18 months. However, performance against the four hour standard had not been as consistent.
6.19	In terms of trajectories, based on the average daily attendances seen between 01.11.21 and 31.12.21, if performance continued on trajectory for the UTC to see 70% of patients by mid-February and performance for UTC remained the same (which had been the case so far) and ED 4 hour performance remained as was, the organisation should see a positive impact on overall four hour performance – reaching almost 83% by mid-February.
6.20	In response to the above West Essex GP Amik Aneja (GP-AA) asked about the UTC and the number of patients attending there. In response the COO stated that it would be necessary to manage attendances at the UTC as it could be seen as being more accessible but steps

	would be taken to educate the public and redirecting patients back to the right location. Plans were underway to increase the number of pre-booked appointments to the UTC to allocate dedicated time. Future plans for the UTC would focus on developing the service further to support primary care and the hospital into the future.
6.21	GP-AA stated he was pleased to hear about the intended increase in terms of pre-booked appointments and plans for two-way texting. The NHS 111 service also supported the demand.
6.22	In line with the recommendation the Board noted the current position and the further actions underway to address the areas below standard.
6.3 Trust's Response to HSE	
6.23	This update was presented by the COO who reminded colleagues of the planned inspection by the HSE which had taken place in October 2021. There had been a small number of recommendations following that visit and the team had worked hard to complete the timeline and actions. The letter presented that day was a working draft prior to final submission the following week. The organisation had met all the recommendations and provided the requisite evidence – all of which had been submitted by the deadline of 31.01.22.
6.4 Electronic Health Record Update	
6.24	This paper was introduced by the CIO and provided confirmation of the process the organisation had been through to develop its OBC and the concerns that had been raised internally and externally around the limitations of the current system and associated BAF risk.
6.25	A huge amount of work had gone into the OBC which had been approved verbally by national colleagues on 17.01.22. Formal written approval was now awaited to proceed to full business case (FBC). The next step, following approval by the Board later that day, would be to go out to procurement with a go-live for the new system anticipated in 2024.
6.26	The TC thanked the CIO, DoF and teams for all their hard work which had led to a great step forward for the organisation.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee	
7.1	NED-JH reminded colleagues the new Strategic Transformation Committee (STC) had been established in line with the recommendations in the Deloitte report. The Committee had inherited the goals of PAHT2030 and new hospital, both of which already had strategies in place which now required some firm timelines. The plan going forward would be to concentrate on the implementation timelines and where off trajectory, to review the strategy itself.
7.2	The DoS stated that he agreed with the above but added that the STC should also be doing some horizon-scanning and to escalate to the Board where changes to strategies were required, forced by changes to the landscape.
7.3	In response the CEO stated the STC had two functions: 1) to track progression and implementation of PAHT2030 (with clear plans and KPIs now required) and 2) the strategies that had been agreed currently were aligned but that could change in coming months so the organisation would need to be agile in terms of reshaping those if and where required.
7.4	NED-HG stated that the emphasis for her would be on the difference between what the STC was involved with and what the Board was involved with and whether the Board had responsibility for strategy.
7.5	In response to a question from NED-CM it was confirmed the membership of STC was made up of various Executives with the Lead Executives being the DoQI/DoS, three NEDs and a couple of other senior staff members. Some primary care representation had been muted.
7.6	In response to a question from NED-HH it was confirmed that individual strategies such as Workforce or Quality and Patient Safety would still be overseen by current individual committees. The STC would then take a view on how they all fitted together and whether or not they aligned to PAHT2030.

7.7	NED-GW asked how issues such as increased ED attendances due to lack of GP appointments would fit with the STC. In response NED-JH confirmed the STC had a system transformation element to its terms of reference. The DoQI added that he had presented some significant detail on the work-streams to the STC and progress was being made in terms of alleviating the pressures with buy-in from clinical leaders in primary care and the primary care networks. Collaborative work (primary and secondary care) would need to continue to sustain the progress.
7.8	NED-JH thanked colleagues for a helpful discussion. It was important to understand clearly the committee's remit. .
7.2 Report from Senior Management Team	
7.9	This paper was for noting and members had no comments.
08 QUESTIONS FROM THE PUBLIC	
8.1	At this point the TC handed over to member of the public Alan Leverett (AL) who had submitted some questions the previous day by email. As a first point, AL congratulated GP-AA in terms of his GP practice in Old Harlow which was one of the best run in the town. AL then stated that his view was that the organisation was not communicating sufficiently with the public in terms of the new hospital. He also suggested that for those older members of the public, social media was not always the best way to provide such communication. He then asked, in terms of the levelling-up announcement the previous day, whether the town would receive a new hospital, and had the associated funding been agreed.
8.2	In response the CEO provided assurance that work was still underway to design and build a new hospital on the greenfield site at the new junction 7A of the M11 motorway. The approval of the national NHP business case was awaited in order for the organisation to understand its timeframe around the build and the funding allocation so that the plans could be developed. The organisation was committed and had undertaken a huge amount of engagement with the public albeit for the previous four to five months there had been little to communicate out to the population. As soon as the outcome of the national NHP business case was known, the team would be back to work and engaging with the public.
8.3	As further assurance the Director of Strategy (DoS) confirmed that the new hospital website had been updated and a new website launched (newpah.org). He continued that every single drawing, design and component had been agreed in conjunction with staff and signed off by staff and the Patient Panel. There had been 125k views on the website and 500 responses to the engagement event. As mentioned earlier the Trust was working closely with the national NHP to drive the benefits for all 48 new hospitals in the programme. In response to two further points raised by AL, it was agreed to close the old microsite and to communicate out to the public that there was a new site.
ACTION **TB1.03.02.22/19**	**Close the previous new hospital microsite and communicate out to the public the details of the new microsite.** **Lead: Director of Strategy**
8.4	As a final point the TC informed members that the Head of Corporate Affairs (HoCA) was currently in discussion with Harlow Council colleagues (thanks to ANED-JK) in terms of the possible use of a facility there for the Trust to hold its Board meetings in public. She would keep colleagues updated.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These were listed as: • Undertake a workshop on risk. The Board had noted: • And agreed the funding for the maternity establishment review. • The current position on VCOD. • The response to the HSE. • The update on EHR and the next steps to procurement/FBC (if approved).

	• The discussion around the remit of the STC and the relationships with primary care and the community. • The very positive feedback on GP-AA's GP practice.
9.2 New Issues/Risks	
9.2	No new risks/issues were identified.
9.3 Any Other Business (AOB)	
9.3	There were no items of AOB.
9.4 Reflection on Meeting	
9.4	In response to a question from the TC, members nodded their agreement that the meeting had considered patient safety and quality and there had been evidence of good governance.
9.5	ANED-JK stated his reflection would be that for the public, there had been too much depth and detail and colleagues should consider what and how it imparted information to enable greater participation. In response AL agreed and that the use of acronyms in particular was frustrating. The TC agreed that would be addressed.
ACTION **TB1.03.02.22/20**	**Address the use of acronyms at Public Board meetings.** **Lead: Trust Chair/Head of Corporate Affairs**
9.6	In response to a question from NED-HH the CEO confirmed that key headlines from the public session were communicated out to staff the following day. The TC suggested that an email could be circulated more widely to the community.
ACTION **TB1.03.02.22/21**	**Consider circulating Public Board headlines to the wider community, not just staff.** **Lead: CEO**
9.7	ANED-LB stated her reflection would be agreement in terms of the use of acronyms (a glossary would be useful) and that a suggestion would be for the public to join at the start of the session for a summary of the key points at which point they could make a decision whether or not to stay for the detail which would be provided during the course of the meeting.
9.8	NEC-CM stated his reflection would be there had been a good level of analysis and the detail in the papers was huge. His view would be that more of a summary was required or a dashboard with a view of the targets and benchmarks. He also agreed with the view on the use of acronyms.
9.9	AL suggested that the Board headlines could be circulated to the public via Your Harlow and there was a similar publication for Hertfordshire. The local authority council in Harlow also ran a quarterly newsletter. The TC thanked him and acknowledged there were some items there to be actioned by herself and the Head of Corporate Affairs.
9.10	The meeting closed at 12:41.

Signed as a correct record of the meeting:	
Date:	07.04.22
Signature:	
Name:	Hattie Llewelyn-Davis
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 07.04.22

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	Defer to May when the dashboard will be ready.	Open
TB1.03.02.22/15	Thanks to Staff Health & Wellbeing Team	Board thanks to be conveyed to Staff Health & Wellbeing colleagues for their efforts during COVID.	DoP	TB1.07.04.22	Actioned.	Closed
TB1.03.02.22/16	Risk Workshop	Lead a Board workshop on risk.	MD	TB1.07.04.22	To be scheduled for June 22 (with a draft to May Board).	Proposed for closure
TB1.03.02.22/17	COVID: Patient Safety	QSC to continue to be updated on how patient safety was being maintained in terms of COVID.	DoN&M	TB1.07.04.22	Update on the 10 key actions re Covid added to the IPC report to QSC.	Closed
TB1.03.02.22/18	QIP RAG	Update the Quality Improvement Plan in the IPR to use the same rating as the system (red, amber, green).	CIO	TB1.07.04.22	Addressed at item 6.2.	Closed

ACTION LOG: Trust Board (Public) 07.04.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.03.02.22/19	New Hospital Micro-site	Close the previous new hospital microsite and communicate out to the public the details of the new microsite.	DoS	TB1.07.04.22	The new website can be accessed via the Trust's own home page or by using the new URL. If the old URL is used it will be redirected to the new website. Social posts have been scheduled highlighting the new site and the latest blogs that have recently been posted. InTouch articles have been published pointing staff to the new site.	Proposed for closure
TB1.03.02.22/20	Acronyms	Address the use of acronyms at Public Board meetings.	TC/HoCA	TB1.07.04.22	Glossary established and ready for April Board.	Closed
TB1.03.02.22/21	Board Headlines	Consider circulating Public Board headlines to the wider community, not just staff.	CEO	TB1.07.04.22	Agreement for communications to be circulated out to the wider community via social media after each Board meeting.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors 7th April 2022.

Agenda item:	2.1
Presented by:	Hattie Llewelyn-Davies
Prepared by:	Hattie Llewelyn-Davies
Date prepared:	21 March 2022
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 and colleagues 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. Board members are asked to note the considerations for NHS foundation trusts and trusts in the pre-election period or 'purdah' leading up to the 2022 local government elections.

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:	Pressure on our services links to the BAF risks: Risk 1.0 Covid and 4.2 Emergency Department
Legislation, regulatory, equality, diversity and dignity implications:	The Board development programme is part of work on the Well Led framework and so directly linked to regulation. EDI and Dignity were a significant part of the workshop on Whistle blowing.
Appendices:	None

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

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

The aim of this 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

The Board agreed that the first priorities for me as the New Chair of PAHT would be:

- To learn more about the Trust, and the system and region in which we work.
- To work with the whole board to progress the recommendations coming from the reviews that the Trust has had over the last six months, including the recent CQC Review.
- To work with colleagues to lead the work arising from the Well Led Review undertaken by the consultants, Deloitte and strengthen our governance as a consequence.

George Wood as the Trust's Senior Independent Director is in the process of gathering feedback on my first six months in post as part of my annual appraisal, to enable us to set new objectives for the financial year. These will be reported back to the board as soon as they are agreed.

3.0 Issues Covered:

Demand on our services:

It is hard to turn on the TV, look at a news website or open a paper without realising the pressure the NHS is under. PAHT has been no exception. During March we have seen one third more patients arriving in our Emergency Department than we would have seen two years ago. This has led to long waits for patients, delays in admitting the sickest to a bed and delays for our colleagues in East Anglian Ambulance Services. Our colleagues throughout the Trust and our partners have worked incredibly hard to manage this extraordinary pressure and on behalf of the board, I would like to say how proud we are of them all and to offer each of them a massive thank you.

Opening of the Alex Lounge:

Following feedback from Staff just over the year ago the board agreed that providing high quality space for our staff to rest and recuperate as part of their working lives was a priority for the organisation. I was very pleased that together with Lance McCarthy and Michael Meredith, we were able to formally open what is now known as the Alex Lounge on a very sunny day two weeks ago. Staff feedback has been very positive, and they have appreciated the commitment to them in providing a really high quality are for everyone to use. There is also some very high-quality agile working spaces on the first floor for any staff members to use when they are working on site. The Board owes a very big thank you to Michael's team for all their work in providing a really great building.

Board Development:

Following on from the Well Led Review last year, the Board continues to engage with a development programme to build our skills and ability to lead the Trust.

In the last two months we have had a session on Whistleblowing, Freedom to Speak Up and reviewed the issues that arose from the Independent review in West Suffolk Foundation Trust. We have also had a development session on effective chairing of meetings provided by NHS Providers, to ensure that we develop a consistent style across the board and its committees. Both sessions have been very valuable and have also given us a chance to get to know our three newest board members outside the formal meetings.

A further session is planned to develop our team working in May.

The Board has also adopted a new system of reporting back from the committees and has adjusted the board agenda as a consequence. This will enable us to increase the assurance provided to the board and improve our governance.

Integrated Care System/Board:

The Non-Executive Members of the Integrated Care Board have been appointed and one of our NEDs, Helen Glenister was on the final interview panel. My thanks to Helen for undertaking this role for us.

It is also my pleasure to record that George Wood has been appointed as the Chair of the Audit Committee and NED for the Mid Essex ICB.

Board appointments:

I am very pleased to be able to announce that Dr. Rob Gerlis has agreed to become an Associate Non-Executive Director on our Board, following an invitation from the Remuneration and Nominations Committee. He will take up this post on 4 April 2022 for a period of two years. This appointment will enable us to build on the significant contribution given to us by Dr Amik Aneja over the last few years. On behalf of all the board I would like to record our thanks to Amik for his time with us, his support has helped to shape our work in establishing a strong “Place” for our local population. Rob will continue this work and will be invaluable to us in helping us to develop new ways of working within our Integrated Care System.

Local government elections:

I have attached guidance from NHS Providers setting out considerations for NHS foundation trusts and trusts in the period of time known as the pre-election period or ‘purdah’ leading up to the 2022 local government elections. We have taken this guidance into consideration when planning the agenda for today’s Board meeting.

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 March 2022

March 2022

2.1

2022 local elections: considerations for NHS providers

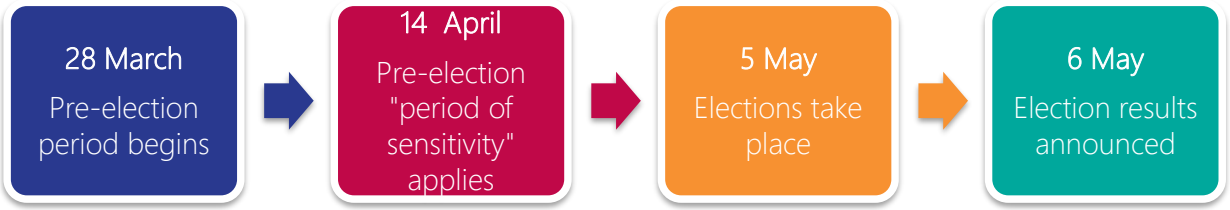
This briefing sets out considerations for NHS foundation trusts and trusts in the period of time known as the pre-election period or 'purdah' leading up to the 2022 local government elections. It highlights the practical implications around providers' activities, including in relation to integrated care systems (ICSs), and with regard to communication during the pre-election period. It also covers the requirements on central and local government, the civil service and arm's length bodies during the pre-election period to maintain political impartiality in carrying out their public duties and ensuring that public resources are not used for the purposes of political parties or campaign groups.

Should you have any questions, please contact John Coutts (john.coutts@nhsproviders.org) if your query relates organisational governance or foundation trust governors, or Kerry Racher (kerry.racher@nhsproviders.org) for all other queries.

1) Elections taking place in May 2022

Local government elections on 5 May will only take place in certain areas of the country. Details of local authorities holding elections this year can be accessed here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792138/Election_Timetable_in_England_2019.pdf

2) Local election timetable



3) What is the pre-election period?

The term 'pre-election period' is used across central and local government to describe the period of time immediately before elections or a referendum when specific restrictions on the activity of civil servants and local government officials, where appropriate, are in place. This period prevents announcements from and activities by public bodies which could influence or be seen to influence the election. The term 'purdah' is also sometimes used to describe this time.

4) When does the pre-election commence?

The pre-election period applies to local authorities from the local publication of the notice of election; this must take place by 28 March 2022 at the latest. There is then a "period of sensitivity" that applies to the national government in the three weeks leading up to the local elections, that is, from 14 April.

5) Rules and regulations during the pre-election period

The behaviour of central government, elected officials, civil servants and arm's length bodies during the pre-election period is governed by the:

- Local Government Act 1986[1]
- 2011 Code Recommended Practice on Local Authority Publicity[2]
- Cabinet Office guidance on conduct for civil servants[3]

Details of how these are applied are set out below.

Local authorities

Although the ordinary functions of councils should continue during the pre-election period, some restrictions do apply, by law, to all councillors and officers. The restrictions on local government during the pre-election period are governed by Section 2 of the Local Government Act 1986.[1] Under these restrictions, councils should "not publish any material which, in whole or in part, appears to be designed to affect public support for a political party".

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[1] Local Government Act 1986. Available at: http://www.legislation.gov.uk/ukpga/1986/10/section/2

[2] Recommended code of practice for local authority publicity (2011). Available at: https://www.gov.uk/government/publications/recommended-code-of-practice-for-local-authority-publicity

[3] Cabinet Office: Election guidance for civil servants https://www.gov.uk/government/publications/election-guidance-for-civil-servants/may-2022-elections-guidance-on-conduct-for-civil-servants-html

The 2011 Code of Recommended Practice on Local Authority Publicity[2] provides guidance for local government on communications during the pre-election period. It recommends that all communication is: lawful; cost effective; objective; even-handed, appropriate; has regard to equality and diversity; and, issued with care during periods of heightened sensitivity.

Central government, civil servants and arm's length bodies

As the UK government will remain in office following the 2019 local elections, and European Parliament elections, government ministers will continue to carry out their functions as usual and civil servants will continue to support ministers in their work.

However, a "period of sensitivity" applies from three weeks prior to the local government elections and will continue to the European Parliament elections; this will commence on 11 April 2019. To support civil servants in UK government departments and the staff and members of non-departmental public bodies and arm's length bodies during the pre-election period and the period of sensitivity in particular, the Cabinet Office has issued specific guidance.[3] This sets out the principles of maintaining the political impartiality of the civil service and ensuring that public resources are not used for party political purposes.

How does the NHS fit in to these elections?

The delivery of public services in partnership with NHS bodies, and the delivery of public health and social care services by local authorities, will often sit at the heart local debate. As such, it is important that NHS providers follow the custom and practice of the pre-election period to avoid any impression of influencing the local election process or its outcomes.

6) Practical considerations for NHS foundation trusts and trusts during the pre-election period

a) Key principles

- No activity should be undertaken which could be considered politically controversial or influential, which could compete for public attention or which could be identified with a party / candidate / designated campaign group.
- Would you do the same for everyone? NHS trusts have discretion in their approach, but must be able to demonstrate the same approach for every political party, official candidate and designated campaign groups in order to:
  - avoid allegations of bias or pre-judging the electorate

  - ensure you will be able to form a constructive relationship with whoever wins the seat
- The NHS may be under the media spotlight, locally and nationally. It is advisable to have a plan in place for:
  - how the organisation will manage the pre-election periods (with both its risks and its opportunities)
  - the potential for the organisation or its partners to be singled out in the media

b) Board meetings and normal regulation

Normal business and regulation needs to continue during the pre-election period. NHS England and NHS Improvement, for example, are not expected to alter the dates on which it expects information from providers. Where a board discussion or sign off is required, there is no problem with holding a board meeting.

Where board meetings need to take place, the agenda should be confined to those matters that need a board decision or require board oversight. Matters of future strategy or the future deployment of resources may be construed as favouring one party over another and should be avoided.

Use of the confidential part or part 2 of the agenda to discuss matters that may be politically controversial is not recommended. Such matters should be deferred until after the pre-election periods.

c) Publishing information and making announcements

Care should be taken not to comment on the policies of political parties or campaign groups and websites should not be updated with any information that may be considered political. The rule of thumb should be that communications activities necessary for patient safety, quality and operational delivery purposes should continue as normal, but any other activity beyond that and not required in the pre-election period should wait until after the election.

Wherever possible, information to be published about the organisation should be factual and released in advance of the pre-election period commencing. After the pre-election period begins, requests for new information are best handled by applying FOI rules.

Organisations should not start long-term initiatives or undertake major publicity campaigns unless time critical (such as a public health emergency) and should instead wait until after the election. Unless strictly necessary, high-level public sector appointments should not be made.

Public consultations should not be launched during the pre-election period. Those already in progress should continue, but it is advisable to extend the period to take account of the pre-election period and avoid public meetings and publicity. Responses received should not be commented on and no announcements should be made until after local government elections.

We would only expect civil servants to release data (such as the regulator publishing trusts' financial returns) when a precise publication date has been pre-announced.

d) Individual NHS providers under the media spotlight

The profile of the NHS – already under intense scrutiny – will increase further as an issue of public, political and media debate during the pre-election period. In particular, it is anticipated that there will be a significant focus on proposals for local service reconfiguration. Each political party will be keen to demonstrate its support for the NHS, and the threat posed by its opponents. At times during local and national campaigning, the NHS will become the issue of the day – the focus may be on a particular issue, place, policy, individual or incident. In this context, it is likely that the depth of debate about particular local instances will be lessened and potentially used as an example of a particular issue facing the NHS nationally.

Any issues that can be predicted to be of interest during the campaign should be prepared for, with relevant information available and agreed spokespeople and lines. Where possible, it is usually easiest to use information for public comment that is already publicly available and can be readily referred to.

Where affected, we would advise that trusts remain neutral, refraining from any commentary and providing only factual information where necessary. Normal patient confidentiality rules apply. It is also worth considering which local and national stakeholders it would be helpful to share information with (both in advance and in the event of any issues arising) in the local health economy and other NHS and regulatory organisations.

e) Political visits and engagement

The Cabinet Office guidance on the pre-election period during local government elections offers specific advice relevant to NHS trusts and foundation trusts in respect of visits. *"Particular care"* should be taken with respect to proposed visits to areas holding elections. Official support must not be given to visits and events with a party political or campaigning purpose.

Use of NHS property for *"electioneering purposes"* is a decision for the relevant NHS body to make, *"but should visits be permitted to, for example, hospitals, it should be on the basis that there is no disruption to services and that the same facilities are available to all candidates. Care should also be taken to avoid any intrusion into the lives of individuals using the services."*[3]

As such, an NHS provider has the discretion to decide whether or not to allow visits by politicians during a local election campaign. When considering whether to host a visit, safety and operational considerations must come first and guidance states that campaign visits should not disrupt services or care[3].

In addition, the same approach must be applied to all requests from all official candidates and political parties, irrespective of their size. All requests from candidates to visit may be declined, but if they are allowed, then all requests should be accepted. If you do not plan to permit any campaign visits, it is worth considering formally advising all candidates and campaign groups in advance at the same time to ensure clear and consistent understanding.

Organisations may wish to engage with the prospective councillors in relevant wards whilst care should be taken to ensure that current councillors are not treated any differently. Again, we would recommend that all candidates and campaign groups are treated in the same way and any invitations or opportunities for engagement are extended to all parties. For example, if one party or campaign group makes an announcement on site, it would be advisable to ensure that all parties do so.

f) Foundation trust governor elections

In law, there is nothing to prevent foundation trust governor elections from taking place during the pre-election period. In practice however, it is best to avoid holding governor elections during this period.

Providers should avoid activities that may be seen to favour one political party or another, and given that foundation trusts have no control over what governors may say in their election statements, at

hustings or elsewhere they cannot guarantee a politically neutral outcome. What might be deemed to be party political can be quite broad – outsourcing, for example, might be associated more with one party that with others. Similarly, while governor elections have for the most part not become party political events there is nothing in law to prevent them from becoming so.

Our best advice therefore is not to hold governor elections during the pre-election period. However if elections are already underway and there is no sensible opportunity to put the election 'on hold' we would suggest that they continue. In those circumstances organisations will need to ensure that candidates do nothing that could be construed as politically biased. If candidates for governor elections are also standing for election as a councillor it will not be feasible to proceed with governor elections.

For further information relating to governor elections please contact John Coutts, governance advisor: john.coutts@nhsproviders.org.

g) Activism onsite or by individual staff or governors

NHS employees and FT governors are free to undertake political activism and public debate in a personal capacity. They should, however, avoid involving their organisation or creating any impression of their organisation's involvement. They are not permitted to use any official premises, equipment (including uniforms) or information they would only have access to through their work and which is not publicly available. Naturally, patient confidentiality must be preserved at all times and normal professional conduct and contractual rules apply as usual in this respect.

Especially given the prevalence of social media and the balancing act people perform in presenting their personal and professional lives and views, it becomes easier to blur or mistake the capacity within which individuals are contributing online. At all times every effort should be made to preserve public professional neutrality while not inhibiting personal activity.

h) Voter registration, postal votes and proxy votes

It might be helpful to advise staff on the trust's provisions for postal and proxy voting to support those – both staff, patients, service users and their families – who may not be able to go to their polling station on the day. National advice is available here: https://www.gov.uk/register-to-vote.

We would advise that **NHS staff and trusts should not undertake any voter registration or proxy or postal voting activity for those in their care** to avoid any possible concern being raised about inappropriate influence.

i) Trade union activities and engagement

Trade unions may be active during the election campaigning on issues concerning their members. All organisations will have existing relationships, channels and protocols for working effectively with trade unions and these should be used as normal. Nevertheless, given the importance of NHS organisations preserving their neutrality, it is worth considering **itemising the local elections and referendum for discussion at an imminent meeting**.

7) Sharing this briefing within your organisation

We suggest trusts share this briefing and/or its specific pre-election planning with all staff and stakeholders who might find it useful to be aware of the steps you are taking.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 7 April 2022

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	31.03.22							
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 and current pressures - Ockenden Review - Staff survey - New hospital - Operating Plan 2022/23 - Integrated Care System and Board developments - Consultant appointments - This is Us *In Action*							
Recommendation:	The Trust Board is asked to note the CEO report; note the progress made on key items and to ratify the offer of a consultant appointment, made through delegated authority to an AAC.							

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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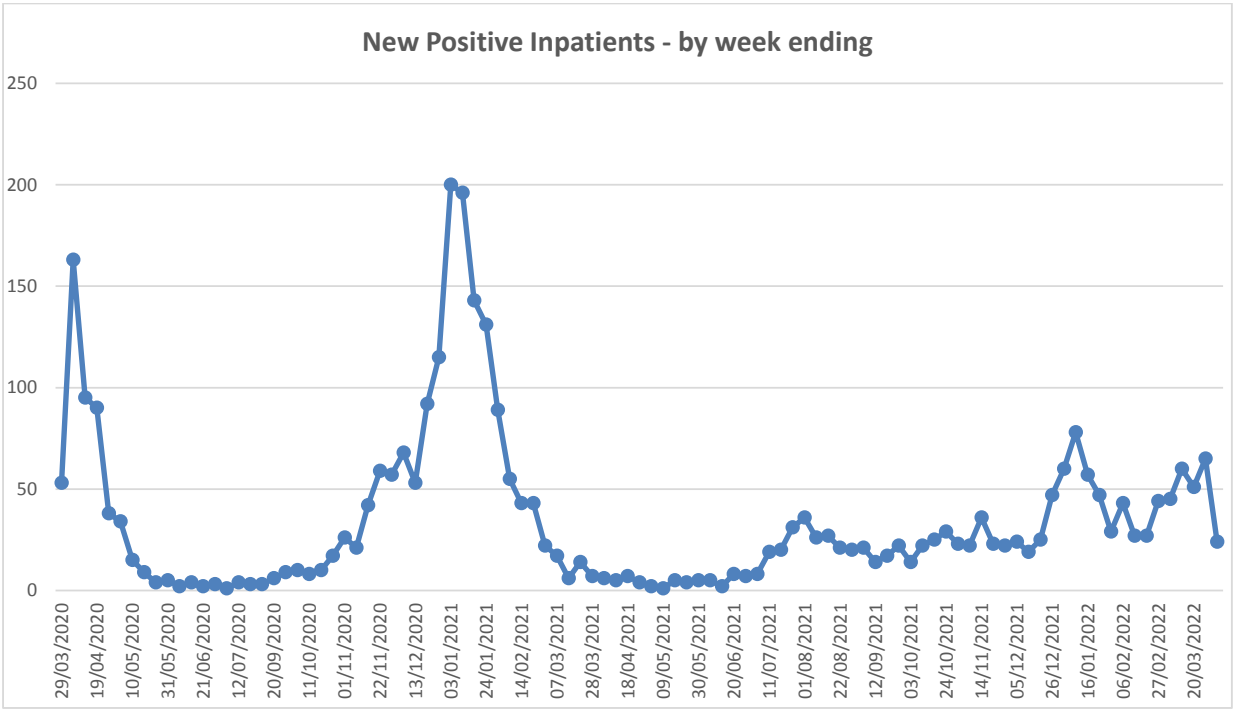
Chief Executive's Report
Trust Board: Part I – 7 April 2022

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

(1) COVID-19 and current pressures

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 current 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 the number of new infections in our local community continue to remain high, impacting on hospital inpatient admissions as a result. New COVID-19 positive inpatient numbers by week for the last 2 years is shown in the graph below.



The proportion of COVID-19 positive inpatients requiring critical care support however remains much lower than in the first two waves as a result of the vaccination programme and the less severe illness from the recent variants. At the time of writing the paper there were 64 COVID-19 positive inpatients in the Trust, of which 2 were receiving critical care support.

This volume of COVID-19 activity, the management of these patients separately from non-COVID-19 patients and the high levels of infections in the local community are putting considerable strain on service provision and colleague sickness levels. We currently have an absence rate of 7.5% across all staff groups with approximately 40% of this due to COVID-19. This is affecting our ability to recover our non-COVID-19 services at the rate that we would wish, although all our teams are continuing to work well to support our recovery and as of 31 March we had 4 patients who had been waiting for

longer than 104 weeks for their elective procedure, all as a result of not being fit enough to have their procedure due to COVID-19.

We are continuing to work closely with ICS 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. Despite the pressures, most of our diagnostic activity and our outpatient activity is now greater than pre-pandemic levels, and we are recovering our performance against the cancer access targets well.

The pressures outlined above are being further exacerbated by the unprecedented and sustained demand that we are seeing for our urgent and emergency care (UEC) services. Pre-pandemic weekly attendances for UEC were averaging 2,120. For the first 3 months of 2022, we have been averaging 2,613, a 23% increase. We are also seeing increasing variability in daily attendance numbers ranging from 273 to 495 (during March), making the management and coordination of care challenging. We have seen our ambulance handover delays increase and our performance against the 4-hour standard remain lower than we would like for our patients, mainly in the mid-60%s.

More detail on both recovery and UEC activity and performance is available in the Integrated Performance Report.

As we move to living with COVID-19, new guidance is being issued in regard to the management of patients. On 30 March, updated national testing guidance was received in relation to the testing of patients, visitors and colleagues, the key changes being:

- Asymptomatic patient testing on days 3 and 5 to be undertaken by LFD rather than PCR
- Remove testing of visitors to the sites
- Planned elective patients to be tested using LFDs ordered from the government website in advance of admission
- Asymptomatic colleagues to continue to undertake LFDs at least twice per week and self-isolate is positive but can continue to work with a household contact provided they remain asymptomatic and LFD negative.

Our Infection Prevention and Control cell, as part of the incident management response governance structure to manage COVID-19, will formally review the new testing guidance on 4 April and make recommendations to the Strategic Cell for ratification.

The spring booster programme for those aged 75+, immunocompromised and care home residents starts in w/b 4 April, with a decision on healthcare workers still to be made.

We continue to maintain high levels of vigilance within the hospital settings including strong compliance with the NHS 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.

As discussed at previous Board meetings, the impact of the pandemic and the pressures and anxieties experienced by colleagues over the last 2 years cannot be underestimated, exacerbated by the increased rate of sickness absence and reduction in fill rates for shifts compounding the pressures on colleagues.

(2) Ockenden Review

The final report of the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, undertaken by Donna Ockenden was published on 30 March 2022.

It builds on the first report, published in December 2020 and on the actions for learning and immediate essential actions that were recommended in this report, for all maternity units across the country.

It is imperative that we ensure that we take all of the learning from the review and implement the 15 national action points (90 actions in total) locally at PAHT to ensure the best quality care for our women and babies.

Our Family and Women's' Divisional triumvirate will ensure that the report is discussed with all colleagues in the maternity service and clear actions and timeframes are put in place. We will track progress through these through the performance and quality governance structure and provide assurance to the Maternity Oversight section of the Quality and Safety Board Committee.

More detail on the review and the report is provided in the relevant agenda item later.

(3) Staff survey

The outcomes and results of the latest national annual NHS staff survey were published on 30 March.

Overall, the results for PAHT in terms of what our colleagues have said, continue to be low in absolute and relative terms, when compared to other acute Trusts in the country.

Unsurprisingly the impact of the COVID-19 pandemic has had a negative impact on how colleagues' experiences of working here, a picture that is replicated across the whole of the country, and something that we will continue to work hard with colleagues to improve.

There are some areas of positivity within the survey results that we can build upon, and these will be picked up through the implementation of our culture workstream as part of our PAHT 2030 strategy to better support all colleagues.

More information on our staff survey and the next steps is provided in the relevant agenda item later.

(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 and the approval of the NHP National Programme Business Case by HM Treasury. 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.

(5) Operating Plan for 2022/23

The NHS Operational Planning Guidance for 2022/23 was issued on 24 December 2021. Our clinical, planning, workforce and finance teams have been working through this and submitted our first draft on 17 March. Our final draft is due for submission to the Integrated Care System (ICS) on 4 April.

Our plan includes a key focus on the recovery of services impacted on by the COVID-19 pandemic including:

- Eliminating 104 week waits and reducing waits in excess of 78 weeks through provision of >110% of activity compared to pre-pandemic levels

- Reducing follow up outpatient attendances, increasing patient initiated follow up appointments and maximising the use of virtual outpatient appointments where appropriate
- Increasing diagnostic activity to >120% of pre-pandemic levels to support early diagnosis and treatment, particularly underpinning the cancer pathways and enabling the recovery of our cancer access standards
- Effectively managing the increasing demand for urgent and emergency care services and supporting the effective discharge of patients out of the hospital, including the use of virtual ward capacity in the community
- Developing and expanding the clinical workforce as required to enable the improvement in quality and the increase in activity outlined in the plan
- Effective management of our financial position, including the increased efficiency with which we use our resources and effective and sustainable cost reductions aligned with improvements in quality and effectiveness
- Implementation of key quality improvements, including our 5 national Commissioning for Quality and Innovation initiatives (CQUINs) and the implementation of the Ockenden maternity recommendations

2022/23 is going to be a challenging year, managing the increased demand for our services, whilst recovering services impacted on by the COVID-19 pandemic, ensuring we still manage COVID-19 patients effectively and continue to develop and improve our services and the quality of care that we provide in line with PAHT 2030.

(6) Integrated Care System and Board developments

Hertfordshire and West Essex (HWE) Integrated Care System (ICS) colleagues continue to work at pace to finalise the executive and non-executive structure of the new Integrated Care Board (ICB). All Board appointments have now been made, in advance of taking on the functions and responsibilities of the 3 Clinical Commissioning Groups (CCGs) from 1 July.

The ICB will have strategic oversight responsibilities for health and care across HWE and will also ensure that health operates more effectively and in a more integrated manner at local level through the 3 place-based partnerships (PBP) within the ICS.

The West Essex PBP will have a place based leader, likely to be a joint post in the first instance between the ICB and PAHT, to support the implementation of the local priorities for health and alignment of all the partners.

(7) Consultant appointments

Following an Advisory Appointments Committee (AAC) on 24 February, an offer of appointment as a consultant radiologist, specialising in musculoskeletal imaging has been made to:

- Dr Taman Rifai

This is fantastic news for the department and the Board is asked to ratify the offer of this appointment, made through delegated authority to the AAC.

(8) This is Us *In Action*

Our amazing colleagues at PAHT continue to make significant improvement for our patients' experience and outcomes on a regular basis and continue to make significant improvements for their colleagues. Many continue to be recognised widely for their achievements.

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

- Complete refresh of Event in a Tent to create 'This is Us week' in June – please look out for more details and get involved
- Opening of the Alex Lounge rest facility available for everyone to use 24/7
- Opening of the agile working space above Alex Lounge to improve access to high quality PCs for everyone
- Opening of the high-quality learning and training environment in the new Alex Learning, Education and Development Centre to replace Parndon Hall
- Enhanced working environments for a number of teams along the mortuary corridor
- Extension of the free car parking for all colleagues for 4 months (until 31 July 2022)
- Refurbishment of the staff restaurant, due to complete later this month
- Free breakfast for all colleagues in w/b 21 March as thank you
- Enhanced Freedom to Speak Up Guardian service, with a Lead Guardian appointed, supporting the 4 additional clinical Guardian appointments
- One-off £100 (net) bonus payment for all colleagues on bands 2 to 7 to recognise the cost of living pressures in advance of a national pay award settlement for 2022/23
- Opportunity for colleagues to sell untaken annual leave, taken up by nearly 400 colleagues
- Appointment of Dr Preethi Gopinath as Director of Medical Education
- Election of Mr Satish Kutty as Chair of the British Hip Society Education Committee
- Mr Ashraf Patel's collection of his MBE from Windsor Castle
- Sign up to the anti-racism charter with UNISON as part of the International Day for the Elimination of Racial Discrimination
- New onboarding programme to replace corporate induction from 4 April to welcome all of our new starts to PAHT in a more positive and seamless way

Author: **Lance McCarthy, Chief Executive**
Date: **31 March 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 – 7 APRIL 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:	22 March 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 decreased from 70 to 66 (table 1 and section 2). There is one new risk scoring 20 that has been raised. The main themes for 13 risks scoring 20 on the SRR are: • Eight for our performance: two ED access standard, three referral to treatment standards, one cancer-waiting times, two for bed pressures on both elective and emergency pathways. • Three for our people two for FAWs covering consultant cover in obstetrics and nursing cover in paediatric urgent care. One for Surgery regarding anaesthetic medical cover. • Two for our patients: electronic storage of maternal CTG reports and system wide midwifery care (new). • Actions taken and mitigations in place for each detailed in section three. No new risks scoring 15 or 16 have been raised since 11 January 2022
Recommendation:	Trust Board is asked to review the contents of the Significant Risk Register and note all new risks added and those with amended scores.

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

Previously considered by:	This paper was reviewed at the Senior Managers Group on 15 March 2022. 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 3 March 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, decreased from 70 in the paper discussed in January 2022 at Senior Management Team and February 2022 Trust Board. The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	Risk Score				
	15	16	20	25	Totals
Covid-19	1 (1)	1 (0)	1 (1)	0 (0)	**3 (2)**
Cancer & Clinical Support	3 (2)	14 (13)	0 (0)	0 (0)	**17 (15)**
Communications	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Estates & Facilities	3 (0)	3 (4)	0 (0)	0 (0)	**6 (4)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience	1 (1)	0 (1)	0 (0)	0 (0)	**1 (2)**
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(1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Learning from deaths	0(0)	1 (1)	0(0)	0 (0)	**1 (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)	0 (0)	0 (0)	0 (0)	**0 (0)**
Workforce	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	2 (2)	1 (0)	4 (2)	0 (0)	**7 (4)**
FAWs Women's Health	4 (4)	4 (4)	0 (2)	0 (0)	**8 (10)**
Safeguarding Adults	1 (1)	0(0)	0 (1)	0 (0)	**1 (2)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Surgery	0 (0)	1 (3)	4 (5)	0 (0)	**5 (8)**
Urgent & Emergency Care	1 (1)	2 (3)	0 (1)	0 (0)	**3 (5)**
Totals	**20 (18)**	**33 (36)**	**13 (16)**	**0 (0)**	**66 (70)**

(The scores from paper presented at SMT in January and Trust Board in February 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 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. Presentation completed of centralised monitoring with decision pending of which to choose to provide CTG storage centrally.

3.1.2 NEW: 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 Hertfordshire 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 have escalated this risk to the team at East Hertfordshire community CCG. Risk discussed at Trust board and across the Local Midwifery Network Service. Monitoring any incidents that occur due to cross boarder working.

3.2 Our People

3.2.1 Family and Women's teams

Consultant cover in obstetrics

- Consultant cover improved and now 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 delivers approx. 3,800 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 were 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 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: Three oversees nurses recruited and going through local training. 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.

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.

3.3.5. Bed pressures for elective care

- Risk that at times of extreme pressure for non-elective beds has an impact on bed availability for elective care as these beds may be reassigned for emergency medical capacity, including outliers. This will reduce elective admissions and operating capacity, (S&CC002/2021 raised November 2021)
  Action: Bronze and silver bed escalation in place, multiple daily meetings to discuss patient flow and escalation, outsourcing to increase elective capacity.

3.4 Our Places - Nil

3.5 Our Pounds: Nil

4.0 No new risks with a score of 15 and 16 have been raised since 11 January 2022

5.0 Recommendation

Trust Board are asked to review the contents of the Significant Risk Register and to note new risks added and those with amended scores.

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

Date: 22 March 2022

The Princess Alexandra Hospital NHS Trust

Trust Board – 7 April 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. The risks have been updated with executive leads and reviewed at the relevant committees during March 2022. Updates are reflected in red font. Following discussions at QSC in February 2022 it is proposed to add a new risk to the Trust's Board Assurance Framework. The risk relates to the recovery programme and is described as: *Risk of poor outcomes and patient harm due to long waiting times for treatment.* The risk has been scored at 15 (5x3) under the patient safety domain and a target risk score of 10 has been assigned. The Chief Operating is the executive lead for the risk. The remaining risk scores have not changed this month and are summarised in Appendix B. The full BAF is attached as Appendix C.								
Recommendation:	The Board is asked to approve the new risk (BAF risk 1.3 Recovery Programme) and note the updates to the other risks.								

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

Previously considered by:	STC, QSC, WFC and PAF in March 2022. The recovery risk was discussed at EMT on 17 and 24 March 2022.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF March 2022

Board Assurance Framework Summary 2021.22

Ref.	Risk description	Year- end score (Apr 21)	June 21	August 21	Oct 21	Dec 21	Feb 22	Year-end score (Apr 22)	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	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	*16 Increased score	16	16	16	16	↔	CEO/ DoN&M
1.1	Variation in outcomes resulting in an adverse impact on clinical quality, safety, patient experience and 'higher than expected' mortality.	16	16	16	16	16	16	16	↔	DoN&M/ MD
1.2	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16	16	16	16	↔	DoIMT/ CIO
1.3	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.							15* New risk		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	Workforce: Inability to recruit, retain and engage our people	12	12	12	16* Increased score	16	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	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20	20	20	20	↔	DoS
3.2	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	16	16	16	16	16	16	16	↔	DoS
3.5	There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16	16	20* Increased score	20	20	↔	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	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16	20* Increased score	20	20	20	↔	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	Revenue: The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are new and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. For the second half of the year (H2) the national finance regime is under development and therefore allocations available to the Trust are uncertain.	New risk	12	12	12	12	12	12	↔	DoF
5.2	Capital: In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	New risk	12	12	12	12	12	12	↔	DoF

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2021-22

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 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 (Recovery paper to Board August 21 and paper being presented to PAF Nov, Trust Board Dec '21) v) Covid risk register	**4x4=16**	i) Adaptability and configuration opportunity of clinical areas	None.	Mar-22	**Score to remain at 16.**	**3x3=9** ~~**February**~~ **June 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 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													
BAF 1.1		Variation in outcomes resulting in poor clinical quality, safety and patient experience.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	4 X 5 = 20	Director of Nursing/ Medical Director **Quality and Safety Committee**	i) Quality and safety governance structures in place ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS iv) Education & training in communication skills such as breaking bad news training. v) Sharing the Learning Programme vi) Commissioner reviews and engagement in quality and safety processes vii) Risk Management Training Programme and refresh of the risk management strategy 2021/22 viii) FTSUG's and 5 clinical FTSUG's appointed ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Patient Experience Strategy xiii) NED lead appointed for Mortality xiv) Mortality Strategy including dashboard in development , tracker, updates on work streams and learning from deaths. SMART software database implemented in July 21 xv) '15 steps' walkabouts (on hold over Covid and starting August 2021)- appreciative enquiry to commence within covid recovery phase xvi) Nursing Establishment review (bi-annually) and successful nursing recruitment campaign xvii) Safer Staffing policy and use of SafeCare to inform daily staffing xviii) Real time patient feedback implemented across all wards xix) Robust management of variations in neonatal outcomes xx) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxi) Medical examiners (MEs) and Lead ME appointed and Strategic Learning from Deaths=established xxii) Complaints workshops held and development of PE strategy as part of Quality strategy (Sept 21) xxiii) Joint GIRFT and Model Hospital quality improvement programme xxiv) Appointment of divisional medical PS&Q leads December 2021 xxv) Quality peer review process in place xxvi) Covid-19 governance structure/meetings in place xxvii) Divisional restructure xxviii) Appointment of DMD (quality) tba xxix) Board approval of PAHT quality strategy November 2021, organisational launch March 2022	i) National Surveys and audits, national quality audits ii) Cancer Survey iii) CEO Assurance Panels iv) Incident Management Group meetings, SIAP meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings/ Vulnerable Patient Group x) PLACE Inspections xi) Medicines Optimisation Group xii) End of Life xiii) AKI & Sepsis Group xiv) Urgent Care Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group, Clinical Compliance Group xxix) ICS Oversight Meeting Monthly - section 31 notice) xxx) Dr Foster (Telstra) monthly mortality reports	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience (bi-monthly), monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates Quality and safety data in the Integrated Performance Report iii) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report iv) CQC inspection reports (ED, Medicine, Maternity, Well-led inspection report November 21, Section 31 notice issued and IRMER May 21 (November 21 - notice lifted) and GIRFT reports) v) Dr Foster reports and engagement vi) Quarterly Coding reports to PAF vii) Freedom to Speak Up Guardians quarterly reports to WFC viii) Patient stories and learning from deaths reports to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) TARN review (March 21) xi) Current HSMR 'as expected, and TARN mortality 'better than expected' xii) Nervecentre business case for ED approved (November 21)	4x4=16	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) NICE oversight and management of compliance with guidance v) Frequency and consistency of approach to M & M meetings vi) Clinical documentation not supported by existing infrastructure **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey 2020/21 action plan in place (Sept 2021) iii) Ongoing work with Dr Foster in relation to mortality iv) EPR development and OBC to PAF/Board September 2021 - approved v) Medical records Committee leading programme of work to improve documentation vi) Review of Mortality Strategy vii) Review of departmental clinical governance meetings agenda, attendance and frequency viii) Q&S metrics to be included in PRMs ix) Raising awareness of 5 patient safety priorities HCG (governance structures and IPR reporting x) Quality first workstream 'back to better' UEC to improve safety and quality for patients	i) Demonstrating an embedded learning programme from Board to ward. ii) Inconsistent re-audit iii) Lack of data to support information on progress with some patient safety metrics.	01/03/2022	**Risk rating to remain at 16.**	**4x3=12 August 2022**
			Effects: i) Higher than expected Mortality rates ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Poor reputation and low staff morale v) Patient harm vi) Loss of confidence by external stakeholders											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population **Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way**													
BAF 1.2		**EPR** The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	Causes: i) Poor clinical engagement with the system, due to lack of usability and limited functionality. ii) Timely system fixes/enhancements iii) Static functionality	**5 X 4= 20**	Chief Information Officer/Chief Operating Officer **Strategic Transformation Committee**	i) Fortnightly DQ meetings held at ADO level ii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) User Training programme. v) Super users in place to deliver focused support. vi) Access Policy vii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) viii) Development of capacity planning tools/information ix) Weekly ICT/COSMIC meetings ongoing x) New EPR Board established – chaired by CEO xi) EPR replacement programme established xii) EPR SOC developed and benefits realisation with link to HIMSS xiii) EPR OBC developed and to be presented to Board September 21 xiv) OBC reviewed and approved by Trust Board, submitted for regional and national approval. Anticipated Jan 22 xv) OBC verbally approved by JISC 17 January 2022 xvi) Procurement process commenced mid February	i) Access Board ii) EPR Programme Board (to be chaired by CIO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and daily DQ reports to organisation ii) Quarterly E-Health reports to PAF iii) Reports to EPR Programme Board iv) EPR SOC approved by SMT, PAF and Board (March to April 21 and May 21 Trust Board). Regional team approval received to proceed straight to OBC. v) EPR OBC approved by SMT (02/09), considered by PAF and approved by Board September 21 vi) OBC verbally approved by JISC on 17 January 2022 vii) Procurement process commenced mid February 2022	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams to ensure completeness of data quality iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training. Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk – assurance PAH have declined supplier request on advice from NHSD.	Mar-22	**Risk rating unchanged**	**4x3=12** **end of 2022**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** OBC developed to procure new EPR solution. Ongoing user training programme underway.				

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 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													
BAF 1.3		Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	Causes: i) Ongoing emergency and Covid-19 demand on the organisation including estates and infrastructure constraints. ii) Staffing gaps due to vacancies, increased retirements and increased annual leave entitlement iii) Ability of staff to return to pre-pandemic efficiency. iv) Large programmes of change underway including development of new hospital, Electronic Health Record and pathway changes across the ICS.	**5 X 4= 20**	Chief Operating Officer PAF	Controls: Covid demand forecast monitoring to allow forward planning of ward capacity Daily reviews of staffing gaps Recruitment to vacancies Annual planning process that forecasts capacity, workforce and financial impact. Demand & Capacity modelling of admitted, diagnostics and out patient activity Health & Wellbeing services in place to support staff, communication of services & encouragement to participate. Opening of the Alex Lounge - for staff rest periods during shifts Opening of new Alex training & education centre to upskill staff for back to pre-pandemic efficiency and new skills Divisional & clinical strategies that underpin the larger strategies such as Trust Strategy, Digital Strategy. Linking of Quality Improvement and CIP programmes to the strategies, EHR & ICS development. Clinical review of patients on the waiting lists and harm reviews including regular review of the patient tracking list.	3 x a day patient placement meetings 3 x a week Covid Incident Management meeting Weekly Bed capacity planning meeting weekly with Executive oversight Divisional recruitment meetings Performance Review meetings Senior Management Team Staff Survey & Pulse Surveys 3 x a week IPC meetings Elective oversight meeting chaired by divisional director. Feedback with ICS and Regulators on a monthly basis.	IPR report to PAF Recovery dashboard to EMT weekly & SMT monthly Divisional IPRs to PRMs Staff Survey & Action plan progress to SMT & Workforce Committee (March 2022) IPC Report to SMT and Quality & Safety Committee Review list report to QSC (March 2022)	**5 x3 = 15**	The 2021 staff survey highlights further concerns regarding staff satisfaction. Uncertainty surrounding the availability of Elective Recovery Funding creates a delay in commissioning additional resources to deliver greater capacity. Patients develop Covid symptoms whilst in patients which requires bed capacity to be closed. Concern over the level of staffing required to support the EHR procurement and development and whether backfill recruitment is possible. **ACTIONS:** Staff survey action plan and workshops Validation and harm review process	None identifed.	Mar-22		**5 x 2 = 10 December 2022**
			Effects: i) Increased numbers of patients and acuity levels ii) Reduced bed capacity and increased demand on critical services ii) Staff fatigue and reduced resilience iii) Potential for patient harm due to cancellation of elective surgery and protracted waiting times.											

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2021-22

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 and Actions	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 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Causes:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels viii) Covid -19 ~~ix) Vaccination as a condition of deployment~~ (legislation revoked) **Effects**: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation. Covid-19 effects - delays in workforceplanning, recruitment programmes and additional health and wellbeing pressures on teams Staff vacancies in key clinical areas.	**5 X 4 =20**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) ~~Event in a Tent held annually~~ This is Us Week annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and doctors xv) Medical staffing review underway (Medical Safer Staffing) xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support and absence line.Back to Better campaign launched March 21 xviii) Communications Strategy approved June 2020 xix) NHS People Plan and ICS People Plan xx) Webinars during Covid (BAME, Vaccination) xxi) Alexnet (extranet for staff)	i) WFC, QSC, SC, PAF, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards v) People Cell established (Covid-19)	i) Workforce KPIs reported to WFC bi-monthly and inluded in IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2020 (reported March 2021) iv) GMC survey (July 21) v) WRES and WDES reports 2021 (WFC and Board) vi) OD Framework approved (WFC June 2020) vii) Medical workforce plan update to WFC November 2020 and June 2021 viii) Dignity at Work report January 2021 ix) Culture and values refresh (EIAT, September 2021) x) Compassionate and inclusive leadership session (Board development session March 21) xi)Here to hear listening event and survey xii Deloitte well-led review survey xiii) NHSE/I pulse survey xiv) NHSE/I FTSU assessment xv) Anti-racism Board session xvi) Board session on leadership development opportunities December '21	**4 x4 = 16**	Pulse surveys targeted for all staff Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Safer Medical Staffing plan in development CV19 staff vaccination implementation plan Actions i) ~~Review of~~ for medical staff rotas Q4 ii) Consultant job planning round Q4 iii) Staff survey action plan underway iv) Review of raising concerns (increase in FTSUGs - completed, lead FTSUG Q3 completed, senior inclusion lead Q3 completed) vi CV19 staff booster implementation plan - Q3 completed vi) NHSE/I Health and wellbeing framework assessment - Q4 vii) Allocate rostering system review assessment and plans - completed vii) Review of management and leadership development provision - completed viii) Deloitte well-led review actions - Q3 to 2022/23 Q2 ix)Coordinated and comprehensive onboarding process Q1 x) Recruitment microsite Q1 xi) Stat/man governance review Q2	None identified.	15/03/2022	**Risk score to remain at 16**	**4 x2 = 8** **March 2023**

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 – 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 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) Inability to undertake planned preventative maintenance viii) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas.	**5 X 5= 25**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place with authorised persons in posts x) Sustainability Manager in post xi) Emergency Capital funding £4.3m xii) Compliance Manager appointed xiii) Significant capital programme for year c.£40m xiv) Green Plan approved for onward submission to ICS (January 2022)	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) Monthy Estates Board meeting	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) H&S reports quarterly to PAF. iv) Ventilation assurance report v) Annual and quarterly report to PAF: Estates and Facilities quarterly report) vi) IPR monthly ix) Annual Sustainability report to PAF (May 2021 and update to PAF Sept 21) x) Capital projects report (PAF monthly, Trust Board Nov 2021 and weekly updates at EMT, reports to SMT, 5 year Capital Plan to Private Board in February 2022)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring - ongoing iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	21/03/2022	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.												

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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
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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) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented 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	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP 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		21/03/2022	**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											

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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 – 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 3.5		**New Hospital:** There is a risk that funding for the new hospital will not be sufficient to deliver the preferred way forward and that the new development can not be delivered to the timescale needed to meet increasing demand.	Causes: ii) Funding is not made available for the preferred way forward ii) enabling works are delayed iv) new design guidance from NHP results in a substantial redesign v) the required SoA can not be delivered within the agreed affordability envelope vi) the land purchase is not completed successfully and in a timely manner vii) Development of new standards and programme approach by NHP has delayed ~~may delay~~ OBC viii) Advisors stood down due to lack of funding Effects i) Hospital remains on existing site and continued investment in existing site will be required ii) Unable to deliver all of the service transformation iii) Unable to manage system demand due to lack of transformation iv) Digital transformation not complete v) Poor staff retention due to failing infrastructure vi) Unable to reach outstanding service provision due to failing infrastructure vii) New hospital~~, if delayed,~~ will be undersized because demand management is delayed viii) Loss of clinical engagement ix) loss of public confidence	**5 X 4= 20**	Director of Strategy Strategic Transformation Committee from January 2022	i) Detailed programme of work ii) New national team appointed to provide transaction support and bi-weekly meetings with lead for scheme iii) continual monitoring-of proposed solution to ensure it is deliverable within the available funding envelope iv) National Programme design convergence review initiated v) Regular meetings with stakeholders, MPs, Council leaders vi) Regular meetings with landowners	i) New Hospital Programme Board ii) Strategic Transformation Committee iii) Trust Board iv) External advisory meetings as required v) Reviews undertaken by NHP	i) Monthly reports to Trust Board and Strategic Transformation Committee. ii) Letters of support received from JIC. iii) confirmation received that programme management structure is appropriate. iv) Landowners have accepted offer in principle v) Positive technical review feedback vii Positive meeting between MP's and Secretary of State	**4 x 5 = 20**	Extended delay to the DCR which is outside of the control of the Trust New lead for national programme appointed resulting in delay on issue of guidance Actions i) Support national team in areas such as Design Convergence Review and commercial strategy ii) Agree Heads of Terms for land transaction iii) Paper on land to NHP and JIC	None.	Mar-22	**Risk score unchanged.**	**3x3=9** **September 2022**

Risk Key														
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Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**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 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard resulting in increased risk to patient safety and poor patient experience.	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Changes to working practice and modernisation of systems and processes iv) Delays in decision making, patient discharges and impacting on flow v) Lack of assesment and short stay capacity, lack of CDU space vi) Increase in volume of patients presenting to ED vii) Volume of ambulance patients and delays offloading patients	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) UEC improvement plans in place and monitored through the UCPB and workstreams ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Expanded footprint of the UTC completed vii) Local Delivery Board in place with system partners. UEC ICS Board in place with COO representation ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries increasing opportunities for re direction and more bookable appointments xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xii) Bookable appointments are being expanded in line with UEC programme across the ICS xiii) Training and education centre reverted back to education facility	i) Operational meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) System Operational Group vii Urgent Care Board	i) Daily ED reports to NHSI ii) Monthly PRM reports iii) Monthly IPR reported to PAF/QSC and Board reflecting ED performance iv)	**4x5=20**	i) Staffing (Trust wide) and site capacity ii) System capacity and demand pressures iii) Leadership changes completed, clinical leads in post, service manager in post. New Nurse Consultant post advertised. Actions: 1. Review of capacity in UTC and SDEC to support attendance and walk in patients through ED 3. Review of weekly medical and nursing staffing in accordance with CQC Section 31 notice 4. Capacity through inpatient wards and and application of red to green oversight in place. Trust participating the National Hospital Discharge Programme 5. Daily review of pathway zero patients and simple discharges 6. Executive oversight of LOS meetings twice weekly 7. Attendance from senior clinicans at the ED safety huddles and real time escalation of all specialty delays	None noted.	21/03/2022	**Risk score to remain at 20.**	**4x3 =12 (July 22)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
BAF 5.1		**Finance - revenue :** The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are know and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. In H2 the financial regime continues to be a breakeven regime. The Trust has received winter funding which it has been unable to spend in full due to the Omicron variant. This has identifieid a risk that the Trust will deliver a surplus greater than one that NHSE will permit (c.£3m).	**Causes:** The main causes of risk are : (i) The current financial regime operates under 'block contract' arrangements. There is limited capacity for Commissioner contracts to be varied. (ii) There is uncertainty of the financial regime to be operated in H2. (iii) Financial plans include a requirement to deliver CIPs with a step change in delivery required in H2 - the ability to control costs and the deliverability of CIPs will be influenced by COVID, restore and recover. (iv) The Trust has a number of cost pressures that will require mitigation. (v) Although the Trust has improved its vacancy rates it remains over reliant on temporary staffing which attracts premium costs - continued improvements in substantive recruitment is required. (vi)The CIP ask in H2 was increased. This increases the potential for non-delivery of the CIP (vii) Elective Recovery Funding activity levels have been increased from M4. Therefore the system may not achieve the required activity levels. Consequently, this may put the reimbursement of ERF in jeopardy. (viii) The Trust has received £16m of winter funding which may not be fully spent by year end.	**4 X 4= 16**	**Exec leads:** DoF **Committee** : Performance and Finance Committee	**Key Controls include :** (i) Agreed H1 financial envelopes including continued levels of COVID funding. (ii) Health Care Group / Corporate performance review meetings are in place where performance is being monitored. (iii) Exec led vacancy control group. (iv) Oversight of the Trust's financial performance by the EMT, SMT, PAF, Workforce and Audit Committee. (v) Monthly monitoring of financial performance by NHSE/I through the submission of financial returns. (vi) Strengthening of financial control and governance including an improved governance process for business case investmentusiness case approval process. (vii) Development of CIP workshops and plans. (vii) Temporary staffing audit underway and focus on reduction in temporary staffing. (viii) Finance Department working with all Divisions to ensure that all spend is captured correctly and that items/services that can be brought forward and delivered prior to the year end are purchased.	**Sources of Assurance :** (i) Performance review meetings - monitoring against plan and forecast (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) CIP tracking (vi) Reduction in run rate spend on temporary staffing	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial rating on internal audit reports. (iv) Unqualified value for money opinion	**4x3=12**	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning. (iii) CIP delivery (iv) Embedding management of temporary staffing costs (v) Existence of manual processes across the Trust	**Gaps in Assurance :** (i) National H2 Financial regime is under development and therefore uncertainty over allocations in H2. (ii) Fully integrated business and operational planning including demand and capacity plans. (iii) Business case benefits realisation process	18.03.22	**Residual risk score not changed.**	**4 x 2 = 8 (Q4 2021/22)**
			Effects: (i) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability.							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling to be regularised. (iii) ~~Consideration being given to the~~ Introduction of a PMO. (iv) Review of Governance Manual/SFI's			

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 Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way													
BAF 5.2		Finance : In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	**Causes:** The main causes of risk to delivery are (i) An over-subscribed capital programme. (ii) Operational pressures that may constrain the delivery of a capital scheme. (iii) Confirmation of external funding sources within a timeframe to allow projects to be completed including adequate planning and procurement preparation. (iv) Incomplete and/or untimely production of business cases that do not facilitate required approvals. (v) Single year funding settlements that do not support development of longer term / 5 year plans and management of a plan over financial years. (vi) As the ICS takes on increasing responsibilities for capital planning the Trust will be competing for capital resource across the ICS. (vii) The development of the New Hospital will continue to be a significant programme of work. (viii) Costs for building projects are increasing therefore adding pressure to the capital programme. (ix) The capital programme has an overplanning margin wich increases the risk of breaching the CRL if all projects deliver. (x) Late in the financial year arrival of PDC	**4 X4 = 16**	**Exec leads:** DoF **Groups:** Capital Working Group, SMT, EMT and Performance and Finance Committee, New Hospital Committee	**Key Controls:** (i) The Trust has developed a 'Risk based' prioritised capital programme which is agreed through the capital working group, SMT, PAF and the Board. The CWG meets monthly to monitor progress on pre agreed schemes. (ii) The Risk Management Committee detail all risk that require capital investment. (iii) The Trust undertakes a six facet survey which informs of all backlog maintenance risks and how this element of capital is spent. (iv) Business cases are required for all capital investment. (v) All capital projects have a senior responsible officer and project lead and report into HCG/Corporate areas. (vi) Application of external funding for additional, ad hoc capital. (vii) Discussion with system partners to ensure that the Trust does not breach its CRL as capital allocations can be moved across the system.	**Sources of Assurance :** (i) Frontloaded capital trajectories that monitor expected performance against plans, including cashflow forecasts. (ii) YTD and forecast reports detailing progress. (including New Hospital) (iii) Internal audit reports. (iv) A prioritised capital programme that allows for flexibility and longer term planning. (vi) Business case review process verifies investments are strategic/operational and meet the Trust's requirements to achieve its objectives.	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) Business cases approved timely. (iii) Substantial internal audit reports. (iv) Reduction in non-compliant waivers. (v) Approval of external funding and receipt of PDC/MoU	**4x3=12**	**Gaps in Control**: (i) Compliance to business case and approval process as this is a new process and is currently being embedded within the organisation.	**Gaps in Assurance:** (i) Improvements in forecasting trajectories and development of longer term capital programme.	18.03.22	**Residual risk score not changed.**	**4 x 2 =8 (Q4 2021/22)**
			Effects: (i) Risk to under/overshoot of CRL.							**ACTIONS:** (i) Business Development Group is being initiated in line with the revised Capital and Revenue investment guidance				

BOARD OF DIRECTORS:	**Trust Board 7 April 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee**			
REPORT FROM:	**Helen Glenister – Committee Chair**			
DATE OF COMMITTEE MEETING:	**25 March 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.6 CQC Update including QPMO update	Yes	Yes, ongoing work	N	QSC was assured on the work underway and progress made to date. The committee was also assured on the plans for transition of the Quality PMO to the Central PMO. QSC noted that the CCG are providing oversight.
2.1 Medicine Division – Quarterly update and Fractured neck of femur update	Yes	No	N	The quarterly update was noted along with the good progress being made by the division including sustained reduction in the number of open complaints, closure of all historic SI's and progress against CQC Must and Should actions - all green and moving towards business as usual. QSC was assured that the alert into fractured neck of femur cases is being addressed and that robust processes are in place.
2.2 IPC update (including COVID-19 and BAF risk 1.0 Covid	Yes	Yes	N	QSC was assured that robust infection control practices are in place and noted the sustained reduction in C.difficile cases. Revised COVID-19 national guidance will be issued on 1 April and work is underway across the integrated care system to identify risks and agree a system view which will be fed back. A higher number of MSSA bacteraemia cases than seen in previous years continues to be monitored ; a task and finish

BOARD OF DIRECTORS:	**Trust Board 7 April 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee**			
REPORT FROM:	**Helen Glenister – Committee Chair**			
DATE OF COMMITTEE MEETING:	**25 March 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				Group has been formed and an action plan has been developed. BAF risk 1.0 Covid was discussed and it was agreed the score should remain at 16.
2.4 Learning from Deaths	Yes	N	N	QSC was content with the practices in place and the learning from deaths. The sepsis alert and investigation was noted. QSC was informed that the medical examiners are piloting reviews of community deaths with St Claire Hospice and GP death scrutiny has also started.
2.6 Research and Development	Yes	N	N	QSC was assured, noted the significant outputs on key projects and congratulated the team.
2.8 Patient Safety & Clinical Effectiveness Report	Yes (partial)	Yes	N	QSC was assured on progress being made on key areas within the report and that robust processes in place. A further update on the timings for closure of open incidents is required.
2.9 Patient Experience	Yes	Yes	N	QSC noted the update: 33% of cases are being closed within their original target date, the remainder are within an agreed extension. 116 cases are open (down from 137 in December). Work is underway to reduce the open cases.
2.10 Patient Panel update	Presented for information	N/A	N/A	The committee noted the positive update and ongoing contribution by the Patient Panel.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board 7 April 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee**			
REPORT FROM:	**Helen Glenister – Committee Chair**			
DATE OF COMMITTEE MEETING:	**25 March 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.11 BAF Risk 1.1 Clinical outcomes	Yes	N	N	QSC supported the recommendation that the risk score remain at 16.
2.12 Safer staffing	Yes	N	N	QSC was assured that processes are in place for managing and monitoring staffing levels. Ongoing monitoring will continue at Workforce Committee.
3.1 Integrated Performance Report	Yes	Yes	N	QSC noted the IPR.
3.2 Review lists/ASI update	Yes	Yes	N	QSC was assured that robust processes are in place.

BOARD OF DIRECTORS: Trust Board 7 April 2022 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality and Safety Committee (Part II – Maternity Oversight)

REPORT FROM: John Hogan – Committee

DATE OF COMMITTEE MEETING: 25 March 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
1.6 QSC Terms of Reference	For discussion			The committee discussed the revised terms of reference which include the enhanced duties in relation to oversight of maternity services and requested members to provide feedback by the next meeting.
2.1 Maternity dashboard	Yes	Yes	DoM/DD-FAWS	The committee was assured about the progress being made with the dashboard and requested that BAME data is included as well as a timeline for remedial actions in the exception reports.
2.2 Maternity Serious Incidents report	Yes	N	N	The committee was assured on processes in place particularly those of systematic post event learning and a summary report is presented to the public Trust Board meetings.
2.5 Maternity and Neonatal Safety Champions Report	Yes	N	N	The report was noted.
2.6 Local Maternity Improvement Board	Yes	Yes	DoN&M/DoM/ DD-FAWS	The report was noted. The committee discussed whether a deep dive into culture would be beneficial and agreed that a small group would look into culture reporting and report back in two months' time.

For information:
Horizon scanning: The committee was informed that the prime focus regionally/nationally was on Ockenden with an expectation the focus of the Part II report would be on neonatal services and the link with maternity and the pathways for transitional care.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 April 2022

4.2

Agenda item:	4.2
Presented by:	Fay Gilder | Medical Director
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Quality First Team Information Team
Date prepared:	March 2022
Subject / title:	Learning from deaths and Mortality Paper – February 2022 data

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

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

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

Previously considered by:	Strategic Learning From Death Group and QSC.25.03.22
Risk / links with the BAF:	BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality"
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:	Appendix 1 Definitions of mortality indices

The Princess Alexandra Hospital NHS Trust

4.2

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

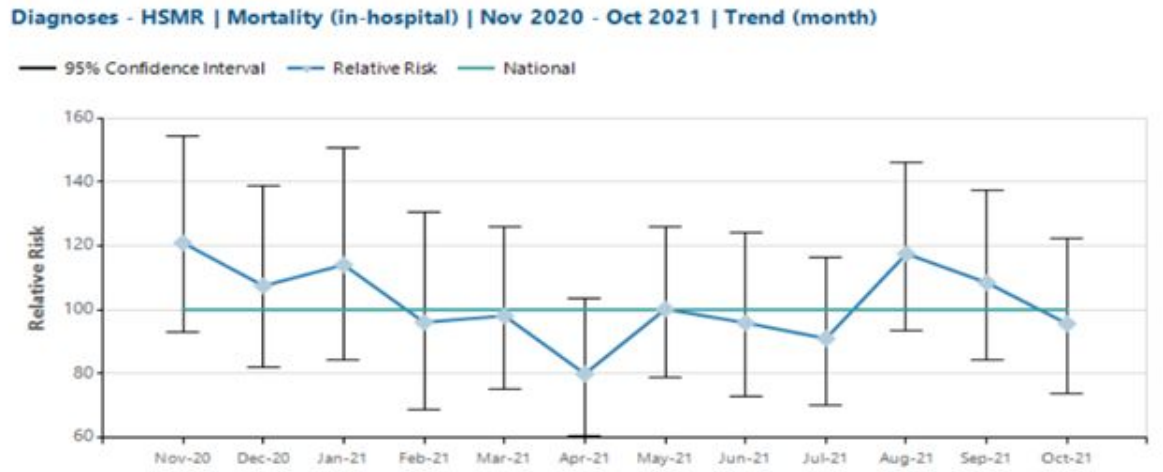
PAHT has a learning from death process that meets the national requirements. The risks associated with this are captured on the learning from death risk register.

3.0 Current Telstra/ NHS Data Headlines

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

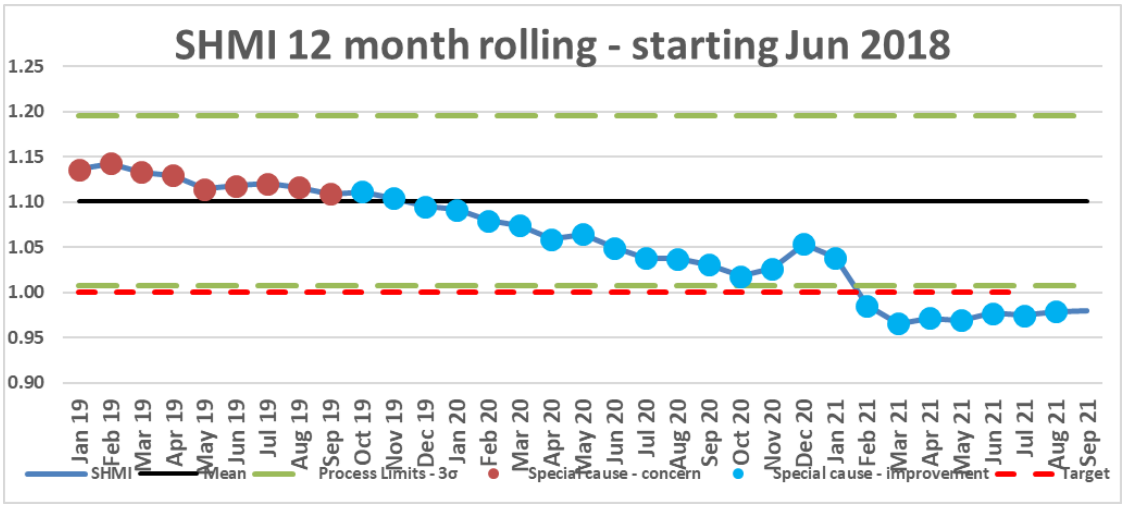
The Relative Risk chart above shows the most recent 12 month rolling data point is 101.4 which is within expected range

3.2 Hospital Standard Mortality Rate (HSMR) – Monthly



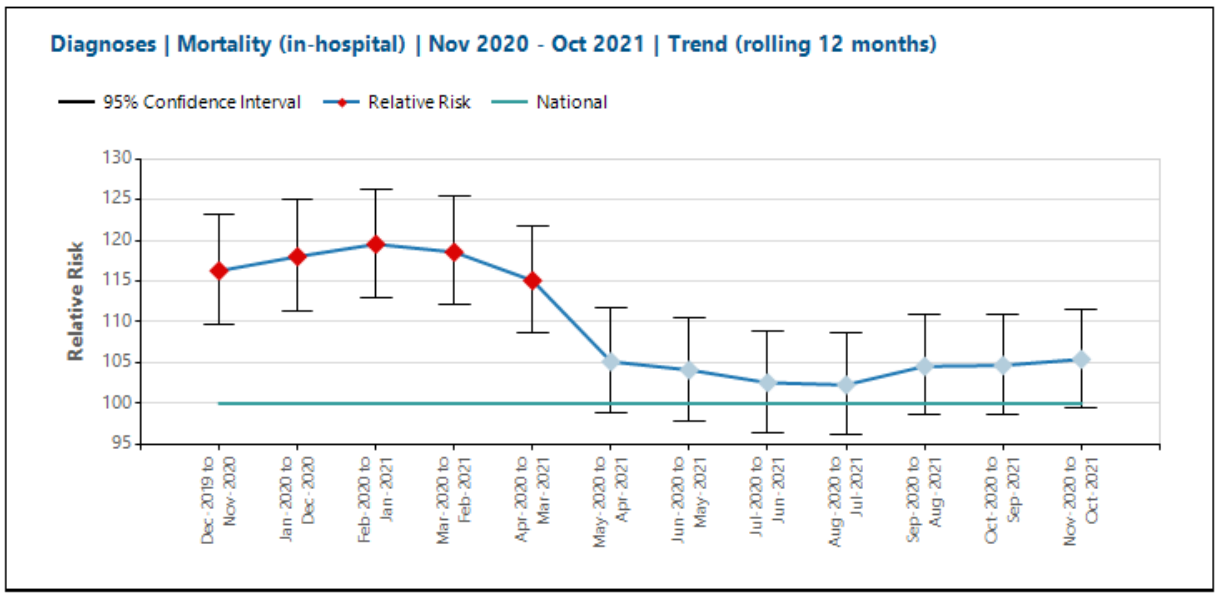
Relative Risk for October 2021 was 95.7. This is within expected

3.3 Summary Hospital-level Mortality Indicator (SHMI)



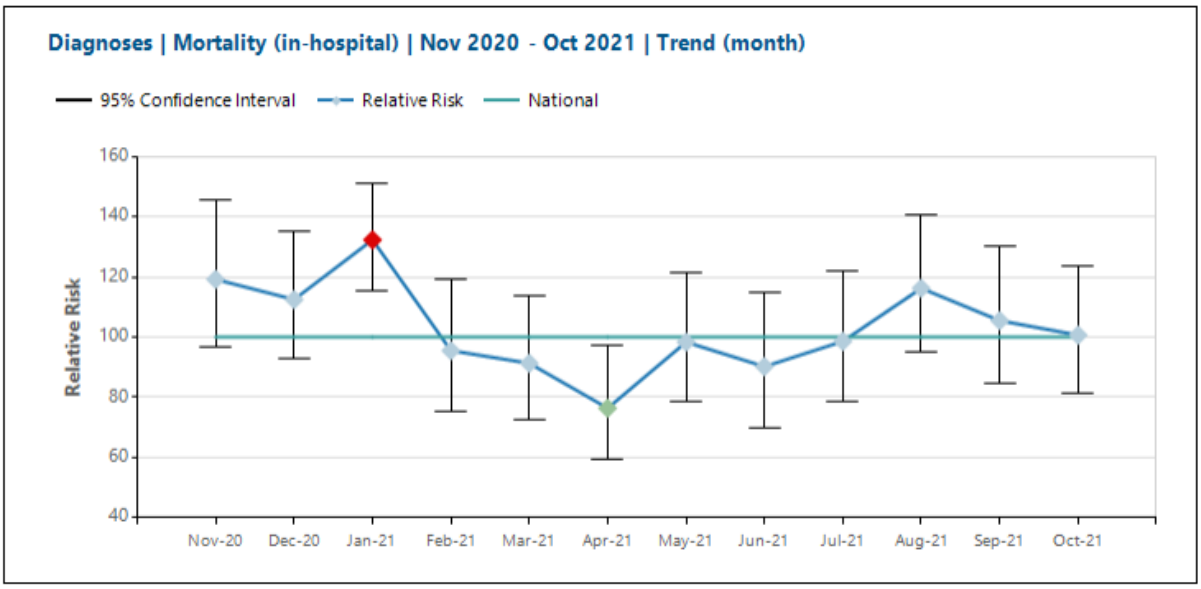
Sept 2021 SHMI value was 0.9798 which is within expected.

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



SMR for the period Nov-20 to Oct-21 is 105.4 and “within expected” range

3.5 Standardised Mortality Ratio (SMR)



SMR for Oct-21 is 100.6 and "within expected" range

3.6 Standardised Mortality Ratio (SMR) outlying groups

There are four outlying groups; (i) fractured neck of femur; (ii) Intestinal Obstruction without Hernia; (iii) Viral Infection; and new for Oct 21; (iv) Sepsis

Deep dives in to the patient records for all outlying groups are being undertaken in order to understand the contributory factors and are reported to the Strategic Learning from Deaths Group (SLfD)

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 March group.

4.1 Sepsis

- The sepsis leads continue to deliver training across the organisation and have recruited further Sepsis/AKI champions with a minimum of 2 in each clinical area.
- The emergency department (ED) team have adapted the sepsis bleep holder role and now ensure a sepsis role is picked up by one of the Advanced Care Practitioners on "Alertive". Their role is to be the first point of contact as soon as a patient arrives in ED with suspected sepsis and to initiate or facilitate the sepsis six care bundle.
- There has been continued improvement in door to needle time for those patients suspected of having neutropenic sepsis.
- All sepsis deaths are reviewed with coding team for validation though this activity was reduced during December 2021 and January 2022 because of staffing constraints.

- There is improved engagement with the paediatric team enabling submission of paediatric sepsis compliance data.
- Paediatric sepsis stamp introduced to promote early review and compliance

4.2 Acute Kidney Injury (AKI)

- E-referral system under development to improve communication with Lister Hospital about renal patients
- Review of all AKI deaths by AKI lead and coding team for validation
- "Think Drink" poster launched initially on care of the elderly wards to raise profile of need for hydration to reduce risk of kidney injury
- Preparation for World Kidney day on 10th March to raise awareness across the Trust
- Ongoing data results following improvements implemented demonstrate improved outcomes for patients with AKI and has resulted in AKI being removed from the SMR mortality outlier alert for PAHT in 2021

4.3 Feedback on the Integrated Care System (ICS) discussion about the use of recommended documentation at end of life

PEACE - Proactive Enhanced Advance Escalation Care Plan
ReSPECT - Recommended Summary Plan for Emergency Care and Treatment

The ICS have opened a discussion on the use of PEACE and ReSPECT documentation across the system. It was confirmed that system wide training has taken place across Essex on the use of the PEACE document. It is widely used by East Essex. ReSPECT is not used consistently across all other areas within the ICS and there was no decision to push this forward. Although the long-term goal is for a universal approach it was confirmed that deeper understanding of requirements from NICE and Ambitions document should be explored first by the ICS.

5.0 Learning from deaths process update

5.2 Mortality Narrative

There were 87 deaths in February 2022 with 23 cases referred for structured judgement reviews (SJRs).
There are 18 outstanding SJRs (over 6 weeks of the patients' death.) This number is continuing to improve (66 in January 2022)
There were 18 COVID related deaths

Details of learning from SJRs are shared with the specialities for discussion and actioning at their local mortality and morbidity meetings (M&Ms).

5.2 Second Review Panel Cases

2 cases were referred for second review:

6.0 Medical Examiner (ME) Headlines

6.1 Details for February 2022

- During February 2022 there were 87 deaths, all scrutinised between 10 Medical Examiners.
- 19 cases were referred to the Coroner:
- 23 cases were referred for an SJR.
- COVID-19: There were14 deaths with positive tests
  No Clinical COVID reported and 6 Nosocomial COVID.

6.2 National Medical Certificate of Cause of Death (MCCDs) issued within 72 hours: (National Target)

- 67 of the remaining 68 were issued in time
- The 19 coroners' referrals are exempt from the Trust Statistics
- 1 did not meet the National target.
- The result is a success rate for February 2022 of 98.5%, above the National target of 95%.

6.3 Developments

Community Deaths

- The MEs started piloting community death scrutiny with St Claire Hospice on the 15th of November 2021 and this is going well with excellent feedback.
- GP death scrutiny started with the assistance of our new staff and the Clinical Director of NHS West Essex CCG.

The Coronavirus Act 2020 ends on the 24th March 2022

- Ward doctors and ED doctors will now be taking over certification responsibilities to ensure the correct paperwork is completed within 72 hours of the patient's death.

7.0 Risks

The Trust has a Corporate Mortality Risk Register and each individual project has its own risks and issues log. This is reviewed as part of the Strategic Learning from Death Group. At last month's meeting it was agreed to add the risk to patient outcomes caused by the long delays from ED to the Orthogeriatric ward. This risk has been placed on the learning from deaths risk register. Medicine and UEC Divisions have been asked to review and place this risk on their registers to improve adherence to the pathway.
Risk before actions required achieved = 4 x 4 = 16

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.

Appendix 1 - Definitions

HSMR (12 month rolling average)

The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

SMR

The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SHMI

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged. Deaths related to COVID-19 are excluded from the SHMI.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 April 2022

4.3

Agenda item:	4.3							
Presented by:	Sharon McNally, Director of Nursing, Midwifery and AHPs							
Prepared by:	Erin Harrison, Lead Governance Midwife							
Date prepared:	11th March 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 was 1 new maternity incident declared since the last report There were 2 maternity incidents closed since the last report Maternity services currently have 3 SI's under investigation 2 of which are being undertaken by HSIB							
Recommendation:	To note the information contained within the report: to be assured that maternity services 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 Part II (Maternity Oversight) 25.03.22
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. Any changes or improvements undertaken in line with the thematic analysis and transformation work are undertaken in line with Equality and Quality impact assessments.
Appendices:	N/A

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The Princess Alexandra Hospital NHS Trust

4.3

1.0 Purpose

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

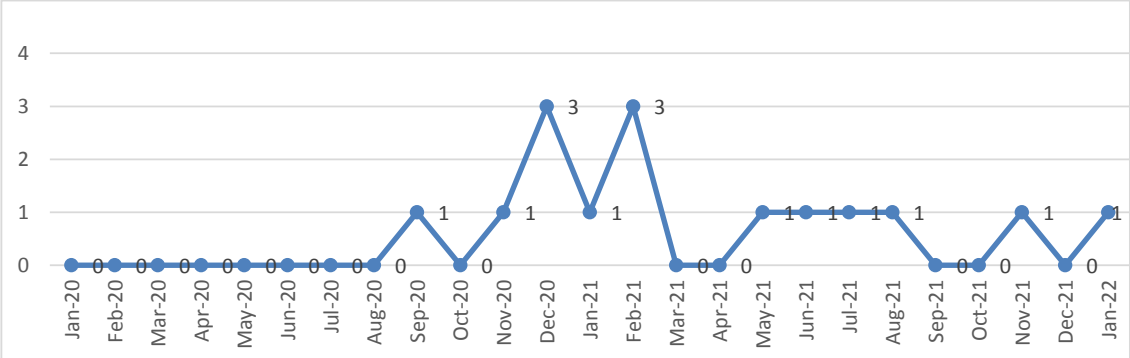
2.0 Background

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 3 SI's under investigation, 2 of which are being investigated by HSIB. Table 1 details the trend of declared SI's within the last 24 months to January 2022.

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



There was 1 new serious incident declared in January 2022. This is a complex case which will undergo a multi-agency approach including PAHT, Lister Hospital, Primary care and EEAST.

Table 2. Serious Incidents declared and submitted for January 2022

Serious Investigations	
Number Declared for January 2022	**1**
Number Submitted for January 2022	**2**
Number Past CCG Deadline as of January 2022 (Not including HSIB/Approved Extensions)	**1**

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to December 2021

Table 3. Top Themes

Total Number of SI's	Theme	Number
15	Obstetric Haemorrhage	6

	CTG interpretation	6
	Compliance with guidance	3
	Hypertension	3
	Intrauterine death	3
	Escalation	2
	Neonatal death	2
	Delay in Care	3
	Hypoxic ischaemic encephalopathy	3
	Laceration at caesarean	1
	Fetal growth	1

Obstetric Haemorrhage

As part of the maternity improvement board there is a workstream leading on postpartum haemorrhage/massive obstetric haemorrhage. All cases are reviewed as part of a multidisciplinary group, there has been an update to the MOH proforma and the workstream are currently reviewing the use of Carbetocin.

CTG interpretation

There is currently a fetal monitoring midwife and an obstetric consultant leading on fetal monitoring within the department. Compliance for attendance at fetal monitoring training is 95% for midwives and doctors; and 95% have passed their CTG competency training. The team hold weekly in house training multi-disciplinary learning sessions and monthly mandatory training; in addition to clinical support on a regular basis.

Each work stream has an identified lead and progress is reported back to the Maternity Improvement Board, the thematic improvement workstreams include:

- Induction of Labour
- Post-Partum Haemorrhage
- Maternity Triage
- Documentation
- LocSSips
- Estates transformation and traditional care
- Handover, ward rounds and huddles

6.0 Oversight

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

6.0 Recommendation

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

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

The Princess Alexandra Hospital NHS Trust

4.3

Trust Board (Public) – 7 April 2022

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:	16.3.2022
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: Red with a reduced overall RN/M fill rate (4.3%) of 85.9%. The fill rate of HCSW has increased by 4.2% to 101.4%. Data should be viewed in context of changing landscape of Covid admissions over the month and continued staff absence. The elective recovery programme recommenced in month with additional pressure on staffing. Detailed staffing data and methodology for safe midwifery staffing has been added to the report this month. Part B: The overall vacancy rate has increased following uplift in staffing following the establishment review, funding of Kingsmoor ward, and our internal review of the in-post numbers. Of note, following these changes the adjusted vacancy rate for RN was 9.8% and Band 5 10.5%. The pipeline of nurses remains healthy and international recruitment will continue to support the gap.
Recommendation:	The committee is asked to note the information within this report.

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

Previously considered by:	QSC.25.03.22 and 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 2: Ward staffing exception reports. Appendix 3 : Ward Level CHPPD

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in February 2022. To provide an update on plans to reduce the nursing and HCSW vacancy rate over 2020/21.

1.0 BACKGROUND

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

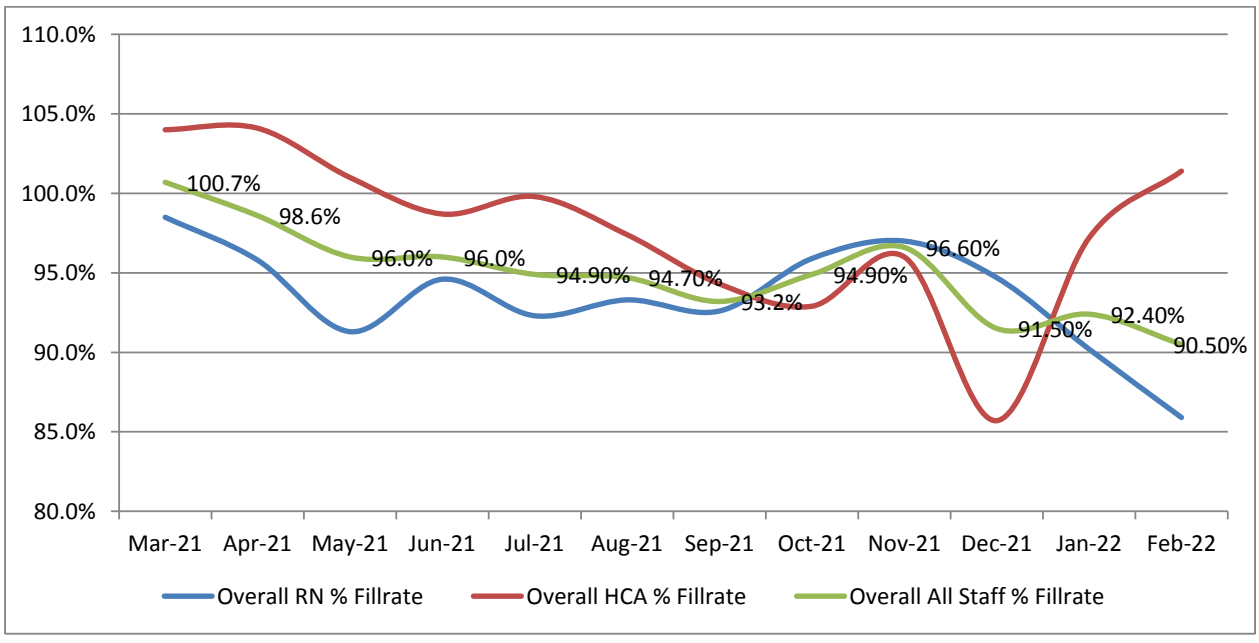
3.0 ANALYSIS

3.1 The Trust Safer Staffing Fill rates for February 2022 reflect changes to the templates following the 2021 establishment review with an increase of 25.63WTE RN across the wards and a decrease of 16.79WTE HCSW.

There was a continued overall reduction of fill in February compared to January by 2.1% due to ongoing high levels of sickness due to Omicron wave. Overall care staff fill rates increased by 4.2% to 101.4% but RN fill rate dropped by 4.3% to 85.9%. Further information on risks and mitigation is provided in 3.6.

3.2 Ward level breakdown of fill rate data is included in Appendix 1; the accuracy of this continues to be dependent on all staff moves being captured on Health Roster

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 February 2022	83.1%	100.8%	89.3%	102.1%	85.9%	101.4%	90.5%
In Patient Ward average January 2022	87.7%	96.7%	93.3%	97.9%	90.2%	97.2%	92.4%
Variance February 20222 - January 2022	↓4.6%	↑4.1%	↓4.0%	↓4.2%	↓4.3%	↑4.2%	↓1.9%



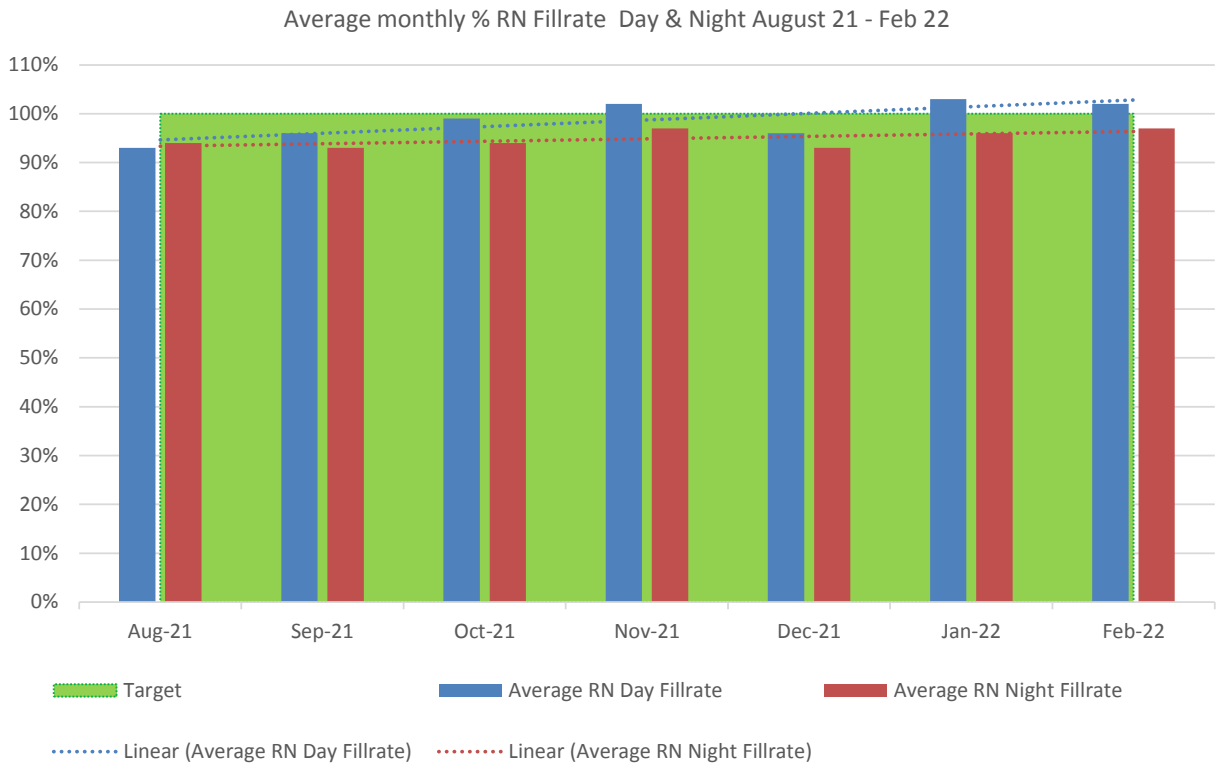
National reporting is for inpatient areas, and therefore does not include areas including the emergency department. To ensure the Board is sighted to the staffing in these areas, the data for these areas is included below using the same methodology as the full UNIFY report

Benchmarking in line with other acute Trusts in the STP the threshold for the RAG rating is a below.

Red <75%	Amber 75 – 95%	Green >95%

	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 (%)
December 2021	96.4%	72.2%	104.3%	78.2%
January 2022	103%	73.5%	96.2%	79%
February 2022	102.4%	70.9%	96.9%	74.5%

Staffing within ED remains subject to a CQC Section 31 notice. There is weekly executive oversight of the nursing (and medical) retrospective and prospective fill rates prior to submission of the data to the CQC. 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. Fill rate was affected particularly in the second half of February by staff sickness.



3.5 Fill rates by ward

Fill rates by ward have been produced against the standard but revised planned templates (Appendix 1). 2 wards (Dolphin and Fleming) reported average fill rates below 75% for registered nurses against the standard planned template during February. Fill rates reported do not include additional support provided to the wards by the Practice Development Team, Theatres and OP nurses during peak levels of staff sickness

Omicron wave

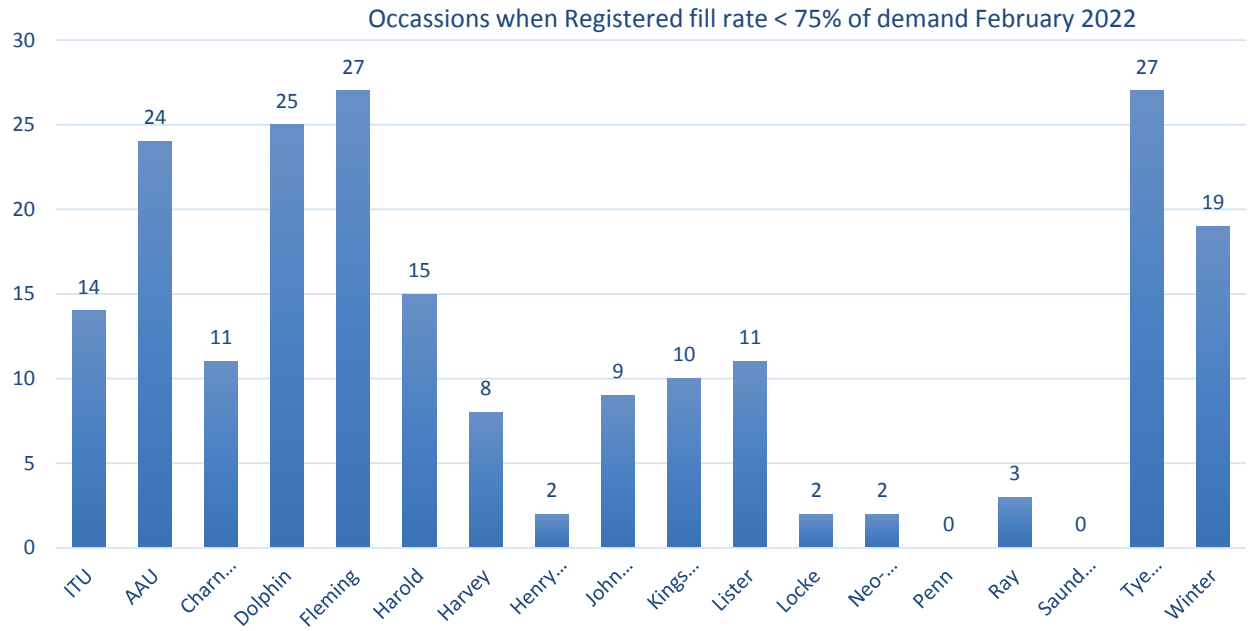
Staffing in February continued to be impacted by Covid related absence. There was increased demand on nurse staffing towards the end of the month with the reopening of John Snow and Henry Moore as elective surgery wards.

Staffing numbers based on acuity and dependency continued to be monitored daily and 3 times a day ADoN/DDoN seven days week during to ensure there was oversight of safest staffing using the safecare data and professional judgement of skill mix, competency and patient acuity.

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



3.8 Care Hours per Patient Day* (CHPPD): has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018).

It 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

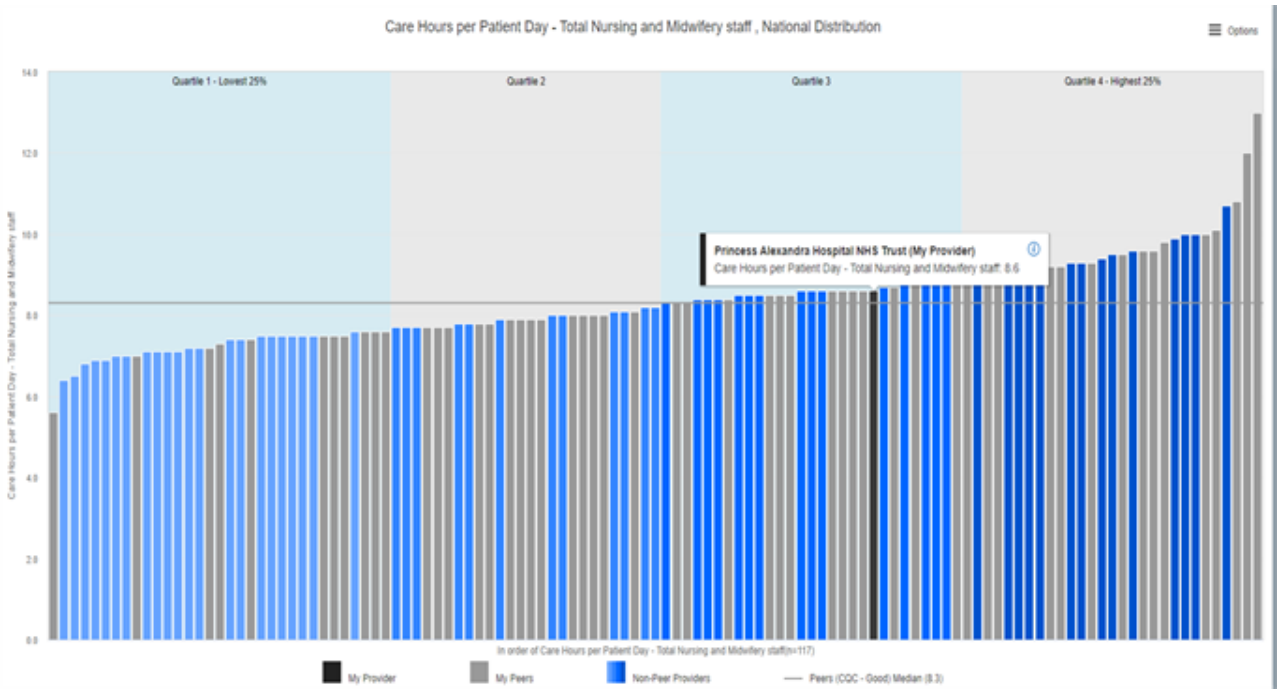
CHPPD covers both temporary and permanent care staff but excludes student nurses and midwives. CHPPD relates only to hospital wards where patients stay overnight.

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.

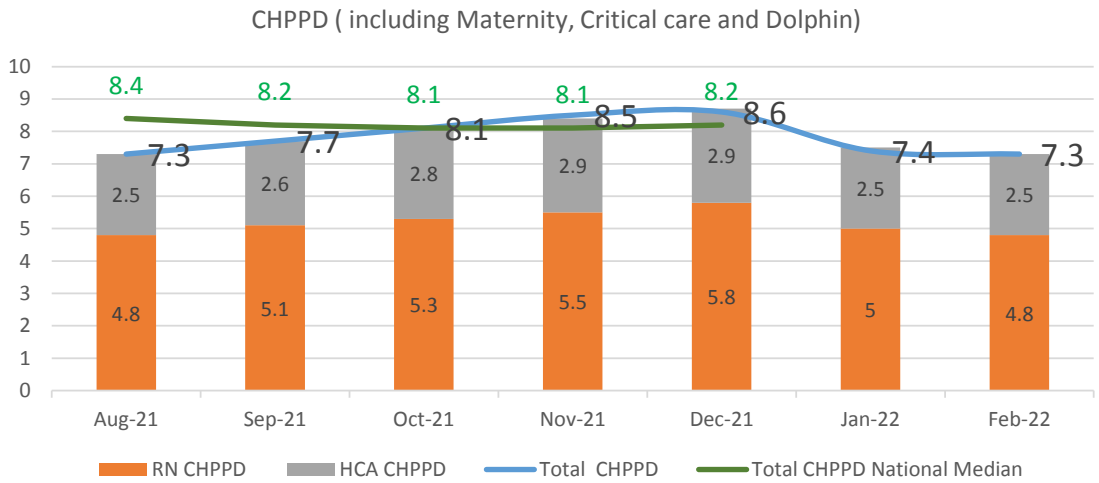
The accuracy of this report is dependant of the rosters being up to date and accurate bed occupancy numbers.
Appendix 3 shows the CHPPD for each ward and the Trust total for February 2022.

Trust comparative data via the Model Hospital portal is presented below based on December 2021 data

	December 2021 data	National Median (December 2021)	Variance against national median
CHPPD Total	8.6	8.2	↑0.4
CHPPD RN	5.8	4.9	↑0.9
CHPPD HCSW	2.9	3.1	↓0.2



The following chart shows Trust total , Registered and Unregistered CHPPD against National Median.
(National Median from Model Hospital)

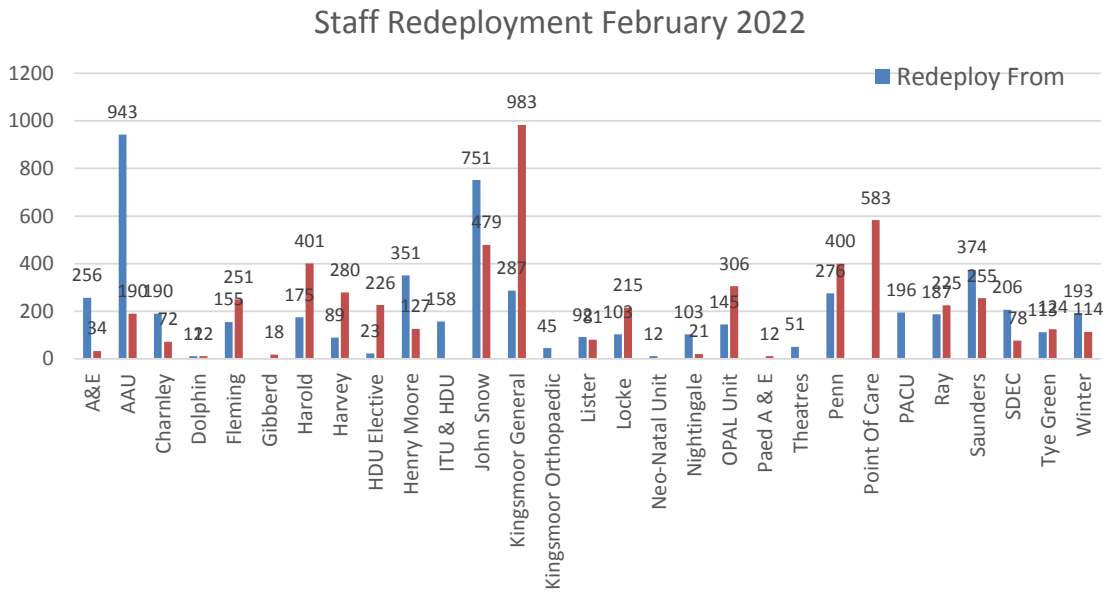


3.9 Redeployment of staff:

The graph below shows how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The graph does not capture the moves of bank or agency staff from the bank or rapid response pools. The graph shows the number of hours of staff redeployed from and to the wards to support safe staffing.

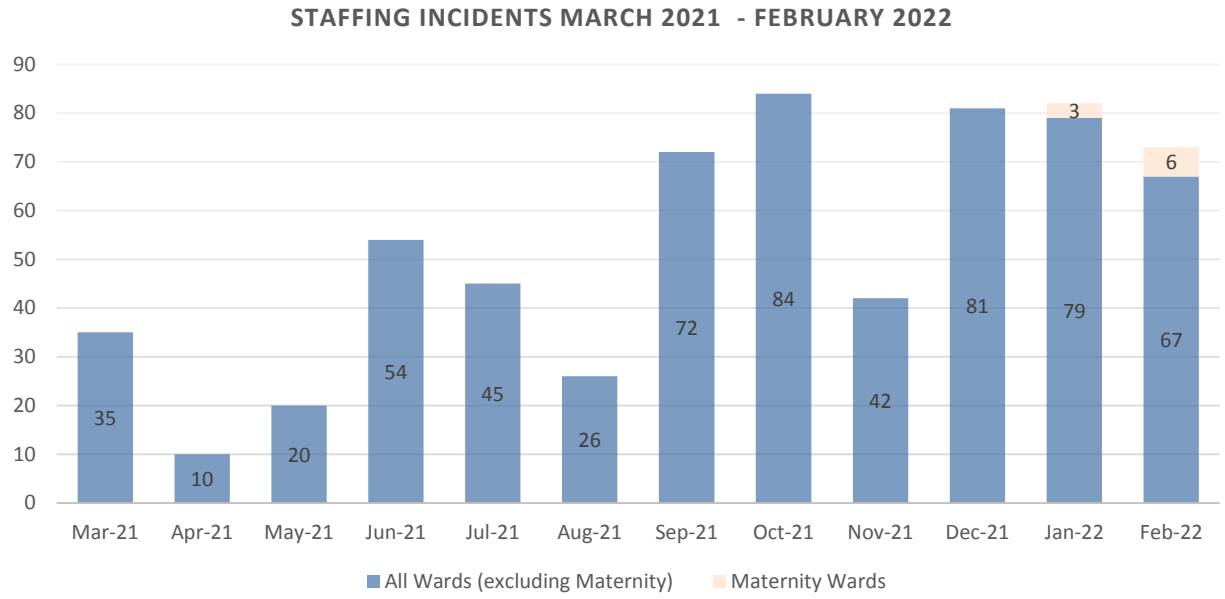
The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare systems.
While essential to ensure the safe staffing across the Trust moving substantive staff can impact on staff satisfaction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

Redeployment of staff to ensure safe care is a key function of safe staffing however staff satisfaction is poor when staff are frequently moved. The senior nursing leadership team work closely with ward managers and teams to ensure there is understanding of the rationale for moves and to ensure there are positive conversations.



3.10 Datix reports:

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded had increased in month to 76 (↓6), Tye Green and Winter Wards are the areas raising the most Datix reports in relation to staffing levels 9 each, with Locke and Lister having 6 each .



Triangulation with patient safety incidents raised has not identified any patient safety issues as a direct result of the staffing concerns in the falls, pressure ulcers, medication delays and communication however the impact on staff with stress and anxiety is noted as well as delays in providing care or transfer of care.

There has not been a statistically significant increase in pressure ulcer harm rates and incidents per 1000 bed days in February against the previous quarter.

3.11 Bank and Agency fill rates

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.

In February, there was a reduction in registered nursing demand ↓351 shifts requested in February compared to January. In January additional demand was added to try and find alternative ways of

RN temporary staffing demand and fill rates: ***(February 2022 data supplied by NHSP 8.3.2022)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
September 2021	2538	1767	69.6%	452	17.8%	87.4%	319	12.5%
October 2021	2982	1862	62.4%	456	15.3%	77.7%	664	22.3%
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%**
February 2021	3086	1739	56.4%	345	11.2%	67.5%	1002	32.5%

The HCSW demand shows a decrease in unregistered demand (↓401 shifts), there was an increase in fill rate from 72.8% in January to 80.7% in February. There were no agency HCA shifts booked for Paediatric ED in January.

HCA temporary staffing demand and fill rates: ***(February 2022 data supplied by NHSP 8.3.2022)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
September 2021	1773	1271	71.6%	0	0%	71.6%	502	28.3%
October 2021	1804	1359	75.3%	0	0%	75.9%	434	24.1%
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%**
February 2021	1539	972	63.2%	151	9.8%	73%	416	27%

4. 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
February	77%	77%	93%	86%	96%	88%	85%	75%

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
February	87%	75%	39%	100%	96%	83%	166%	66%

Intrapartum acuity

The maternity service implemented the use of the Birthrate Plus intrapartum acuity tool in 2022. 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 February the Labour Ward did not achieve a 85% confidence factor in the month – 50.6% of recordings were made where staffing met acuity. 73.21% 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 February the Birth Centre did not achieve 85% positive acuity in the month – 23.8% of recordings were made where staffing met acuity. 25.6% 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. The majority of negative acuity is amber with up to 1 midwife short with no percentage of occasions being red which equates to more than 1 midwife short.

5. Red flags

In total there were 7 red flags recorded during this reporting period. The majority of these related to delays in the induction of labour process (n=2, 29%) and the co-ordinator not able to maintain supernumerary status (n=3, 43%). All delays for induction of labour and the inability for the co-ordinator to be supernumerary will be incident reported via the DATIX system.

Action: Review of the Induction of labour pathway especially the process for prioritisation at times of high activity

5.1 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.

5.2 Supernumerary status of the coordinator

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 3 occasions (43%) during the reporting period.

Action: Review of the Escalation policy to ensure that it supports the supernumerary status of the coordinator and clearly defines the actions to take to mitigate in times of high activity / acuity.

5.3 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 95 management actions taken. The majority of these related to redeploying staff internally (n = 74, 48%), utilise on call midwife (n=14, 9%), managers/specialists working clinically (n = 10, 7%) and escalation to the manager on call (n=14, 9%)

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

February	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	7	0	3	95	50.6	1.8%	22%	123/168	73.21%
Birth Centre	0	0	0	0	23.8%	0%	2.4%	43/168	25.6%

6. 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	23	56% exceptional care needs	6	57%	0%	38%	56/84	67%
Postnatal Ward	2	80% extra care babies	0	32%	0%	7%	74/84	88%

Antenatal Ward - There were 30% 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=12) and the inability to fill a vacant midwifery shift with bank or agency (n=24). The majority of red flags related to delayed or cancelled time critical activity (n=20, 80%) and delay between admission for induction of labour and beginning of process (n=3, 12%) Clinical actions taken during this period were a delay in ongoing induction of labour (n=22, 92%). Management actions were to escalate to the manager on call (n=2, 33%), manager working clinically (n=1, 17%), staff unable to take allocated breaks (n=1, 17%) and redeploy staff internally (n=1, 17%). The distribution of care hours allocated for extra needs included (n=19 hours, 56%) for exceptional care needs and (n=15 hours, 44%) for safeguarding.

Postnatal Ward – There were 86% of no relevant staffing factors recorded in this period. The red flags related to delayed or cancelled critical activity (n=2, 100%). Clinical actions taken during this period were a delay in discharge (n=3, 100%). Management actions were to redeploy staff internally (n=4, 100%). The distribution of care hours allocated for extra needs included (n=697.5 hours, 80%) for extra care babies, (n=70 hours, 8%) for safeguarding and (n=69 hours, 8%) for exceptional needs.

There has been a workforce review completed by the director of midwifery to review staffing in each ward area. This was presented to the Trust board in February, and work is underway in resetting the cost centres and ensuring the correct roster templates in all areas. In addition, a maternity improvement board has been implemented with a number of improvements workstreams. One workstream is reviewing the induction of labour process.

B: Workforce:

5.0 Nursing Recruitment Pipeline

An internal audit of the establishment and in post numbers was undertaken in January and it was identified that the pipeline data in the table below was not reconciling with the data on ESR and the vacancy rate published in the Integrated Performance Report (IPR). A number of discrepancies were identified in the tracker, the most significant of which was some of the international nurses being double counted. Following this review the ‘in post numbers’ have been reset in the January data which has resulted in a slightly higher vacancy rate that had been previously reported in this report.

The nursing establishment has been uplifted in February to include uplifts to the establishments from the establishment review and funding of Kingsmoor ward to enable recruitment. The uplift and results of the reset of the in-post numbers has meant that the overall vacancy rate has increased to 10.73% and the Band 5 vacancy rate to 12.2%. There are planned recruitment for international nurses in March and this will continue into 22/23. Funding is provided by NHSE to cover international nursing recruitment costs. The Trust us seeing an increase in leavers which is not unexpected following the lifting of Covid measures. A proactive focus on retention is embedded within the nursing recruitment workstreams.

Nursing Establishment v Staff in post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	1015.48	1015.5
Staff in Post WTE	915.00	920.00	922.00	937.00	936.00	936.00	961.58	967.58	966.58	894.00	915.80	916.80
Vacancy WTE	51.25	46.25	44.25	29.25	30.25	30.25	4.67	-1.33	-0.33	72.25	99.68	98.68
Actual RN Vacancy Rate	5.3%	4.8%	4.6%	3.0%	3.1%	3.1%	0.5%	-0.1%	0.0%	7.5%	9.8%	9.7%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Band 5 Establisment WTE	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	527.85	569.79	569.79
Band 5 Staff in Post WTE	498	502	516	520	523	548	558	558	571	508	510	516
Vacancy Band 5 WTE	24.2	20.2	6.2	2.2	-0.8	-25.98	-35.98	-35.98	-48.98	19.85	59.79	53.79
Actual Vacancy Rate	4.6%	3.9%	1.2%	0.4%	-0.2%	-5.0%	-6.9%	-6.9%	-9.4%	3.8%	10.5%	9.4%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RNs (not Band 5)	3	2	3	1	4	3	0	7	0	2	1	2
Band 5 Newly Qualified + Local	1	0	3	0	1	18	9	1	0	13	1	1
Band 5 International Recruitment	11	16	13	8	10	12	8	8	18	10	12	12
Band 5 Starters	**12**	**16**	**16**	**8**	**11**	**30**	**17**	**9**	**18**	**23**	**13**	**13**
Total Starters	15	18	19	9	15	33	17	16	18	25	14	15

Projected Leavers WTE												
	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Dec-21	Jan-22	Feb-22	Mar-22
RNs (not Band 5) Leavers	4	4	2	6	7	2.6	4	8	6	3	2	7
Band 5 Leavers	6	12	2	4	8	4.82	7	9	5	7	11	7
Total Leavers	**10**	**16**	**4**	**10**	**15**	**7.42**	**11**	**17**	**11**	**10**	**13**	**14**
N&M Turnover %	9.27%	10.83%	10.42%	10.80%	11.51%	11.67%	12.04%	12.74%	12.76%	13.16%	13.85%	

The Trust receive support for recruitment of healthcare support workers from NHSE/I. The table below provides the pipeline and recruitment trajectory for HCSW. The establishment has been adjusted in Minth to reflect the changes as a result of the establishment review and funding of the enhanced care team. Despite the recruitment team working closely with the practice development team, department leads in supporting the recruitment and on boarding of this group of staff turnover remains high and an area of focus for the Recruitment and Retention Nurse. Recruitment days remain popular and there are 36 due to commence in March. NHSE/I have extended the financial offer to support HCSW recruitment into 2022.

Establishment V Staff in Post			
	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	416	423.64	423.64
Staff in Post WTE	354.00	359.50	385.50
Vacancy WTE	62	64.14	38.14
Actual B2/B3 Vacancy Rate	14.9%	15.1%	9.0%
Forcast Vacancy Rate in Business Plan			

Actual/Projected Starters Pipeline			
	Jan-21	Feb-21	Mar-21
Band 2 Starters	**18**		**36**
Total Starters	**18**		**36**

Projected Leavers WTE			
	Jan-21	Feb-21	Mar-21
Total Band 2/3 Leavers	**18**		**10**
HCSW Turnover %	21.20%	21.98%	

5.1 Apprenticeships

The Trust has been working for some time on supporting HCSW to undertake apprenticeship's either as a Nursing Associate or via a 2+2 route to registered nurse in partnership with Anglia Ruskin University and direct entry degree nurse associates. In 2021/22 we will have 11 HCSW qualifying as RN via the apprenticeship route and 2 NA's.

Over 2021/22 this programme has been extended as part of the join work within the ICS to grow our own future nursing workforce. The now includes direct entry student nursing associates and degree nurse apprenticeships. The following table provides a breakdown of the numbers of HCSW currently undertaking an apprenticeship programme.

Apprenticeship Programme	**Number of Apprentices**
Degree Nurse Apprenticeship (2+2 or 4 year programme)	
Years 0-2	28
Years 2-4	22
Student Nursing Associate (2 year programme)	4
Total	**54**

Depending on the academic and clinical supernumerary time required by specific course's HCSW Apprentices are required to be off rota for between 2-3 days per week. There is back-fill funding for this which covers some temporary staffing backfill costs but the number of staff on apprenticeships is having an impact on HCSW fill rates in conjunction with ongoing vacancy rates.

6 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 15.03. 2022

Appendix 1

Ward level data: fill rates February 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

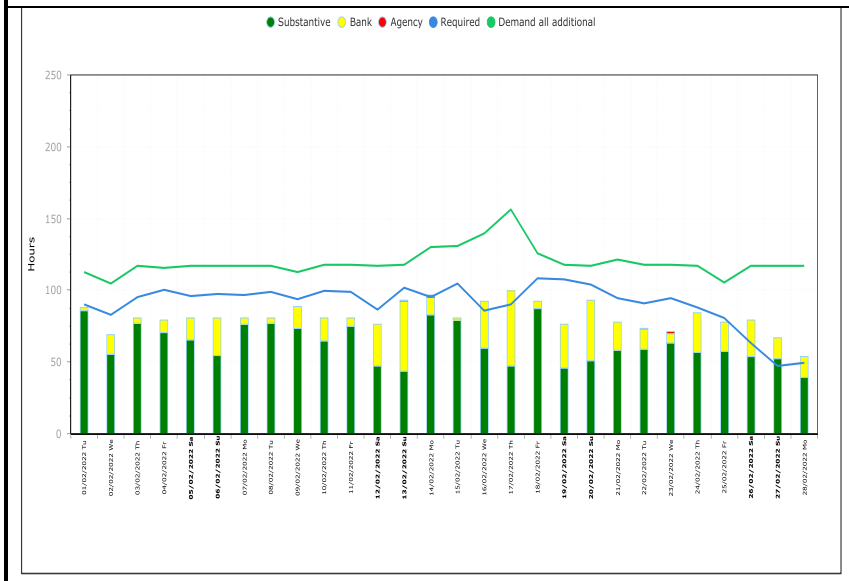
	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	80.7%	48.4%	78.3%	25.0%	79.5%	36.7%	74.2%
Saunders Unit	96.8%	87.7%	107.3%	122.8%	101.2%	101.0%	101.2%
Penn Ward	105.3%	89.3%	108.4%	105.7%	106.6%	95.5%	102.7%
Henry Moore Ward	108.9%	120.9%	100.2%	57.1%	104.6%	90.1%	101.1%
Harvey Ward	81.9%	92.6%	95.3%	119.4%	87.4%	105.4%	93.9%
John Snow Ward	101.3%	63.1%	91.0%	96.9%	96.5%	74.0%	86.6%
Charnley Ward	85.7%	139.1%	78.3%	135.7%	82.1%	137.5%	97.9%
AAU	80.0%	114.4%	80.1%	140.3%	80.1%	126.7%	90.4%
Harold Ward	78.0%	80.9%	89.6%	104.7%	83.0%	90.6%	86.0%
Kingsmoor General	83.1%	71.1%	102.3%	93.5%	91.2%	80.2%	86.4%
Lister Ward	79.5%	145.7%	103.7%	107.8%	88.6%	127.6%	103.2%
Locke Ward	87.3%	119.8%	97.6%	108.6%	91.8%	114.5%	97.8%
Ray Ward	93.4%	125.3%	110.7%	110.7%	100.7%	118.3%	106.1%
Tye Green Ward	71.0%	111.9%	84.2%	110.1%	76.7%	111.2%	90.1%
Winter Ward	74.5%	97.7%	109.8%	104.3%	87.9%	100.9%	92.7%
Fleming Ward	61.6%	120.3%	89.4%	99.9%	72.1%	110.5%	83.0%
Neo-Natal Unit	90.8%	133.4%	92.0%	127.6%	91.4%	130.5%	97.9%
Dolphin Ward	70.4%	99.7%	72.0%	118.2%	71.1%	105.8%	79.8%
Total	82.7%	99.9%	91.0%	105.8%	86.4%	102.5%	91.3%

Appendix 2

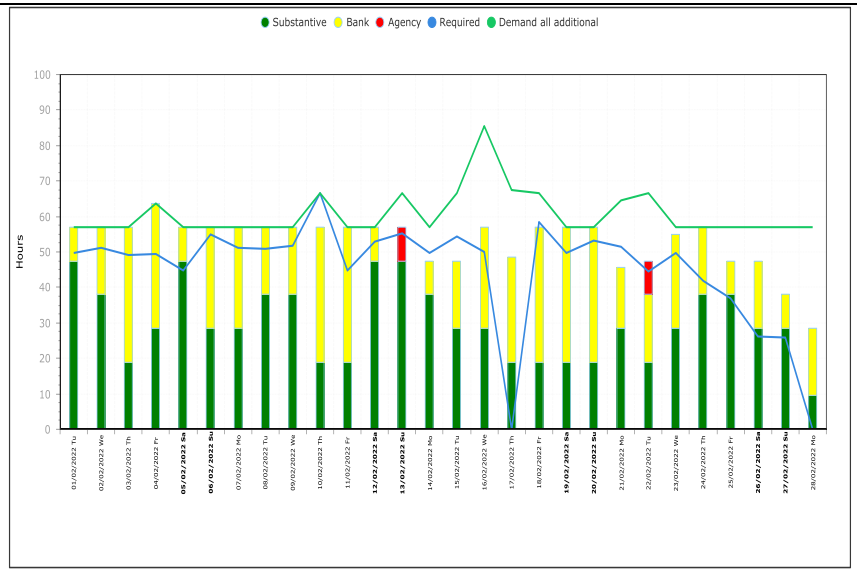
Ward staffing exception reports
Reported where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. Please note further review of data sets will enable a more robust and detailed analysis going forward (February data)

Report from the Associate Director of Nursing for the HCG								
Ward	Analysis of gaps				Impact on Quality / outcomes			Actions in place
Fleming Ward	72.1% overall RN fill rate				No significant increase in pressure ulcers or falls.			Ward manager worked clinically alongside team. Cardiology CNS provided clinical support for all or part of their shift when the clinical acuity required.. Cardiac Cath lab staff redeployed to support. Planned staffing not adjusted to actual demand as per graph below although still shortfall on most days but not on nights
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS	
Number in month	2	3	1	0	4	0	1	

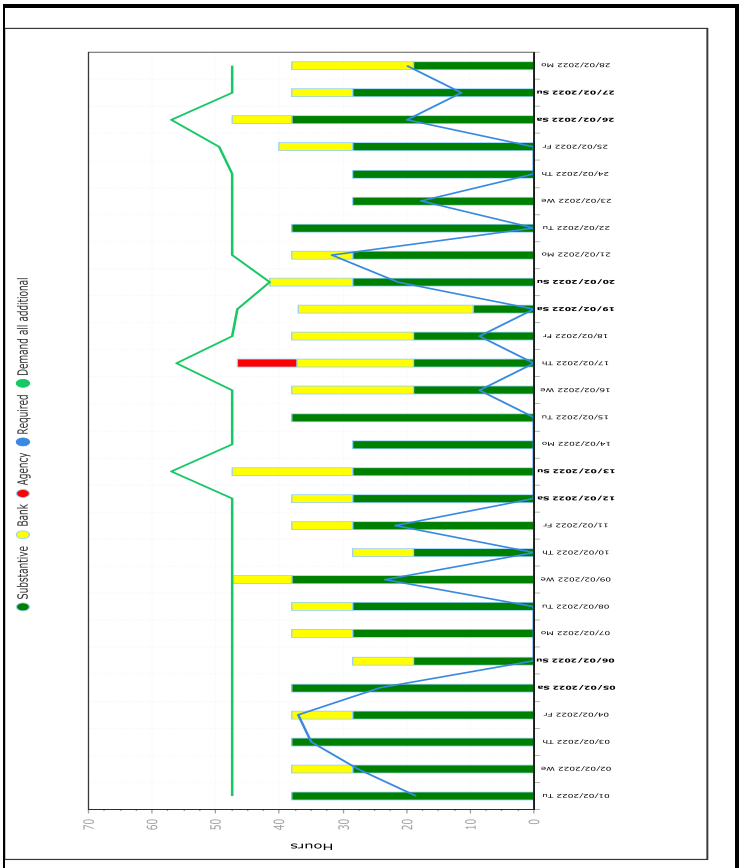
Required vs Actual Day

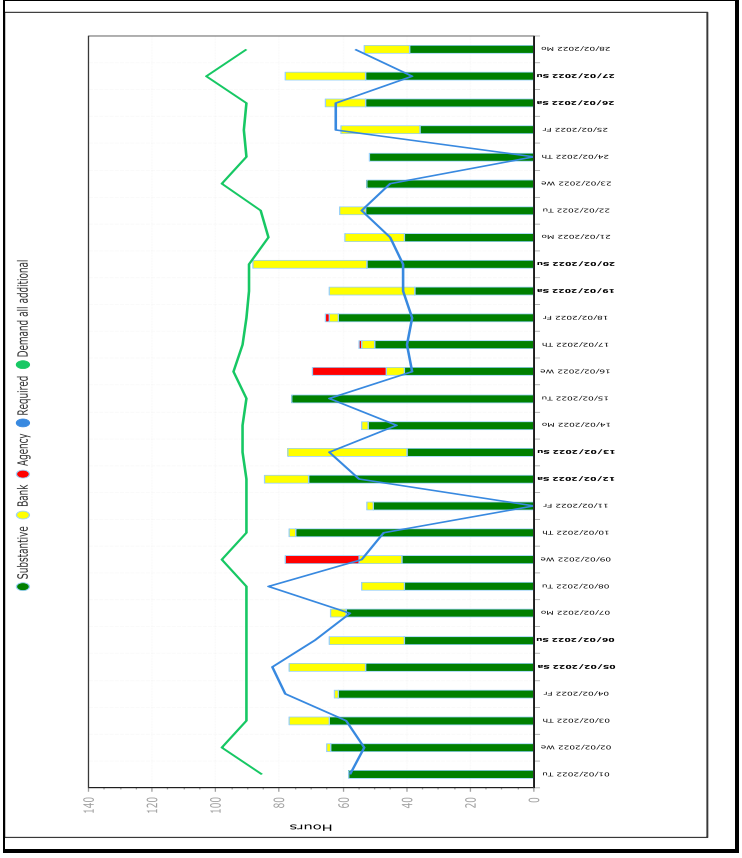


Required vs Actual Day



Report from the Associate Director of Nursing for the HCG							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
Dolphin Ward	71.1% Overall RN fill rate			Capacity was flexed daily according to staffing levels. Reduced activity to Dolphin with use of UTC and hospital at home pathways.			Closed beds dependent on staffing levels. Redeployed staff from Paeds ED and NICU to support. Managers and specialist nurses supported where required.
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			


Substantive
Bank
Agency
Required
Demand all additional
Hours
70
60
50
40
30
20
10
0


Substantive
Bank
Agency
Required
Demand all additional
Hours
140
120
100
80
60
40
20
0

Appendix 3

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

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total (including Maternity)	**2.5**	**4.8**	**7.3**

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Total	**4.7**	**2.4**	**7.1**
ITU & HDU	28.5	1.9	30.3
Saunders Unit	4.0	2.2	6.3
Penn Ward	4.1	2.0	6.2
Henry Moore Ward	5.3	1.5	6.8
Harvey Ward	3.6	2.4	6.0
John Snow Ward	3.7	2.2	5.9
Charnley Ward	3.7	2.5	6.2
AAU	5.1	2.3	7.4
Harold Ward	3.4	2.4	5.7
Kingsmoor General	4.0	2.8	6.8
Lister Ward	3.7	3.2	6.9
Locke Ward	4.5	2.0	6.5
Ray Ward	4.3	2.2	6.5
Tye Green Ward	3.2	3.0	6.2
Winter Ward	3.7	2.5	6.2
Fleming Ward	3.5	2.1	5.6
Neo-Natal Unit	7.5	2.2	9.7
Dolphin Ward	8.5	4.2	12.8

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Maternity Ward Total	**2.8**	**6.0**	**8.8**
Labour Ward	11.0	3.7	16.7
Birthing Unit	17.0	7.4	24.4
Samson Ward	2.5	2.3	4.8
Chamberlen Ward	6.2	1.7	7.9

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 April 2022

4.5

Agenda item:	4.5
Presented by:	Sharon McNally, Director of nursing, midwifery and AHPs
Prepared by:	Giuseppe Labriola, Director of Midwifery
Date prepared:	14th February 2022
Subject / title:	Ockenden Review of Maternity Services – one year on

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	Donna Ockenden's independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust was published in December 2020. The review identified 7 Immediate and Essential Actions (IEAs) to be addressed by all Maternity Units using the Assurance Assessment Tool, which included the recommendations from the **Morecambe Bay investigation** report and the **Ockenden report.** One year on, maternity services have been asked to discuss progress with implementation of the 7 IEAs outlined in the Ockenden report. This is to include the plan to ensure full compliance alongside PAHT's maternity workforce plans at public Board before the end of March 2022. This paper provides the progress and current status against the Ockenden immediate and essential actions which includes the recommendations from the Morecambe Bay investigation.							
Recommendation:	To note the information contained with this report and the ongoing work regarding the implementation and embedding of the immediate essential actions.							

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

Previously considered by:	Quality Committee (Maternity assurance): February 2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Regulatory requirements in relation to Ockendon report (2020), and the Morecambe Bay report (Kirkup, 2015) Any changes to local policy or procedures consider EDI through Equality Impact Assessment.
Appendices:	Appendix 1: PAHT's compliance against the 7 immediate safety actions Appendix 2: Summary of Kirkup and Ockendon Appendix 3: Maternity services workforce plan.

1.0 Purpose

The Ockendon report (2020) identified 7 Immediate and Essential Actions (IEAs) to be addressed by all Maternity Units using the Assurance Assessment Tool (AAT). The AAT includes the recommendations from the **Morecambe Bay investigation** report alongside the **Ockenden report.** In line with national expectations, this paper outlines our current baseline assessment against the AAT.

A summary of the Kirkup Report (Investigation into Morecambe Bay Maternity Services, 2015), and the Ockendon Report (Investigation in Shrewsbury and Telford Hospital NHS Trust Maternity Services, 2020) is included in appendix 2.

2.0 Analysis of our 7 IEAs

In response to the Ockendon report, all providers were asked to submit evidence against the 7 IEAs (July 21) using the Assurance Assessment Tool (AAT). All provider submissions were reviewed independently though a national framework. The results were provided to the individual Trusts identifying if the evidence submitted met the required standards.

Following the initial review of our submission evidence, further evidence was submitted (Nov 21) and reviewed by the regional team, where a further 12 elements were agreed as compliant.

Appendix 1 provides the full details of PAHT's compliance against the 7 immediate safety actions. Table 1 provides a summary against each immediate essential action

Table 1. Overview of compliance with immediate essential actions

Immediate Essential Action	Compliance
1. Enhanced Safety	94%
2. Listening to women and families	82%
3. Staff training and working together	67%
4. Managing complex pregnancy	100%
5. Risk Assessment throughout pregnancy	93%
6. Monitoring fetal wellbeing	67%
7. Informed consent	57%
WF Maternity Workforce planning	70%

Table 2 details our current position against each criterion which requires further improvement.

Table 2. Improvement plan for each element

IEA	Areas of further improvement needed	Comments
1. Enhanced Safety	**Plans to implement the perinatal clinical quality surveillance model** – Local Maternity and Neonatal System (LMNS) Standard Operational Procedure (SOP) and minutes that describe how this is embedded in the Integrated Care	PAHT has implemented a new maternity assurance committee starting in February 2022. Maternity Quality Assurance reported quarterly – commenced October 2021

	System (ICS) governance structure and signed off by ICS	
2. Listening to women and families	**Trust safety champions –** action log and actions taken. Evidence of meeting at least bi-monthly**.** NED identified as support for maternity safety champion with name of NED and date of appointment, and role descriptors	Maternity safety champions roles refreshed. New Executive Director appointed to fulfil role. SOP written to detail role descriptors
3. Staff training and working together	**Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward –** SOP created for consultant led ward rounds **External funding allocated for the training of maternity staff is ring fenced and used for this purpose only –** confirmation from DoF, Evidence from budget statements, evidence of funding received and spent, evidence that additional external funding has been spent on funding including staff can attend in work time, Maternity Transformation Progamme spend reports to LMNS	Twice daily consultant-led ward rounds take place on the Labour Ward. Audit to be completed to review compliance. New maternity transformation workstream "Handover, Huddles and ward rounds" reviewing this. Further evidence required for allocation of monies from Health Education England (HEE) and Continuing Professional Development (CPD) per head.
5. Risk Assessment throughout pregnancy	**Intended place of birth, based on the developing clinical picture –** evidence of referral to birth options clinic	Birth options clinic SOP currently being produced. New Consultant Midwife post for midwifery led care and public health will lead and strengthen this pathway
6. Monitoring fetal wellbeing	**Appoint a dedicated lead midwife and lead obstetrician with demonstrated expertise to focus on and champion fetal monitoring –** evidence of participating in incident investigations and reviews, name of dedicated midwife and obstetrician. Evidence that they are engaged in fetal wellbeing monitoring and are adequately supported. Interface with external units and agencies to learn about and keep abreast of development in the field, and to track and introduce best practice. Lead on the review of adverse outcomes involving poor FHR interpretations and practice **Submit TNA that clearly articulates the expectation of all professional groups at all MDT training and core**	Lead midwife and obstetrician in post. Both clinicians lead on the fetal monitoring study days and weekly learning sessions. All cases of poor outcomes involving Fetal Heart Rate (FHR) interpretation are reviewed by the two clinicians. This will be formally introduced in job descriptions for evidence. Evidence required of how the leads gain their specific knowledge updates (attending national fetal monitoring forums) Training Needs Analysis (TNA) is being updated in view of NHS Resolution (NHSR) requirements.

	competency training. Also aligned to NHSR requirements.	
7. Informed consent	**Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery -** Information on maternal choice including choice for caesarean delivery. **Women must be enabled to participate equally in all decision-making processes –** CQC survey and associated action plans, SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care**.** And where this is recorded. **Women's choices following a shared and informed decision making processes must be respected -** SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where this is recorded. **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website -** Co-produced action plan to address gaps identified. Information on maternal choice including choice for caesarean delivery.	Pathway in development to aid decision making for place of birth. This will include referral to birth options clinic for maternal choice for caesarean section birth SOP being developed to detail this process. Linking in with Maternity Voices Partnership (MVP). Maternity handheld notes are currently being refreshed to assist with this process. Website development is currently in progress. New video tours being produced in collaboration with the Maternity Voices Partnership (MVP).
WF	**Demonstrate an effective system of clinical workforce planning to the required standard** Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	Full workforce review completed and presented to Trust in February 2022 by Director of Midwifery (DoM). Discussions at LMNS board have taken place in regards to joint recruitment, staff passports, rotation to support workforce planning and retention.

Maternity services workforce plans

A full workforce review was completed by the director of midwifery, and presented to the Trust board in February 2022. The identified investment with the midwifery workforce was approved and the service has a phased approach in recruiting to these posts. PAHT is fully engaged with the East of England region and has expressed an interest in recruiting 6 WTE international midwives. The workforce review describes a three-year plan with our midwifery workforce. Detail of the review and plan is included in appendix 3.

4.0 Recommendation

The ongoing assurance of compliance and sustainability of improvement will be supported by Regional Chief Midwives. Further updates on progress will be provided to the new maternity assurance committee on a scheduled workplan. It is requested that the Board accept the report with the information provided and the ongoing work with the implementation of the immediate essential actions.

Author: Giuseppe Labriola – Director of Midwifery
Date: 14.02.2022

The Princess Alexandra Hospital NHS Trust

4.5

APPENDIX 1

PAHT's compliance against the 7 immediate safety actions

IEA 1

IEA	Question	Action	Evidence Required	PRINCESS ALEXANDRA HOSPITAL NHS TRUST
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%
			Submission of minutes and organogram, that shows how this takes place.	100%
		Total		**100%**
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	100%
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**100%**
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%
			Submit SOP	100%
		months Total		**100%**
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%
			how parents and women are involved in the PMRT process as per the PMRT guidance.	100%
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%
		NHS Resolution's Early Notification scheme Total		**100%**
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	0%
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	100%
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**67%**
IEA1 Total				**94%**

IEA 2

IEA2	Q11	services	Evidence of how all voices are represented.	100%
			Evidence of link in to MVP; any other mechanisms	100%
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%
			Name of NED and date of appointment	100%
			NED JD	100%
		Non-executive director who has oversight of maternity services Total		**100%**
	Q13	feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
		service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	0%
			Log of attendees and core membership.	100%
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%
		Trust safety champions meeting bimonthly with Board level champions Total		**75%**
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
		for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		**100%**
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%
			Name of ED and date of appointment	0%
			Role descriptors	0%
		Non-executive director support the Board maternity safety champion Total		**33%**
IEA2 Total				**82%**

IEA 3

IEA3	Q17	must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%
		Evidence must be externally validated through the LMS, 3 times a year. Total		**100%**
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night, 7 days a week (e.g. audit of compliance with SOP)	100%
			SOP created for consultant led ward rounds.	0%
		multidisciplinary ward rounds on the labour ward. Total		**50%**
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%
			Evidence from Budget statements.	0%
			Evidence of funding received and spent.	0%
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	0%
			MTP spend reports to LMS	0%
		maternity staff, is ring-fenced and used for this purpose only Total		**0%**
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			Attendance records - summarised	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**100%**
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night, 7 days a week (E.G audit of compliance with SOP)	100%
		twice daily (over 24 hours) and 7 days per week. Total		**100%**
	Q23	vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%
		training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training		**100%**
IEA3 Total				**67%**

IEA4

IEA4		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and for referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	
	Q24			100%
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%
		Centre & agreement reached on the criteria for those cases to be discussed and for referred to a maternal medicine specialist centre Total		**100%**
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 5% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%
		Women with complex pregnancies must have a named consultant lead Total		**100%**
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 5% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%
			specialist involvement and management plans agreed between the woman and the teams.	100%
		involvement and management plans agreed Total		**100%**
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		Saving Babies' Lives care bundle Version 2 Total		**100%**
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%
			Submission of an audit plan to regularly audit compliance	100%
		a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%
			Criteria for referrals to MMC	100%
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**
IEA4 Total				**100%**

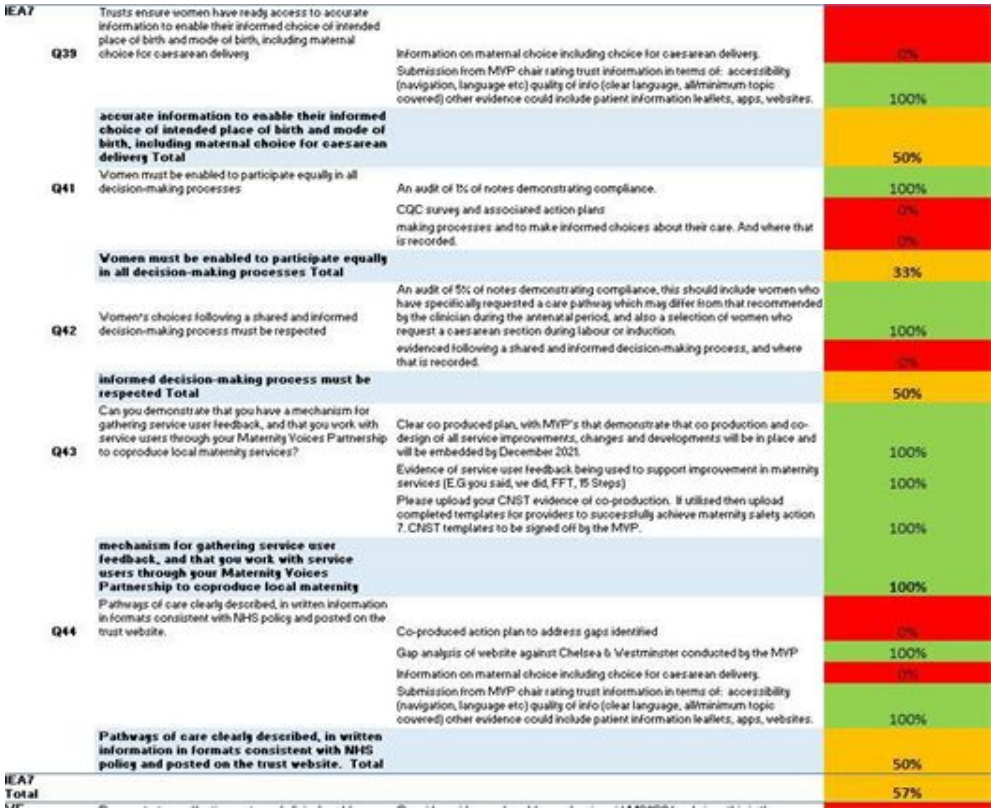
IEA5

IEA5		antenatal contact so that they have continued access to care provision by the most appropriately trained professional		
	Q30		How this is achieved within the organisation.	100%
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%
			What is being risk assessed.	100%
		every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**100%**
	Q31	intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	0%
			Out with guidance pathway.	100%
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%
			SOP that includes review of intended place of birth.	100%
		of the intended place of birth, based on the developing clinical picture. Total		**75%**
	Q33	review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%
			How this is achieved in the organisation	100%
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP to describe risk assessment being undertaken at every contact.	100%
			What is being risk assessed.	100%
		ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to		**100%**
IEA5 Total				**93%**

IEA6

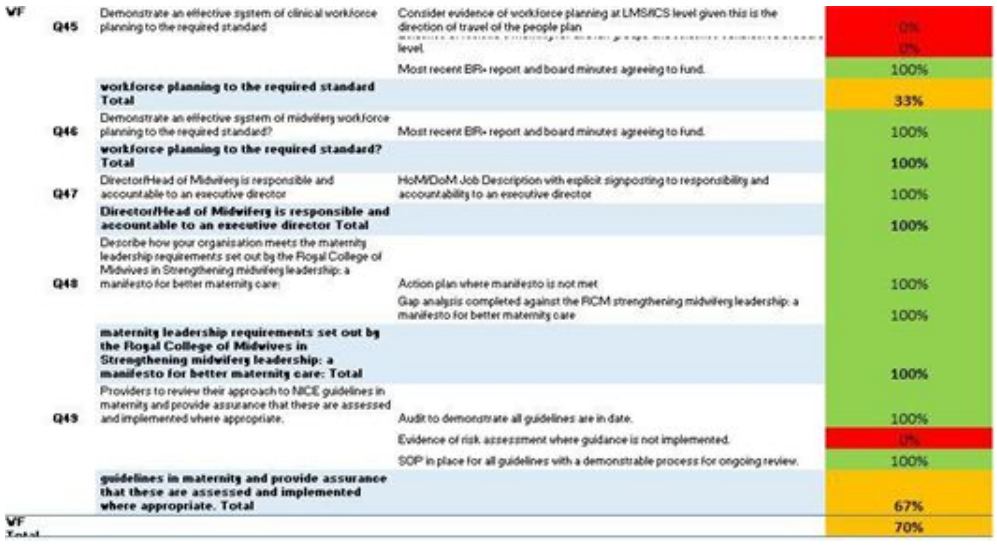
IEA6		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring		
	Q34		Copies of rotas / off duties to demonstrate they are given dedicated time.	100%
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%
			Incident investigations and reviews	0%
			Name of dedicated Lead Midwife and Lead Obstetrician	0%
		Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**50%**
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health		
	Q35		Consolidating existing knowledge of monitoring fetal wellbeing	100%
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%
			Keeping abreast of developments in the field	100%
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	0%
			training.	100%
		demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**63%**
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		
	Q36		Audits for each element	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?		
	Q37		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			Attendance records - summarised	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	0%
		maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**67%**
IEA6 Total				**67%**

IEA7



IEA7		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery		
	Q39		Information on maternal choice including choice for caesarean delivery.	0%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		50%
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 5% of notes demonstrating compliance.	100%
			CQC survey and associated action plans	0%
			making processes and to make informed choices about their care. And where that is recorded.	0%
		Women must be enabled to participate equally in all decision-making processes Total		33%
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%
			evidenced following a shared and informed decision-making process, and where that is recorded.	0%
		informed decision-making process must be respected Total		50%
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
		mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity		100%
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	0%
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%
			Information on maternal choice including choice for caesarean delivery.	0%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		50%
IEA7 Total				**57%**

WF



WF		Demonstrate an effective system of clinical workforce planning to the required standard		
	Q45		Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	0%
			level.	0%
			Most recent BR+ report and board minutes agreeing to fund.	100%
		workforce planning to the required standard Total		33%
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%
		workforce planning to the required standard? Total		**100%**
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**
	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%
		maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		**100%**
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%
			Evidence of risk assessment where guidance is not implemented.	0%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	100%
		guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		67%
WF Total				**70%**

APPENDIX 2

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Kirkup Report (Investigation into Morecambe Bay Maternity Services)

The Kirkup Report, published in March 2015, was an independent investigation into the management, delivery and outcomes of care provided by the Maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013.

This Report detailed serious failures of clinical care in the maternity unit. The problems fell in five principal areas.

1. Clinical Competency

The clinical competence of a proportion of staff fell significantly below the standard required for a safe, effective service. This included failures to recognise warning signs in pregnancy, in labour and newborn babies.

2. Team Working

The working relationships between different groups of staff were extremely poor particularly between midwives, obstetricians and paediatricians with instances of failure to communicate important clinical information about individual patients.

3. Over-zealous pursuit of natural childbirth

Over-zealous pursuit of the natural childbirth approach led to inappropriate and unsafe care and there were instances of women inappropriately classified as being at low risk and managed incorrectly.

4. Failure to risk assess place of birth

Advice to mothers that it was appropriate to consider delivery at FGH was significantly compromised by a failure to assess the risks. Neonatal services were not equipped to deal with pre-term babies who needed intensive care.

5. Grossly deficient response to serious incidents

The response from clinicians to serious incidents was grossly deficient. The investigations were almost always uni-disciplinary, and often carried out by the same senior midwife. Reports were brief, failed to identify key failures of care, and showed evidence of adopting an inappropriately protective approach to midwives. 'Blame-shifting' behaviour predominated, and no dissemination of lessons learnt.

Recommendations

There were 44 recommendations as a result of the review, 8 that were specific to Morecambe Bay NHS Trust and the remainder were recommendations for the wider NHS including Trusts, maternity services NHS England, Department of Health, CQC,

In view of the review, Maternity Services were asked to review their practice, identify gaps and develop action plans in relation to the recommendations following the Kirkup Report. All the recommendations were reviewed and an action plan was developed by the Trust in 2015. This action plan has had a further review in February 2022.

Ockenden Report

The Ockenden report was published in December 2020 detailing the findings from an 'independent review of the quality of investigations and implementation of the recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust'.

The review initially identified 23 cases for consideration; however, following the contacts made by a number of families and the cases provided by the Trust for review, the total number had reached 1862 at the time of publication.

The report was based on the review of 250 cases and conversations with over 800 families (who had raised serious concerns about their care).

The report identified 7 **Immediate and Essential Actions** and recommended that all Maternity Units implement these actions immediately.

To support the implementation, NHSE/I developed a Maternity services assessment and assurance tool (MSAAT) to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) and to provide assurance of effective implementation to boards, Local Maternity System, and NHS England and NHS Improvement regional teams. These included the recommendations from the Morecambe Bay Investigation which gave the service the opportunity to revisit their compliance against these actions and identify areas that required further focus.

Following this, Maternity units were asked to submit the evidence against the 7 IEAs, as well as some additional questions on the Future NHS platform.

APPENDIX 3

Phased workforce plan

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Phase 1 (FY 2021-2022): realigning the cost centres and ensuring our staff are in the correct places. This will involve consultations with staff who may be affected. Conducting a training needs analysis for our maternity support workers. Funding released to enable the recruitment process to commence for the following posts: 1 WTE Consultant Midwife, 0.60 WTE Diabetic Midwife, 1 WTE Matron, 0.19 WTE Registered Nurses, 1 WTE Perinatal Mental Health Midwife, 5.90 WTE Registered Midwives, 5.77 WTE Maternity Support Workers, 4.28 WTE Maternity Care Assistants, 1 WTE Governance Administrator. The recruitment timelines for these posts are likely to have minimal impact on the 2021/2022 budgets, with temporary staffing costs only being incurred for the Registered Midwives and Maternity Care Assistants roles.

Phase 2 (FY 2022- 2023): starting a comprehensive training package for our maternity support workers and re-defining their roles and responsibilities. During this time, it is not appropriate or safe to skill mix the midwives on the unit. Releasing funding for the following posts: 1 WTE Preceptor Support Midwife, 1 WTE Fetal Medicine Midwife.

Phase 3 (FY 2024 - 2025) : would be applying a 90:10 split in appropriate areas with suitably trained staff with a further workforce review of the service looking at the midwifery establishment.

For our medical workforce, we currently are out to advert to recruit for 4 WTE Consultant Obstetrician posts.

BOARD OF DIRECTORS: Trust Board (Public) 7 April 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 28 March 2022

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 GMC Survey	Partial	Y	N	WFC received assurance in regards to the plans in place to improve the outlying areas identified in the GMC survey. It was agreed for the following issues to be addressed in the next report in 6 months; medical rotas and junior doctors' health and wellbeing.
2.2 Workforce Report	Yes	Y	N	WFC received assurance on the progress being made to improve workforce metrics/KPIs. WFC were assured in regards to the plans in place to improve direct agency bookings; which included direct booking being reviewed through the bank and agency steering group. The key themes from exit interviews across the Trust were noted. The main themes being work/life balance and promotions.
2.3 Staff Survey Results	Partial	Y	Trust Board to discuss in a workshop.	WFC agreed to discuss the staff survey results in a workshop with the Board to receive assurance on the impact of the results and how they will be addressed. WFC recommends the amendment of priority 3 and the addition of priority 4 to the Board.
2.4 Finance Thematic Review	Yes	Y	N	WFC noted the key themes from exit questionnaires taken from leavers within the finance department. It was noted an inclusive action plan would be completed by April.
2.5 Service Developments	For Information	N	N	WFC noted the recent service developments within the People directorate including; manager self-service, new starter e-forms

BOARD OF DIRECTORS: Trust Board (Public) 7 April 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 28 March 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				and the introduction of the recruitment and retention steering group.
2.6 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.
2.7 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16.
2.9 Health and Wellbeing Report	Yes	N	N	WFC received assurance in regards to recent initiatives and activities including; the successful opening of the Alex Lounge.
3.1 Communications Update	For Information	N	N	WFC noted the recent communications activities including; the new Our Journal publication.
4.1 Learning and OD Update	Yes	Y	N	WFC were assured on the learning and organisational development activities including; the launch of the new onboarding process in April.
4.2 ICS Update	For Information	N	N	WFC noted the recent work undertaken with ICS partners including; temporary staffing, flexible working, vascular and pathology services.
4.3 Horizon Scanning	For Information	N	N	WFC noted the Health and Care Bill workforce duty amendment was to be returned to the House of Commons and the planned independent review of the Disclosure and Barring Service.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 April 2022

5.2

Agenda item:	5.2
Presented by:	Mandi Osoba, associate director of learning and organisational development
Prepared by:	Mandi Osoba, associate director of learning and organisational development Charlotte Jefferson, organisational development manager
Date prepared:	20 March 2022
Subject / title:	NHS Annual Staff Survey 2021: national benchmarking and response plan

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	This paper sets out the results for the Annual Staff Survey 2021, benchmarked nationally against all other acute/acute and community trusts, and our next steps in using this data to drive improvement.
Recommendation:	For review and discussion regarding how to best utilise the results to drive improvements in staff experience. The Board is asked to note the benchmarking results, response plan and share any feedback.

Trust strategic objectives:

Patients	People	Performance	Places	Pounds
x	x	x		

Previously considered by:	EMT – 10-03-22 SMT – 15-03-22 and WFC.28.03.22
Risk / links with the BAF:	BAF Risk 2.3 Workforce: Inability to recruit and retain our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC - KLOE well led The Equality Act 2010 No potential areas of impact on EDI identified To avoid any potential negative impact, equality impact assessments carried out on collaborative initiatives
Appendices:	Appendix 1. People Promise elements, key themes and sub-scores Appendix 2. Significance testing on theme scores Appendix 3. Detailed benchmarked results Appendix 4. Initiatives to improve the health and wellbeing of our people

The Princess Alexandra Hospital NHS Trust

NHS Annual Staff Survey 2021: national benchmark scores

1.0 Introduction

This paper sets out the results for the Annual Staff Survey 2021 benchmarked nationally, and our next steps in using this data to drive improvement.

2.0 Background

The national benchmark report frames the survey results against national benchmark scores, and against the NHS People Promise. The NHS People Promise sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

3.0 Guidance on the national benchmark report

Key information about the benchmark report is detailed below:

- Most of the survey questions have been aligned (where possible) to the People Promise and the themes of 'staff engagement' and 'staff morale'.
  - Some questions do not align with these elements
  - **Appendix 1** provides full details of the questions within each theme.
- PAHT is benchmarked against 126 acute and acute and community trusts.
- Not all survey questions are benchmarked: some are not comparable due to some questions asking for demographic or factual information.
- The results are presented in the context of the best, average and worst results for similar organisations.
- Significance testing for 2020 vs 2021 is only available for the staff engagement and staff morale themes (not the People Promise elements, as this is newly introduced).
  - **Appendix 2** provides full significance testing information.

4.0 Benchmarked response rate

Our response rate to the survey was 47%, 1% higher than the median response rate of the comparison group (46%). This compares to a response rate of 38% in 2020, 7% lower than the median response rate of 45%.

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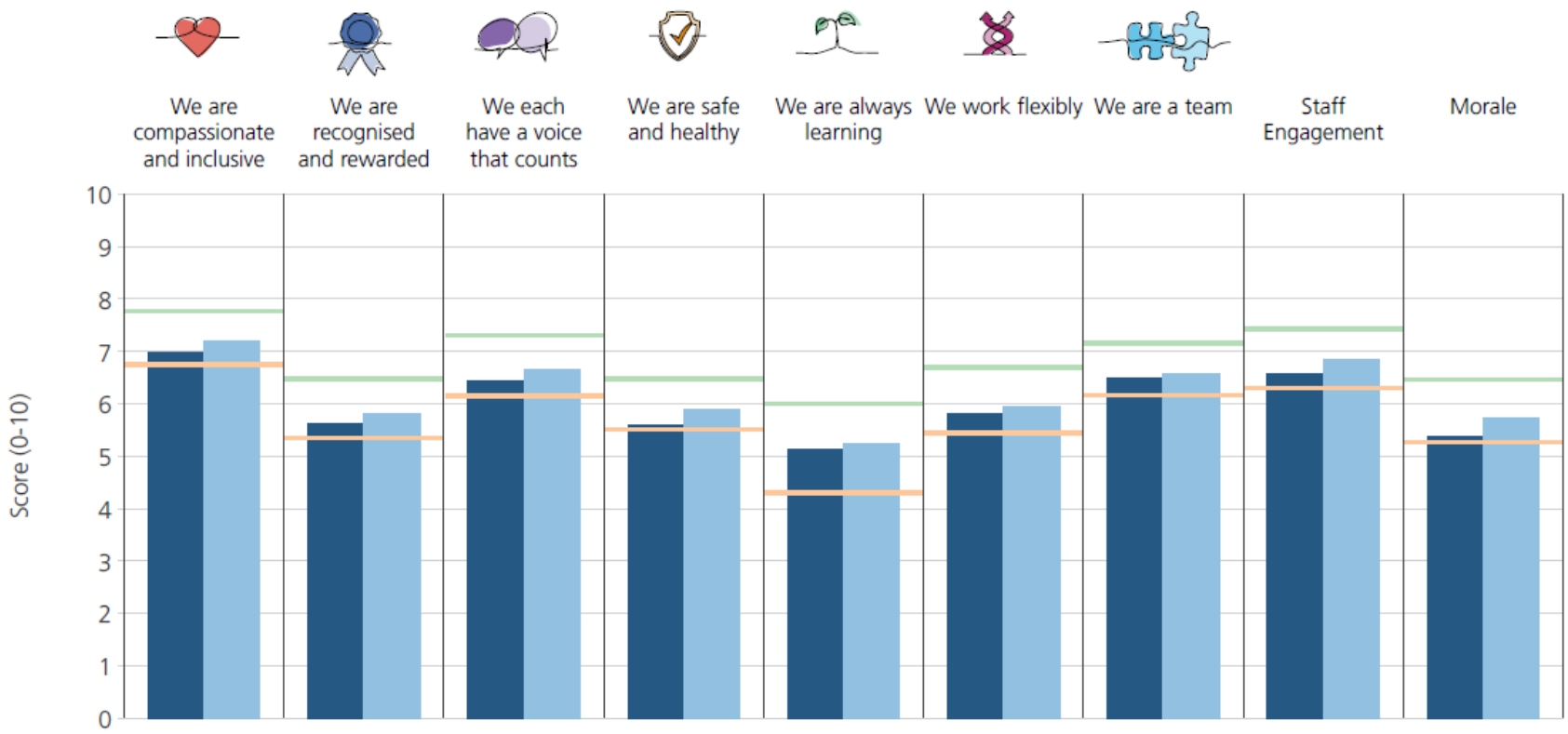
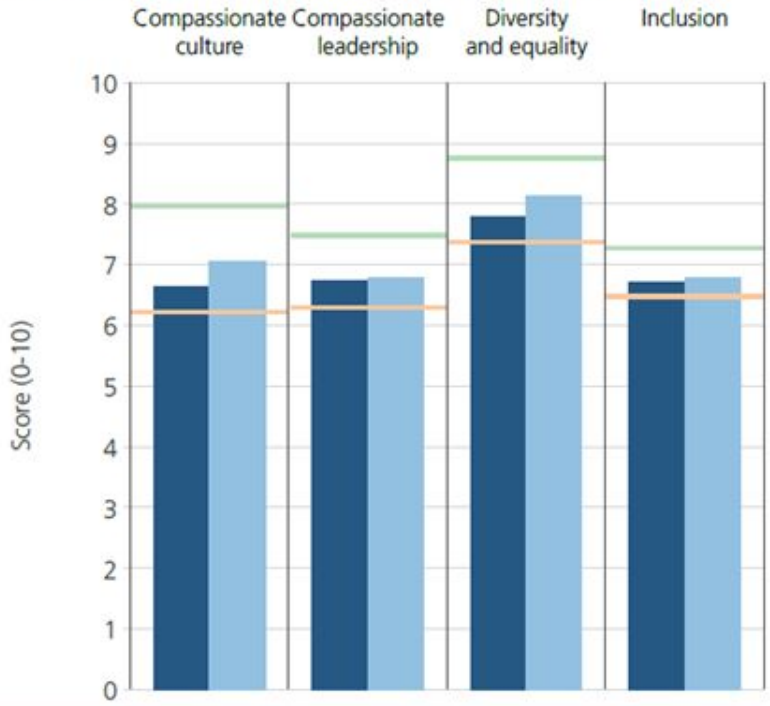
5.0 People Promise and theme overview results



	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

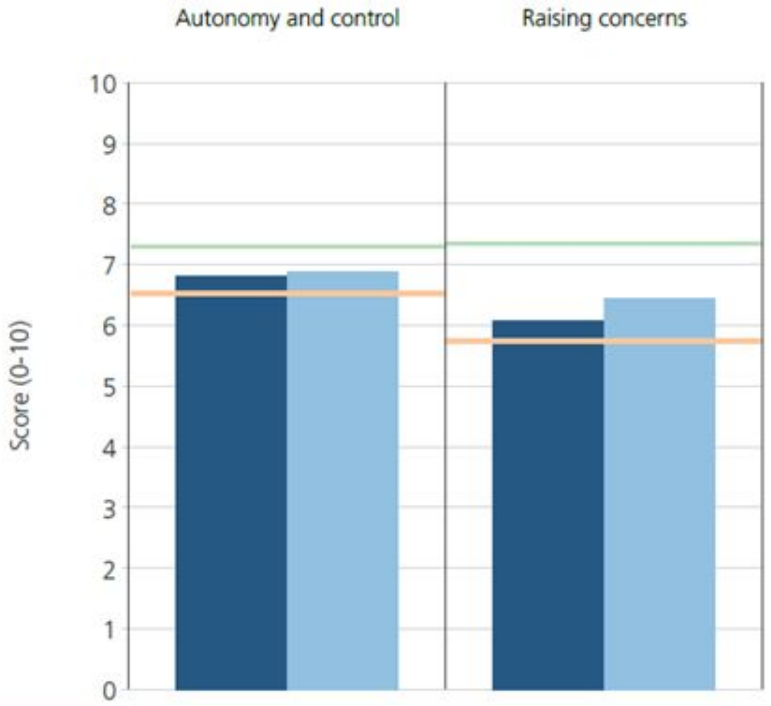
6.0 People Promise sub-score results

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	6.6	6.7	7.8	6.7
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	1,689	1,688	1,694	1,696

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	6.8	6.1
Average	6.9	6.4
Worst	6.5	5.7
Responses	1,713	1,669

* Promise element 2 features no sub-scores and so is not included in this section of the benchmarking report

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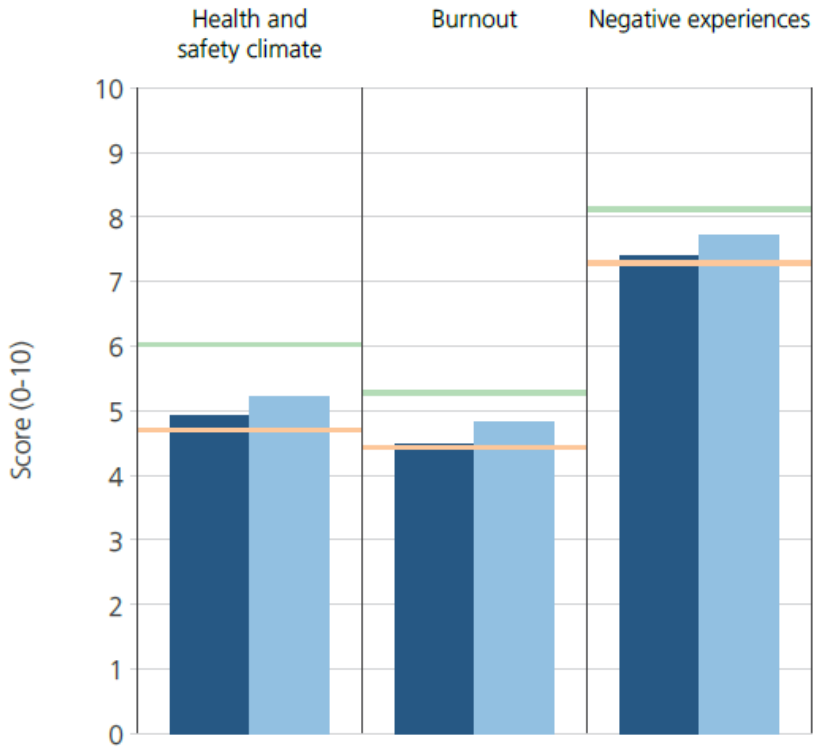
Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	4.9	4.5	7.4
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	1,715	1,702	1,698

Promise element 5: We are always learning

	Development	Appraisals
Best	6.9	5.1
Your org	6.0	4.2
Average	6.3	4.2
Worst	5.7	2.8
Responses	1,698	1,622

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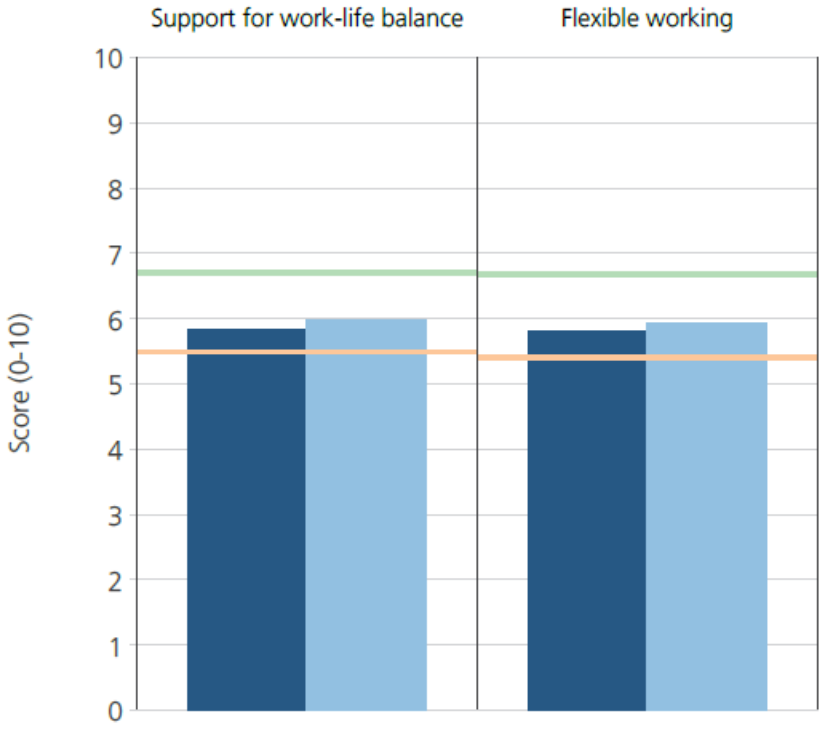
Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	5.8	5.8
Average	6.0	5.9
Worst	5.5	5.4
Responses	1,719	1,716

Promise element 7: We are a team

	Team working	Line management
Best	7.0	7.3
Your org	6.4	6.5
Average	6.5	6.6
Worst	6.2	6.2
Responses	1,714	1,692

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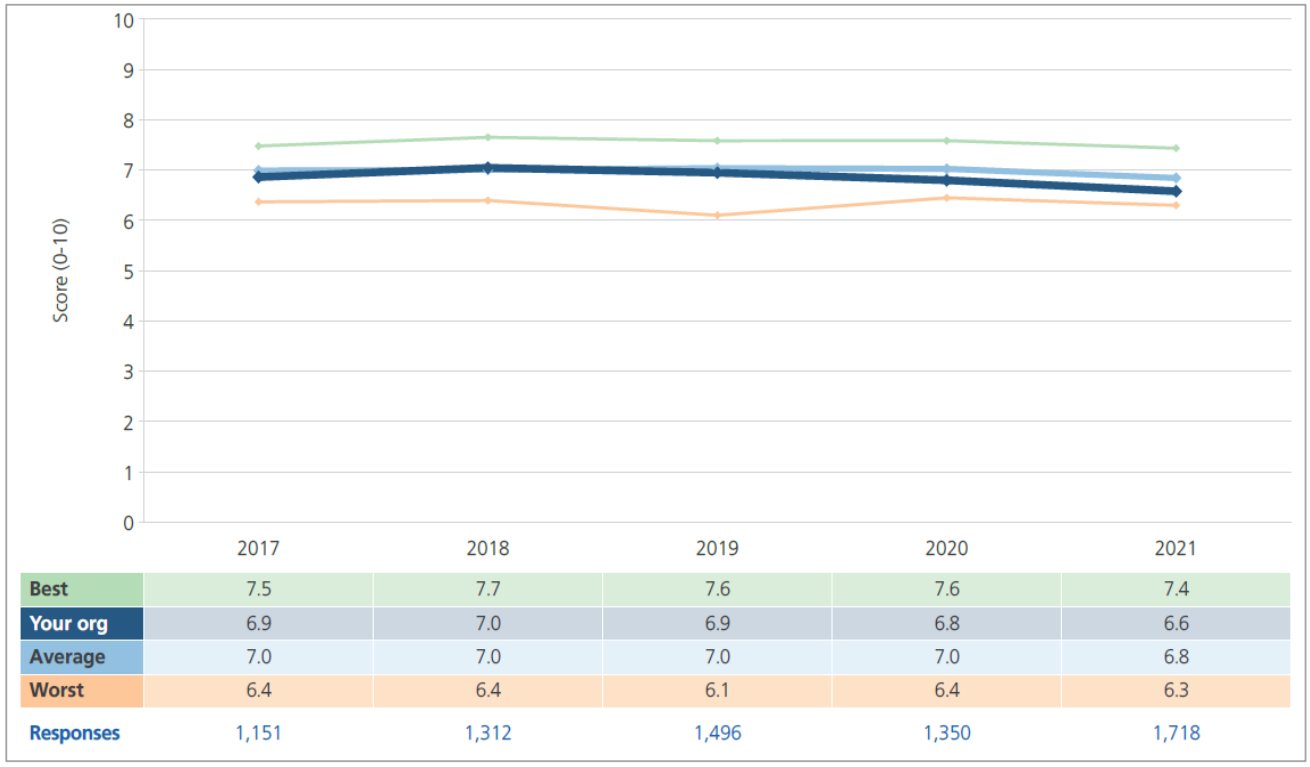
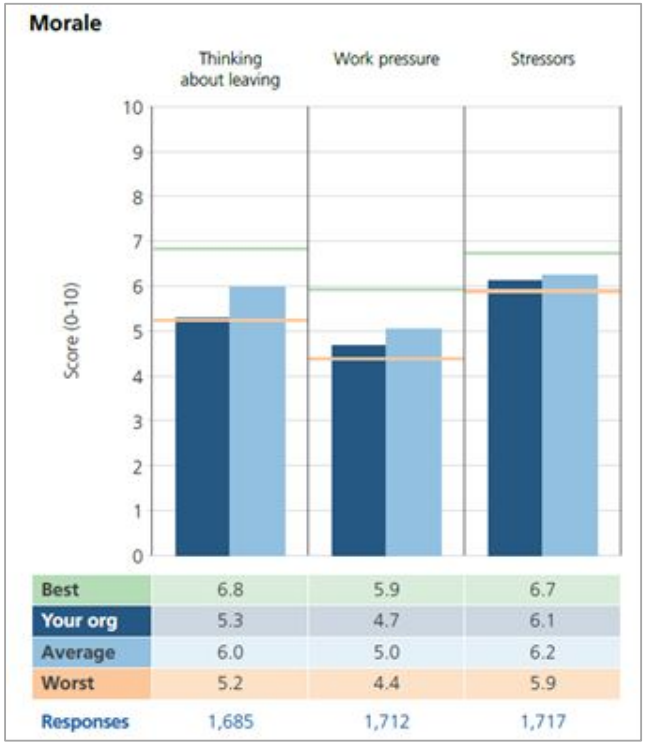
7.0 Staff engagement theme breakdown and trend

	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	6.9	6.6	6.1
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	1,687	1,714	1,690

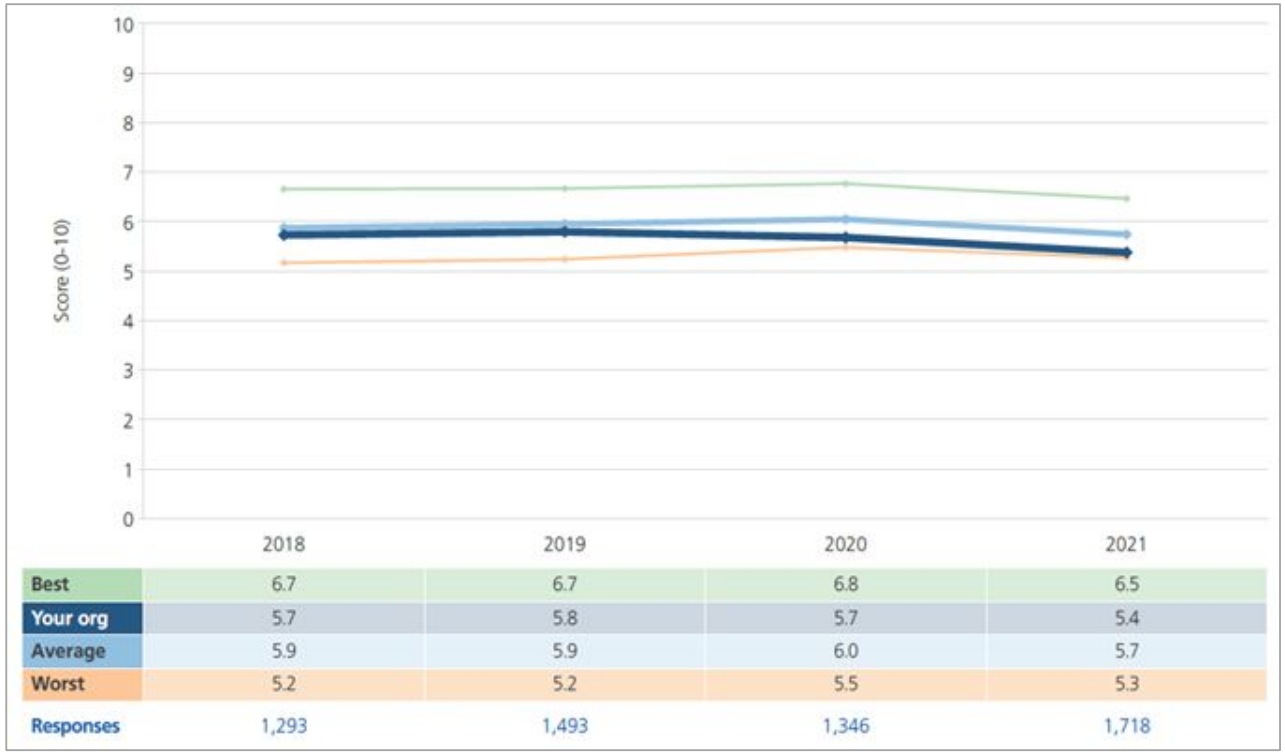


	2017	2018	2019	2020	2021
Best	7.5	7.7	7.6	7.6	7.4
Your org	6.9	7.0	6.9	6.8	6.6
Average	7.0	7.0	7.0	7.0	6.8
Worst	6.4	6.4	6.1	6.4	6.3
Responses	1,151	1,312	1,496	1,350	1,718

8.0 Staff morale theme breakdown and trend



	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	5.3	4.7	6.1
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	1,685	1,712	1,717



	2018	2019	2020	2021
Best	6.7	6.7	6.8	6.5
Your org	5.7	5.8	5.7	5.4
Average	5.9	5.9	6.0	5.7
Worst	5.2	5.2	5.5	5.3
Responses	1,293	1,493	1,346	1,718

9.0 Detailed benchmarked results

The national benchmark report further details a breakdown of each question asked within the survey.
Appendix 3 *provides the full report and a summary of the sections.*

10.0 Key results summaries

This section pulls out key summaries of the results, including:

1. **Questions for which PAHT scored better than the national average**
    - Note: all other questions not included in the question groupings below (which can be benchmarked) scored worse than the national average.
2. **Questions for which PAHT scored the worst nationally**
3. **Questions for which PAHT scores show an ongoing worsening** (over 4 years)
    - Note: there are no questions showing improving scores over consecutive recent years.

The tables below show the variance between our PAHT scores and the national average scores. The data is depicted as:

- green = our score is better than the national average
- red = our score is worse than the national average

10.1 Questions for which PAHT scored better than the national average

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%

The Princess Alexandra Hospital NHS Trust

10.2 Questions for which PAHT scores are the worst nationally

Question number	Question	PAHT score	National average score	Variation (PAHT vs. national score)
Q5a	I have unrealistic 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%

10.3 Questions for which PAHT scores have worsened consecutively over the last 4 years (from and including 2018)

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%

The Princess Alexandra Hospital NHS Trust

11.0 Top four staff survey improvement priorities

Based on the results, our staff survey 2021 top four improvement priorities are:

- **Priority one:** improving the physical and mental health and wellbeing of our people
- **Priority two**: improving our learning and safety culture, encouraging people to openly share feedback or concerns and ensure this is acted upon - improving psychological safety
- **Priority three:** embedding our *This is Us* management practices and leadership promise in our ways of working
- **Priority four:** ensuring our workforce plans support teams being effectively staffed to deliver high quality services

12.0 Responding to the results

12.1 Using the staff survey findings to drive improvement

The table below outlines our staff survey response plan – engaging people across the Trust in the development/implementation of improvement plans.

Month	Activity	Progress
February 2022	**Initial results received via Picker** (survey provider) and shared at EMT and SMT	Complete
March 2022	**Senior manager briefings held by OD team** (outlining headline results and plans on further sharing the results and developing improvement plans)	Complete
	National benchmark results received via the Survey Coordination Centre and reviewed at EMT, SMT, Strategic Workforce Committee	Complete
	Top four staff survey improvement priorities agreed at SMT	Complete
	Divisional survey results workshops held for managers (sharing the results and interactive discussions to propose improvement actions)	Underway
April 2022	**Staff survey improvement plans** to be submitted by senior management teams by 22 April	Not started
	Organisation-wide improvement project groups to be established as required (for improvement actions spanning across divisions)	Pending requirement
May 2022	**Results roadshows** to be run within divisions by senior management teams (open for all staff – opportunity to further share the results and the improvement plans)	Not started
	Commence monthly progress updates at PRMs and through local governance	Not started
June – September 2022	**Delivery against improvement plans** with pace, led by divisional senior management teams	Not started
	Positive change stories shared by divisional senior management teams locally and via Trust-wide communications	Not started
October 2022	**Staff survey 2022** commences	Not started

12.2 Improvement work aligned to our top four improvement priorities

There is already a wealth of work ongoing and planned to improve the experiences of our people at PAHT, which will connect with and support the staff survey improvements plans. A summary of work being led through the People team is provided in the table below.

Top four staff survey 2021 improvement priorities	Ongoing / planned trust-wide improvement work led through the People teams
Priority one: improving the physical and mental health and wellbeing of our people	A full list of initiatives to improve the health and wellbeing of our people is provided in appendix 4.
Priority two: improving our learning and safety culture, encouraging people to openly share feedback or concerns and ensure this is acted upon - improving 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. • 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. • 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 at PAHT.
Priority three: embedding our *This is Us* management practices and leadership promise in our ways of working	• 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. • 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* • Planned delivery of *This is Us* awards to recognise people for their positive ways of working, management practices and leadership styles. • Planned delivery of a PAHT2030 Ready development programme, building senior leaders' transformational change skills in alignment with *This is Us*

Priority four: ensuring our workforce plans support teams being effectively staffed to deliver high quality services	• 2022/23 workforce planning currently underway will include review of operational workforce needs and data trends. • Planned implementation of a strengthened process to monitor progress against the workforce plan

In addition, the quality and patient safety strategy (namely the aspects in relation to just culture, learning from incidents, and creating a culture of kindness and compassion) will support improvements aligned to our top four priorities.

13.0 Recommendation

The Board is asked to note the benchmarking results, response plan and share any feedback.

Appendix 1. People Promise elements, key themes and sub-scores

Survey Coordination Centre

People Promise elements, themes and sub-scores

Please note that you can navigate to the results of a particular score or question result by clicking on it in the table below.

People Promise element	Sub-scores	Question
We are compassionate and inclusive	Compassionate culture	Q6a, Q21a, Q21b, Q21c, Q21d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15*, Q16a, Q16b, Q18
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	[No sub-scores]	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q17a, Q17b, Q21e, Q21f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
We are always learning	Development	Q20a, Q20b, Q20c, Q20d, Q20e
	Appraisals	Q19a, Q19b, Q19c, Q19d
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Theme	**Sub-scores**	**Question**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q21a, Q21c, Q21d
Morale	Thinking about leaving	Q22a, Q22b, Q22c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q15 (historical calculation)* , Q16c, Q22d, Q28b		

*Please note: The approach to calculating the results for Q15 has changed for 2021, to include 'don't know' responses. These results feed into the Diversity and equality sub-score and the We are compassionate and inclusive promise element, as well as the WRES and WDES indicators. The Q15 results based on the historic calculation are reported in this section for transparency, but do not feed into any measure.

4

Appendix 2. Significance testing on the theme scores

The table below presents the results of significance testing conducted on the theme scores calculated in both 2020 and 2021*. Note that results for the People Promise elements are not available for 2020. The table details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2021 score is significantly higher than last year's, whereas ↓ indicates that the 2021 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

People Promise elements	2020 score	2020 respondents	2021 score	2021 respondents	Statistically significant change?
We are compassionate and inclusive			**7.0**	1691	N/A
We are recognised and rewarded			**5.6**	1722	N/A
We each have a voice that counts			**6.4**	1661	N/A
We are safe and healthy			**5.6**	1677	N/A
We are always learning			**5.1**	1611	N/A
We work flexibly			**5.8**	1712	N/A
We are a team			**6.5**	1691	N/A
Themes	**2020 score**	**2020 respondents**	**2021 score**	**2021 respondents**	**Statistically significant change?**
Staff Engagement	**6.8**	1350	**6.6**	1718	↓
Morale	**5.7**	1346	**5.4**	1718	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

For more details please see the technical document.

Appendix 3. Detailed benchmarked results

Further benchmark results are available via the embedded file below, and broken down into the following sections:

NHS_staff_survey_2021_RQW_full.pdf

- **People Promise and theme results by Covid-19 classification** (all staff, worked on Covid-19 specific ward or areas, redeployed, required to work remotely or from home)
- **People Promise detailed information** by promise elements
    - We are compassionate and inclusive (compassionate culture, compassionate leadership, diversity and equality, inclusion)
    - We are recognised and rewarded
    - We each have a voice that counts (autonomy and control, raising concerns)
    - We are safe and healthy (health and safety culture, burnout, negative experiences)
    - We are always learning (development, appraisals)
    - We work flexibly (support for work-life balance, flexible working)
    - We are a team (team working, line management)
- **Staff engagement theme** (motivation, involvement, advocacy)
- **Staff morale theme** (thinking about leaving, work pressure, stressors
- **Questions not linked to the People Promise or themes**
- **About respondents: background details**
- **Workforce equality standards** (WRES and WDES)

Appendix 4. Ongoing/Planned Initiatives to improve the health and wellbeing of our people

Health and wellbeing initiatives – overarching

- Ongoing menopause support available via the Peppy app and a new policy
- Ongoing work towards achieving menopause friendly accreditation as an organisation
- Appointment of a Trust Wellbeing Guardian at board level
- Ongoing inclusion of wellbeing at corporate induction
- Ongoing inclusion of managers' health and wellbeing responsibilities via managers' induction
- Delivery of monthly Schwartz Rounds
- Ongoing inclusion of health and safety at corporate induction and managers' induction
- Ongoing strengthening of wellbeing conversations with all staff e.g., as part of appraisals, sickness absence management, 1-1s
- Opening of the Alex Lounge – staff only facility to support health and wellbeing (including free tea and coffee, air charging points and a quiet area)
- Increasing of the range of food options that can be accessed 24/7
- Planned collaboration with a local food bank to support PAHT where needed
- Ongoing focus on increasing awareness of health and wellbeing support via printed and digital communications
- Promotion of the Total Reward System on ESR as a tool for staff to access local and national staff benefits
- Promotion of national wellbeing events such as national walking month, mental health awareness week, know your numbers week, world suicide prevention day and national hydration week
- Increasing flexible working opportunities e.g., piloting of self-rostering, introducing different shift patterns, increased recruitment promotion of flexible working
- Ongoing promotion of Vivup as a way for staff to access discounts available via the Trust
- Ongoing collaboration with ED&I groups regarding the wellbeing agenda
- Ongoing promotion of supportive policies for emergency childcare needs, as well as a Maternity Leave, Paternity Leave, Adoption Leave and Shared Parental Leave policies
- Lead Freedom to speak up guardian appointed, supporting strengthened links with health and wellbeing
- Current health and wellbeing collaboration with senior medical leads to drive 'high impact actions to improve working lives for junior doctors' (national programme of work)

Self help

- Ongoing promotion of our Employee Assistance Programme
- Ongoing access to a wide range of health and wellbeing apps
- Promotion of 'My way my health' wellbeing website (developed by the ICS)
- Ongoing access to NHS weight management services
- Ongoing access to an online portal supporting physical activities

- Ongoing smoking cessation support
- Ongoing access and promotion to financial support and webinars
- Ongoing access to MSK referral pathway – via PhysioMed
- Introduction of long-term condition pathway for long covid and menopause

Psychological Support

- Ongoing access to the Here for you service - mental health hub providing psychological support, tailored reflective sessions, webinars to support burnout, long covid etc.
- Ongoing access to Mental Health First Aiders
- Introduction and continued development of a cohort of health and wellbeing champions
- Planned delivery of menopause awareness training (all staff and managers)

Trust Board – 7 April 2022

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject / title:**	5.3 Ogechi Emeadi, director of people, organisational development and communications Ogechi Emeadi, director of people, organisational development and communications 31 March 2022 Board equality, diversity and inclusion champion							
Purpose:	**Approval**	**X**	**Decision**		**Information**		**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The report seeks 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 regards to service user health outcomes, experience and access to services, as well as how representative and supported our workforce is and inclusive leadership. This will bring the number of board champions to six.							
Recommendation:	The committee is asked to approve: i. the EDI champion as a sixth board champion role ii. the chair of the board of directors, as the EDI board champion iii. for the role to be reviewed after six months							
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:	BAF 2.3 - Workforce: Inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC – Well Led Equality Act 2010 Equality Delivery System 2
Appendices:	. N/A

Board Champion for Equality Diversity and Inclusion

1. Introduction

The paper set out the proposal to adopt a sixth board champion role for equality diversity and inclusion (EDI).

2. Enhancing Board Oversight: A new approach to non executive director roles across all trusts

NHS England and Improvement's 'Enhancing board oversight: A new approach to non executive director (NED) roles across all trusts' recommends that there are five NED champion roles and the remaining areas of responsibility are discharged through committee structures.

In January's 2022 Trust Board - Private the five champion roles were approved. Within this approach EDI is not listed as a board champion role.

However, the new approach is recommended but is not mandatory and the guidance states that 'if trusts consider NED champion roles are an effective tool to provide assurance to their board on specific issues, then they have the flexibility to implement that approach.'

3. Equality and Diversity Board Champion

NHS organisations duty under EDI is set out in the Equality Act 2010 and the Public Sector Duty requirements 2011.

To strengthen our approach ensuring that EDI is in everything we do, in everything we say and all the actions we take as an employer, a provider of services to our local community and key partners, we seek to establish the board champion for EDI.

The EDI board champion will provide assurance to the board and will:

- Challenge the trust to include EDI in everything we do and actively create and support a compassionate and inclusive culture
- Act as a 'critical friend' to question the impact of decisions on EDI
- Ensure the Board holds senior leaders to account for the way EDI is undertaken
- Seek data to show what's happening within the trust (inputs and outputs)
- Continually and strategically 'sense-check' the EDI agenda for the trust and prompt improvement / developmental actions if needed.

The board champion for EDI will work closely with the EDI workforce lead (director of people) and EDI patient and service user lead (director of nursing midwifery and allied health professionals).

4. Appointment and tenure

If it is agreed to establish the role, it is proposed that this role should be undertaken by chair of the trust, Hattie Llewellyn-Davies, in the first instance. This will demonstrate to all that EDI is an organisational priority.

It is further proposed that should be reviewed after six months.

5. Recommendations

The committee is asked to approve

i. The board champion for EDI as a sixth board champion role
ii. Hattie Llewellyn-Davies, chair of the board of directors, as the EDI board champion
iii. For the role to be reviewed after six months

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

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) 7 April 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2022**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 M11 Financial Results	Y	N	N	The Trust reported a surplus position in M11 of £1.6m against a breakeven plan. The M12 forecast outturn was £3m. Assurance was provided that the year-end position would be lower.
2.2 Operating Plan	Partial	Y	N	The first draft of the 2022/23 activity, workforce and narrative plans had been submitted and the Trust anticipated achieving all the national requirements with the exception of the 25% reduction in follow-up appointments which needed to be validated. The current version was endorsed for Board approval the following week but further detailed work is required on the activity plan before the second submission is due on 04.04.22. The financial plan was discussed and members were partially assured as further work is required to reduce the planning gap of £14.8m.
2.3 Capital Programme	Y	N	N	The Trust was forecasting to achieve the capital resource limit (CRL) spend despite over-commitment of £0.8m at the month end as mitigations had been agreed.
2.4 Contracts Update	Y	N	N	The Committee noted the current status of contracts and the ongoing work plan to achieve agreements on all the Trust's service contracts. It was agreed going forward that reporting would be by exception only.

2.5 BAF Risk 5.1 (Finance – Revenue) and BAF Risk 5.2 (Finance – Capital)	Y	N	N	It was agreed that both risk scores would remain at 12.
3.2 BAF Risk 4.2 – 4 Hour Emergency Department Constitutional Standard	Y	N	N	It was agreed that the risk score would remain at 20.
3.3 Insourcing Request	Y	N	N	The request to contract for Q1 2022/23 in-sourcing was approved by PAF and agreed spend of costs of c.£3.1m before the final ICS and PAH 2022/23 plans and the Elective Recovery Funding (ERF) forecast were confirmed. Current forecasted ERF was £8m for PAHT.
3.4 New BAF Risk 1.3: Recovery Programme	Y	N	N	This risk related to the Trust's recovery programme and was described as: *Risk of poor outcomes and patient harm due to long waiting times for treatment.* The risk had been scored at 15 (5x3) under the patient safety domain and a target risk score of 10 had been assigned. It had been discussed at EMT and PAF recommended it to Board for inclusion in the Board Assurance Framework.
3.5 AAU Deep Dive	Y	N	Yes, budget setting to be reviewed (DD-Medicine &UEC and finance colleagues)	Urgent & Emergency Care (UEC) provided a detailed review in terms of benefits realisation for the Adult Assessment Unit (AAU) since go-live on 24.02.22. It terms of future deep dives it was agreed there should be a review of spend against the original plan/business case. It was pleasing to note however that the project had been successful.
BAF Risk 4.2 – Estate and Infrastructure	Y	N	N	It was agreed that the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 April 2022

Agenda item:	6.2
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	21st March 2022
Subject / title:	M11 2021/22 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	x

6.2

Key issues:

Patients		
Patients	**C. Difficile**	Following a period of increased cases since October 2020, we have seen 6 months of performance at or below the mean and remaining in common cause variation
	CTG training compliance for midwives	Performance is now over 92% and above the upper control limit following the fourth consecutive month of improvement
People		
People	**Appraisals**	Returned to common cause variation following two months near the lower control limit.
	Statutory and Mandatory Training	In specal cause variation, and nine points now showing a statistically consistent trend. Performance has remained at 87%, 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 a 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 four months as a result of the focus on our recovery continues
	Cancer 2 week wait	Remains in special cause varation, and has dipped to significantly below the lower control limit
	Cancer 62 day pathway	Performance remains in special cause variation. 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. Changes in service delivery continue to show improvements a number of indicators within the ED pathway
	Diagnostics	Performance back in common cause variation after a sustained period in special cause variation. Performance is above the mean for the first time since March 2020
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. The volume has dropped, but still significantly above the upper control limit
	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 recorded a surplus of £1.598m at the end of month 11, against a break even plan.The Trust is currently forecasting to underspend on its winter pressure funding and an surplus of up to £2.998m by year end. The Trust is actively working to reduce the forecast surplus.
	CIP	The Trust has only delivered £4.580m of savings against a year to date plan of £6.251m. The Trust continue to forecast delivery of the CIP target however up to £6.437m of the target will be through non recurrent funding against a full year target of £7.052m for the full year.
	Capital Spend	Year-to-date capital spend is £18.230m against a revised capital plan of £18.798m. This under-performance of reflects timing differences and the Trust is expects to achieved spend against its Capital Resource Limit
	Cash	The Trust continues to have a healthy cash balance of £65.800m. There is a continued push to reduce aged payables & improve the Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains below the national target

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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:	QSC.25.03.22 and PAF.31.03.22
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	M11 IPR

6.2

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report for February 2022

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Performance Summary

Patients		
Patients	**C. Difficile**	Following a period of increased cases since October 2020, we have seen 6 months of performance at or below the mean and remaining in common cause variation
Patients	**CTG training compliance for midwives**	Performance is now over 92% and above the upper control limit following the fourth consecutive month of improvement
Pounds		
Pounds	Surplus	The Trust recorded a surplus of £1.598m at the end of month 11, against a break even plan.The Trust is currently forecasting to underspend on its winter pressure funding and an surplus of up to £2.998m by year end. The Trust is actively working to reduce the forecast surplus.
Pounds	CIP	The Trust has only delivered £4.580m of savings against a year to date plan of £6.251m. The Trust continue to forecast delivery of the CIP target however up to £6.437m of the target will be through non recurrent funding against a full year target of £7.052m for the full year.
Pounds	Capital Spend	Year-to-date capital spend is £18.230m against a revised capital plan of £18.798m. This under-performance of reflects timing differences and the Trust is expects to achieved spend against its Capital Resource Limit
Pounds	Cash	The Trust continues to have a healthy cash balance of £65.800m. There is a continued push to reduce aged payables & improve the Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains below the national target

People		
People	**Appraisals**	Returned to common cause variation following two months near the lower control limit.
People	**Statutory and Mandatory Training**	In specal cause variation, and nine points now showing a statistically consistent trend. Performance has remained at 87%, and below the target of 90%.
People	**Sickness Absence**	In common cause variation and continues to perform at or near the target. We have continued to see a 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 four months as a result of the focus on our recovery continues
Performance	**Cancer 2 week wait**	Remains in special cause varation, and has dipped to significantly below the lower control limit
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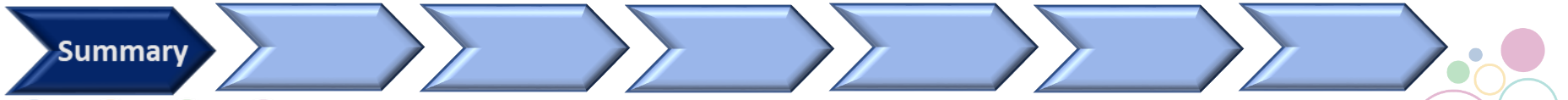
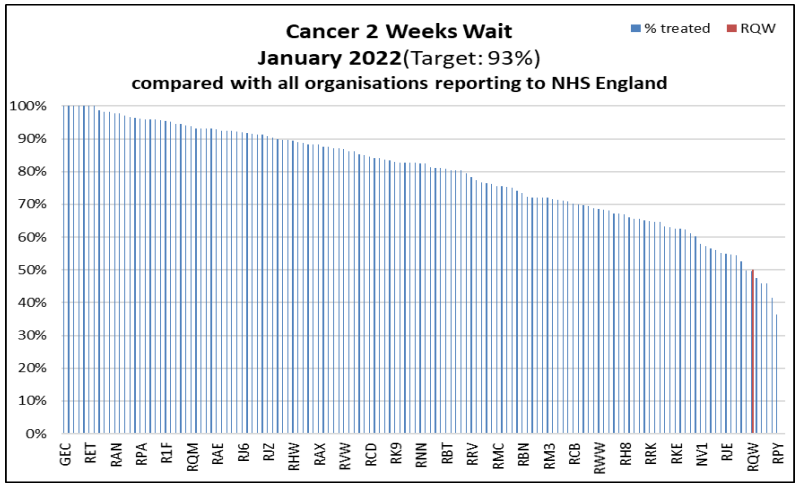
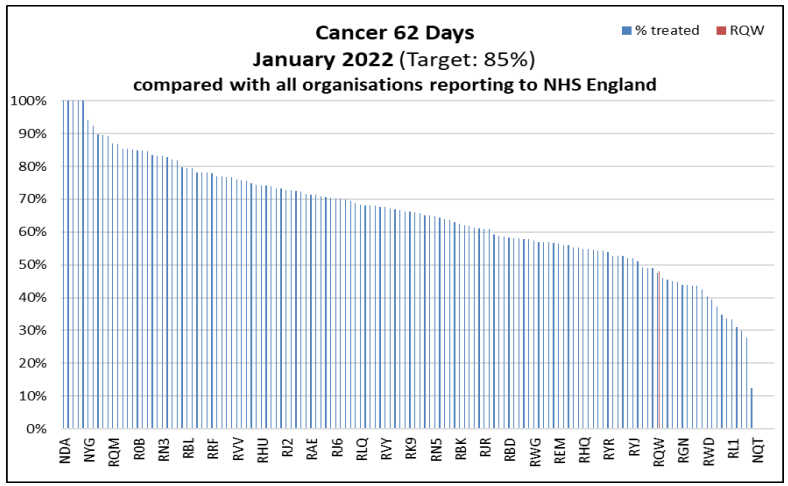
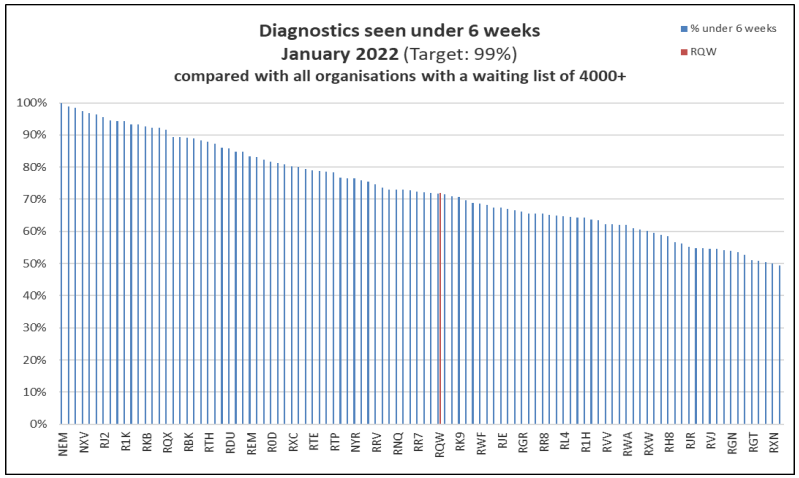
Performance	**Four hour standard**	Remains in special cause variation. Changes in service delivery continue to show improvements a number of indicators within the ED pathway
Performance	**Diagnostics**	Performance back in common cause variation after a sustained period in special cause variation. Performance is above the mean for the first time since March 2020
Performance	**52 week waits**	Still is special cause variation, with a continued focus on clinical priority patients. The volume has dropped, but still significantly above the upper control limit
Performance	**Bed Occupancy**	Bed occupancy remains at a high level, and has been in special cause variation for the previous ten months.

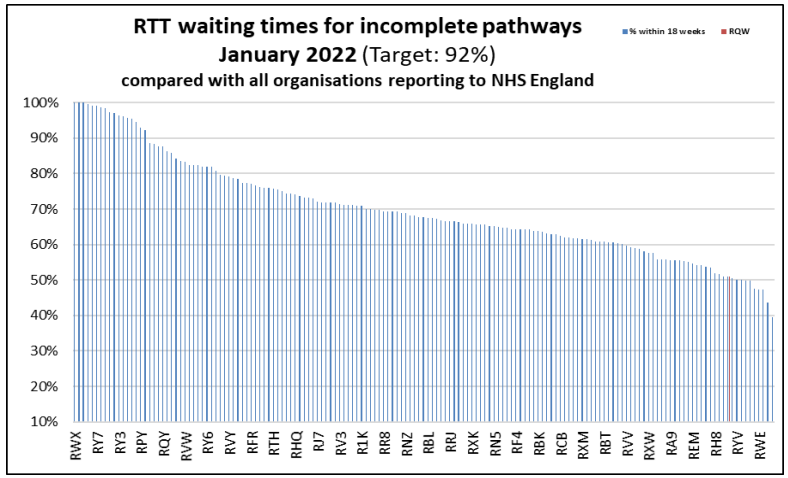


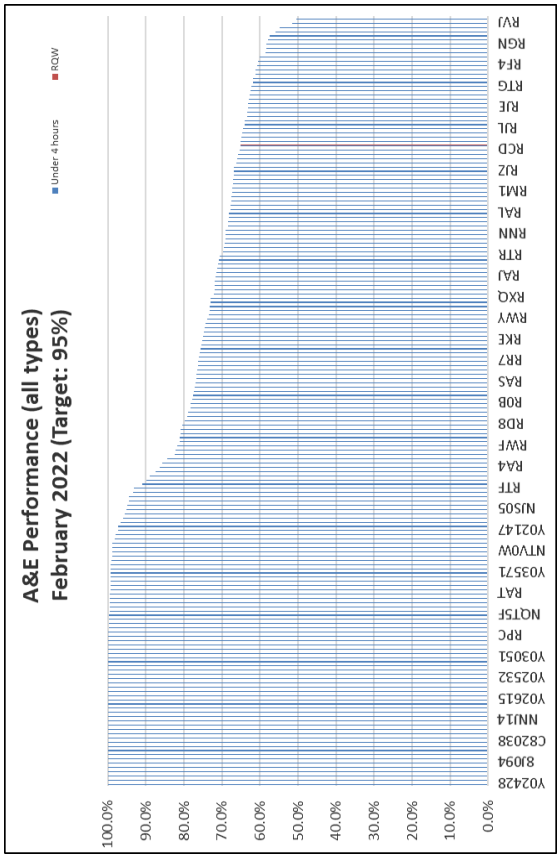
National Benchmarking

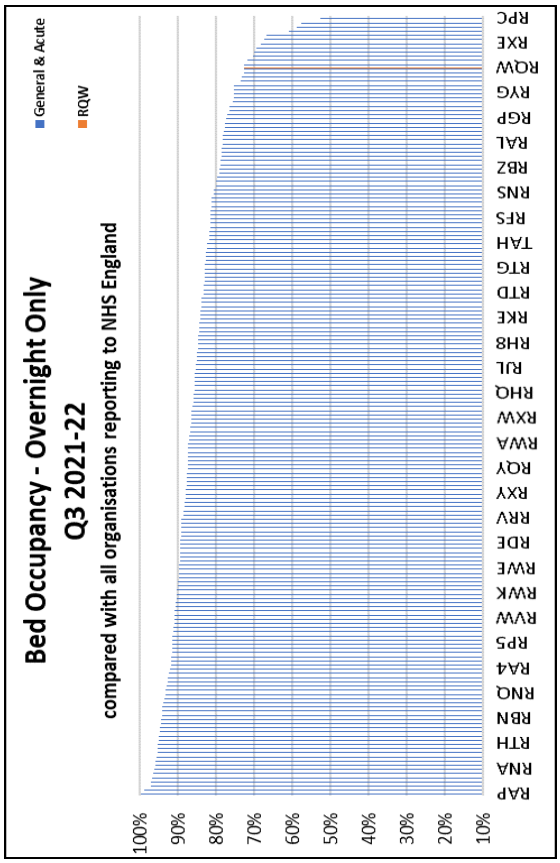


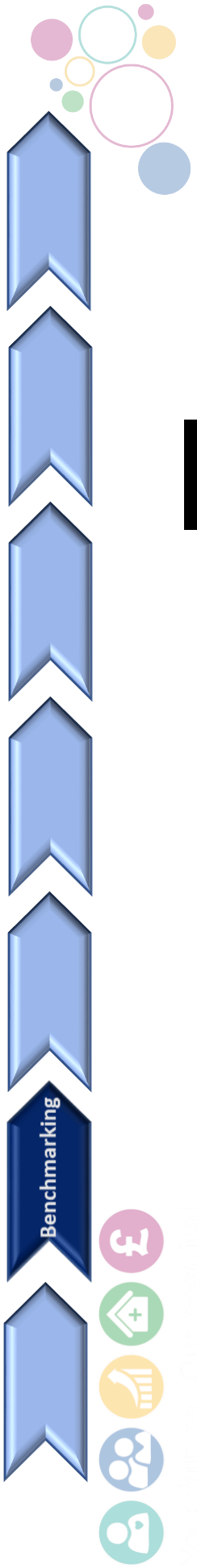







A&E Performance (all types)
February 2022 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
RYJ
RGN
RF4
RTG
RJE
RJL
RCD
RJZ
RM1
RAL
RNN
RTR
RAJ
RXQ
RWY
RKE
RR7
RA5
R0B
RD8
RWF
RA4
RTF
NJ505
Y02147
NTY0W
Y0357J
RAT
NQ7SF
RPC
Y03051
Y02532
Y02615
NNJ14
C82038
8J094
RF4
Y02428


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%
RPC
RXE
RQW
RYG
RGP
RAL
RBZ
RNS
RFS
TAH
RTG
RTD
RKE
RH8
RJL
RHQ
RXW
RWA
RQY
RXY
RRV
RDE
RWE
RWK
RYW
RP5
RA4
RNQ
RBN
RTH
RNA
RAP


Benchmarking

6.2

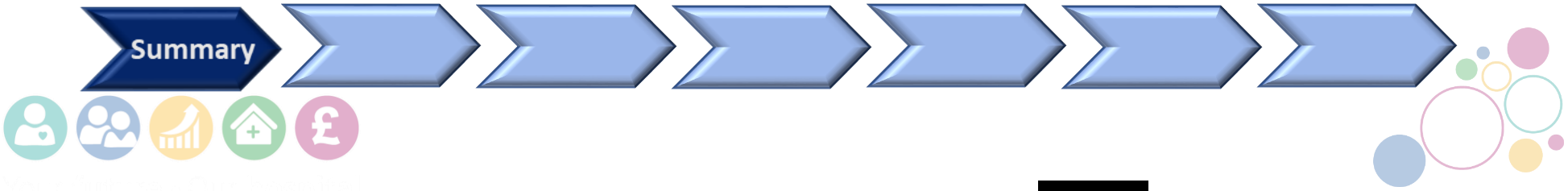
The difference between common and special cause variation

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

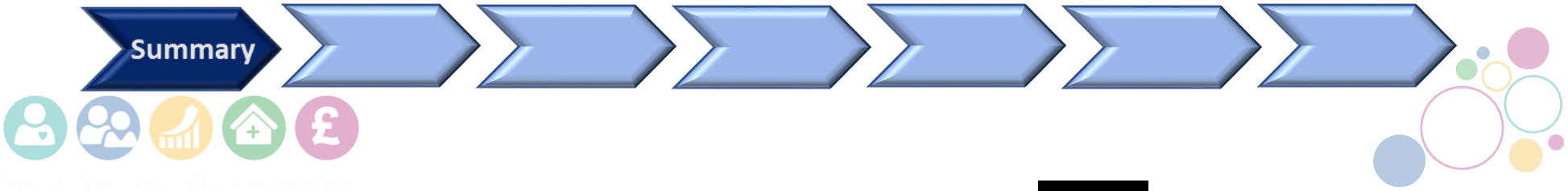
- Is due to irregular causes that are not inherent in the design of the process
- Results in an unstable process that is not predictable
- Also known as non-random or assignable variation
- Shown as blue or orange markers on our SPC charts



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

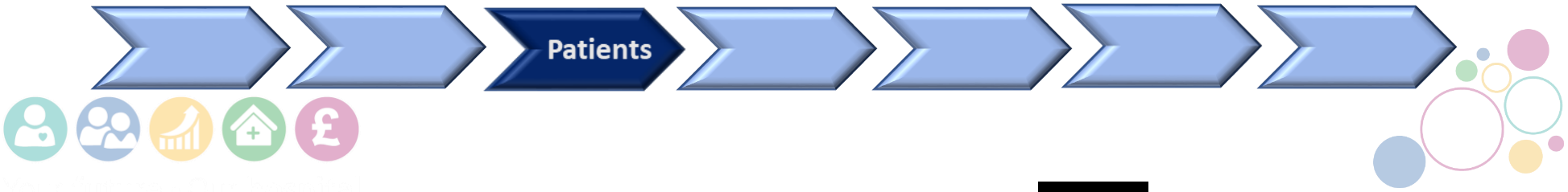
- A single point outside of the upper or lower control limits
- A run of points above or below the average (mean) line.
- Six consecutive points increasing or decreasing
- Two consecutive points near the upper or lower process control limits



Patients

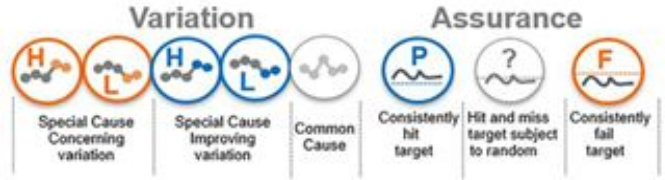
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

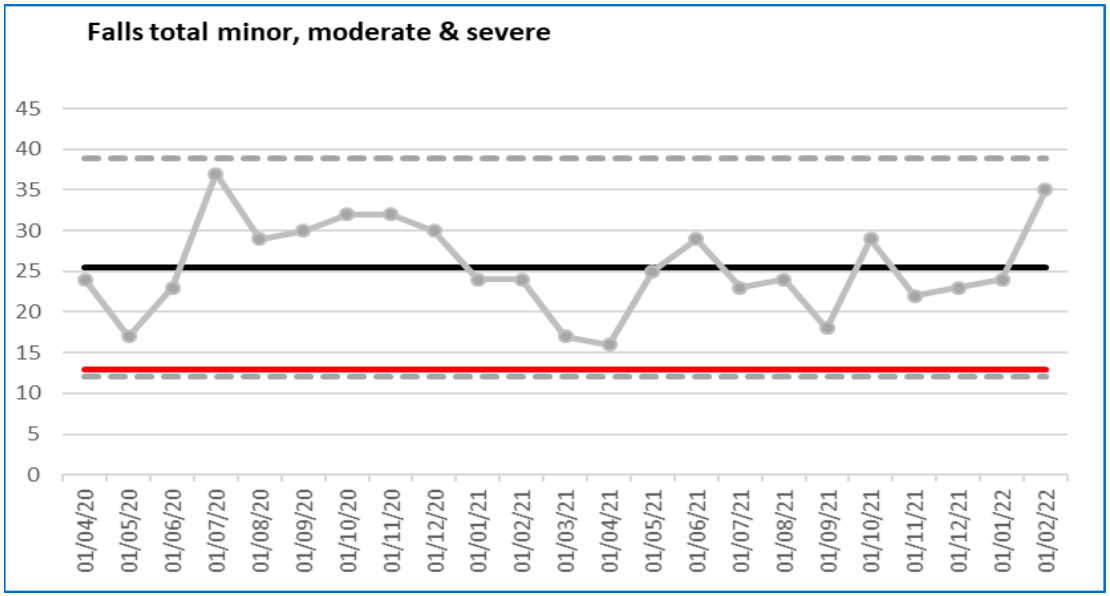
Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
C. Difficile	Following a period of increase in cases since Oct 2020, the incidence of C. Difficile has seen a sustained reduction since Oct 21.	For recognition	NA
CTG training midwifes	Following focused work within the maternity services, the CTG training level of midwifes has reached compliance of > 90%	For recognition	NA



KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Feb 22	20	25			18	3	33
Compliments	Feb 22	0	50			126	-110	361
PALS	Feb 22	283	none			281	147	414
Complaints closed within target	Feb 22	10	none			5	-3	14
% of complaints where an extension has been agreed	Feb 22	58%	none			42%	5%	78%
Mixed Sex Accommodation Breach	Feb 22	6	0			7	-4	18
Serious Incidents	Feb 22	3	none			5	-4	14
MSSA	Feb 22	1	none			1	-1	3
CDIFF	Feb 22	3	none			5	-2	12
Hand Hygiene	Jan 22	97%	none			92%	75%	109%
eColi	Feb 22	2	none			1	-2	4
Klebsiella	Feb 22	1	none			1	-1	2
Pseudomonas	Feb 22	0	none			0	-1	1
Falls per 1000 bed days	Feb 22	9	9			9	6	11
Falls total minor, moderate & severe	Feb 22	35	13			26	12	39
Pressure Ulcers per 1000 bed days	Feb 22	5	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Feb 22	8	3			4	-3	11
Total number of mothers delivering in birthing unit/home	Feb 22	17%	20%			11%	0%	23%
Number of mothers delivering in Labour Ward/Theatres	Feb 22	82%	75%			88%	76%	101%
Number of women due to deliver at PAH adjusted for misc/TOPs	Feb 22	317	375			332	272	391
Smoking rates at booking	Feb 22	8%	none			9%	4%	14%
Smoking rates at delivery	Feb 22	11%	6%			10%	5%	15%
Breast feeding rates at delivery	Feb 22	74%	74%			76%	66%	85%
Total Planned C-Sections	Dec 21	20%	none			15%	8%	23%
Total Unscheduled C-Sections	Dec 21	21%	none			18%	13%	24%

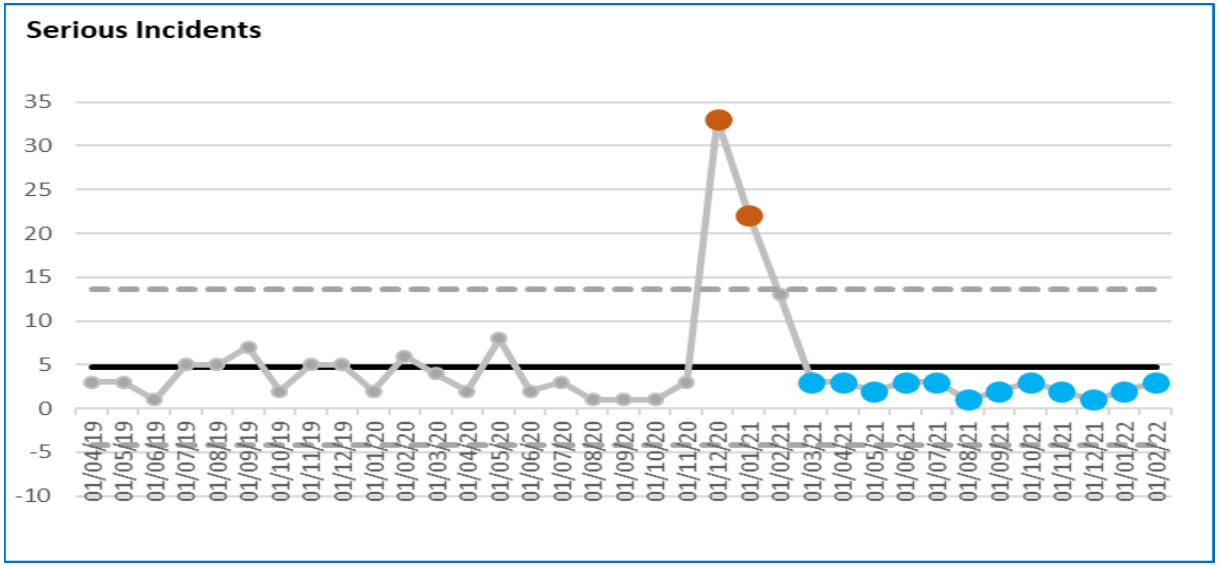
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Feb 22	3%	none			4%	1%	7%
CTG training compliance midwives	Feb 22	94%	85%			68%	47%	89%
CTG training compliance doctors	Feb 22	82%	85%			73%	48%	99%
Still births	Feb 22	0	none			1	-1	3
Patients detained under MHA	Feb 22	0	none			0	-1	2
Patients detained under section 136	Feb 22	0	none			1	-2	3
Mental health patient incidents	Feb 22	16	none			11	-1	23
Mental health patient complaints	Feb 22	0	none			0	-1	1
Mental health patient PALS	Feb 22	3	none			2	-1	4
Patients with LD and Autism accessing inpatient services	Feb 22	21	none			24	1	48
Patients who died in their preferred place of death	Jan 22	54%	none			57%	21%	92%
C-DIFF Hospital onset healthcare associated	Feb 22	0	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Feb 22	0	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Feb 22	1	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Feb 22	2	none			1	-2	5
Covid-19 new positive inpatients	Feb 22	142	0			133	-123	389
MRSA	Feb 22	0	0			0	0	1





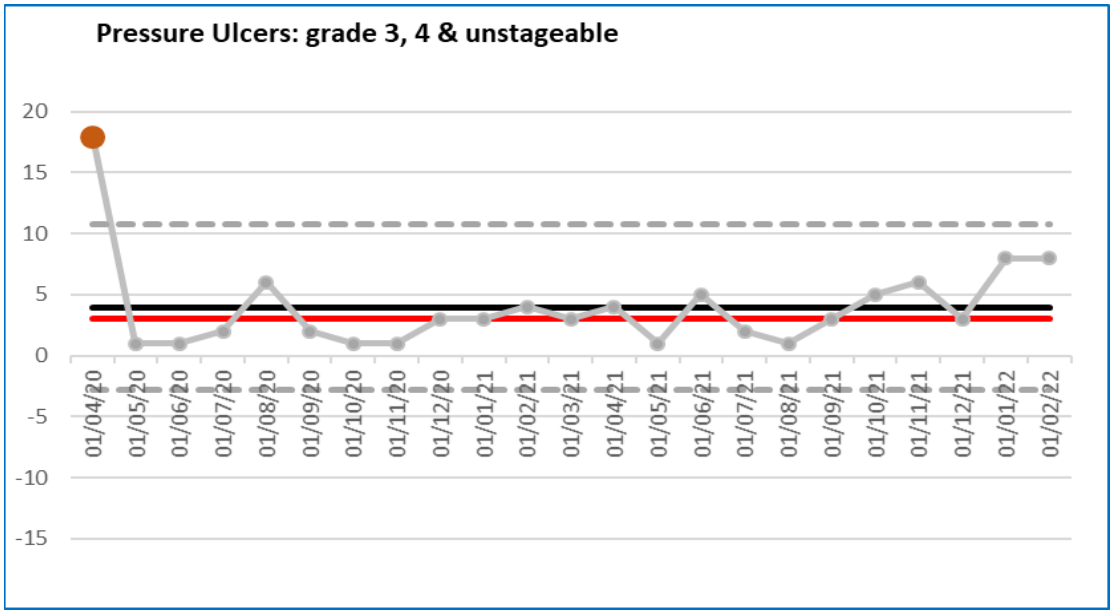
Feb-22
35
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

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	The Trust's falls action plan aim is to reduce falls with harm by 50% by the end of March 2022	1. Strategic falls action plan is in place and actions continue to be implemented	1. Nursing/care staff levels continue to be challenging across the trust and this will be having a direct impact on falls numbers



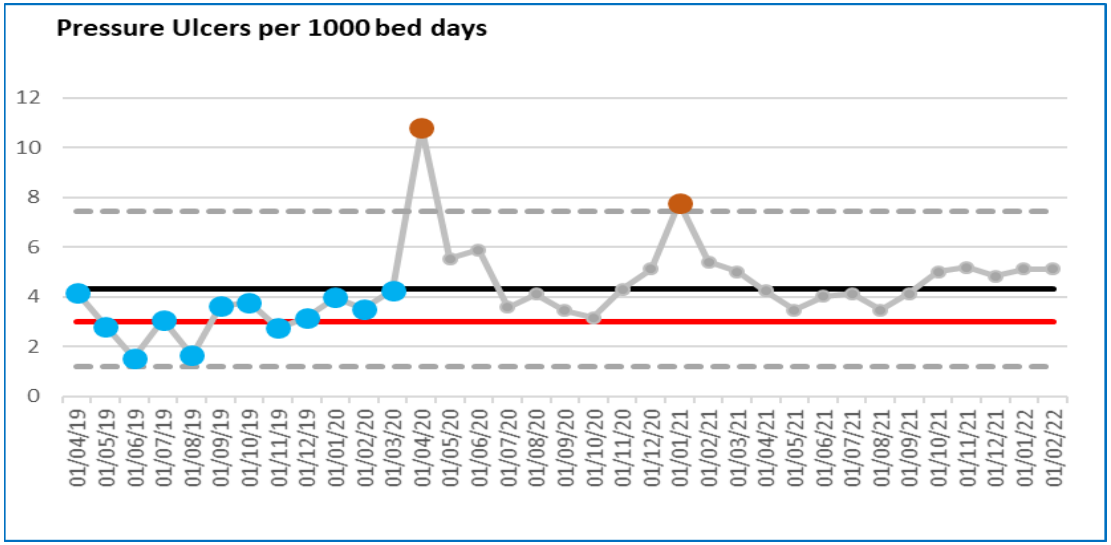
Feb-22
3
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent

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.	Incident management group meets twice a week to review new incidents & those with completed investigations. During February 2022, the trust raised three SIs. In month, five SI were closed. The trust has 16 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.



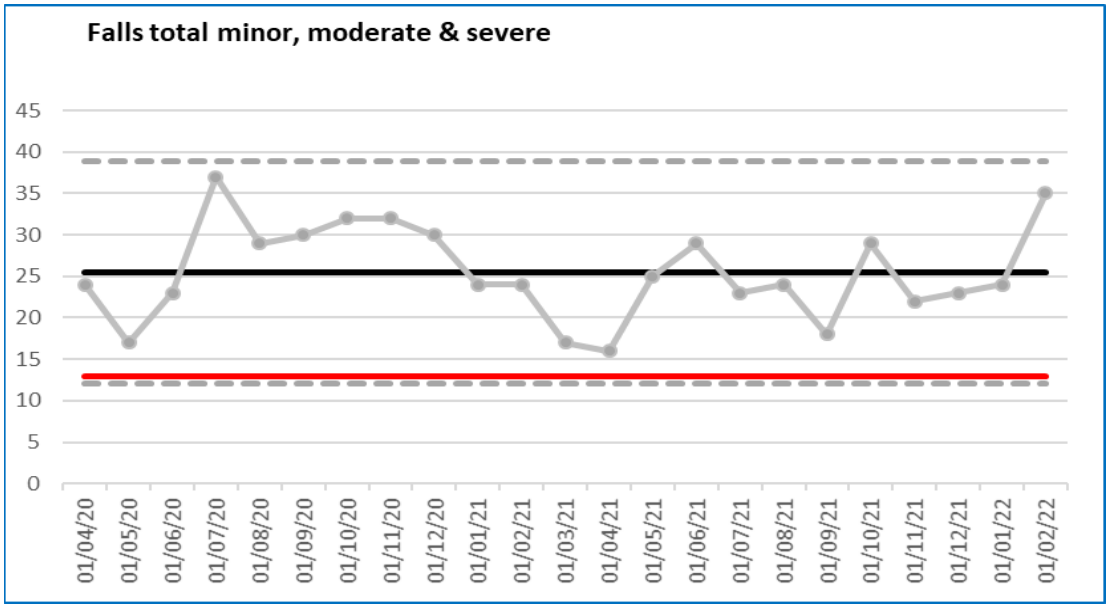
Feb-22
8
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers: grade 3, 4 & Unstageable	Common cause variation while hit & missing the target	Eight moderate harms	Eight 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.



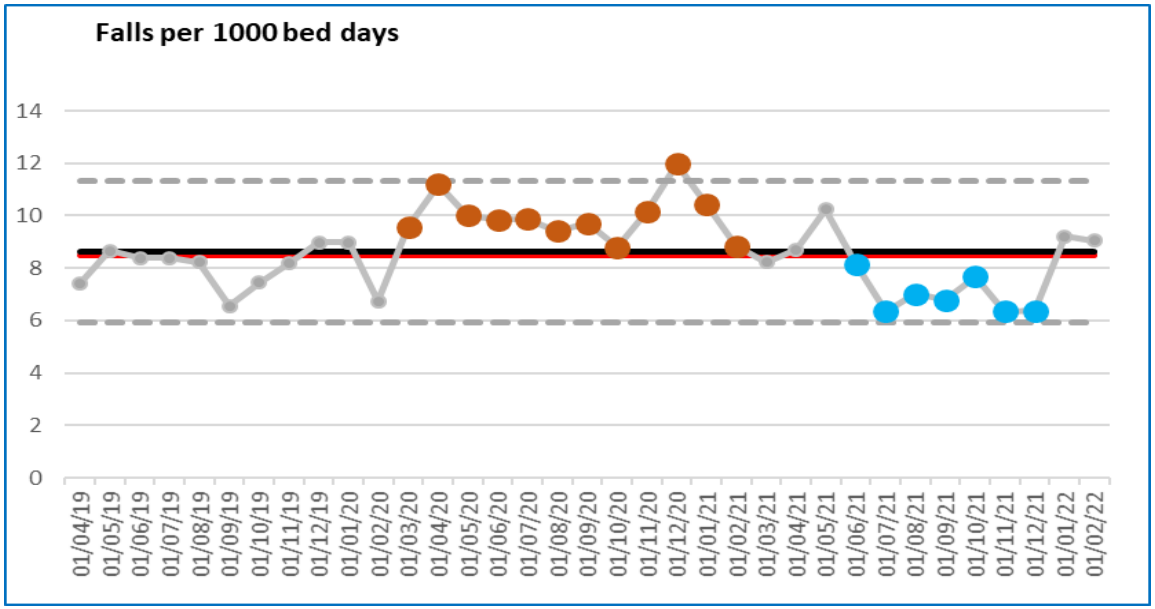
Feb-22
5
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers per 1000 bed days	Common cause variation while hit & missing the target	There were a total of 69 pressure ulcers in January, 8 more than December. Of those 69 PUs, there were a total of 53 patients injured, meaning 9 patients sustained more than one pressure ulcer during admission, the higher being one patient with 5 pressure ulcers (COVID pneumonitis patient in ITU due to prolonged hours of proning, sadly passed away). Eight 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.	The highest number of hospital acquired pressure ulcers were from Henry Moore COVID ITU with a total of 12 pressure ulcers. These were mainly sustained to face, chest & knees due to prolonged hours of proning. Intensive care unit has now agreed to trial proning patients directly on dolphin mattress as opposed to face cushions to attempt & reduce the number of PUs. John Snow (COVID) ward followed with 8 pressure ulcers in total. 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.



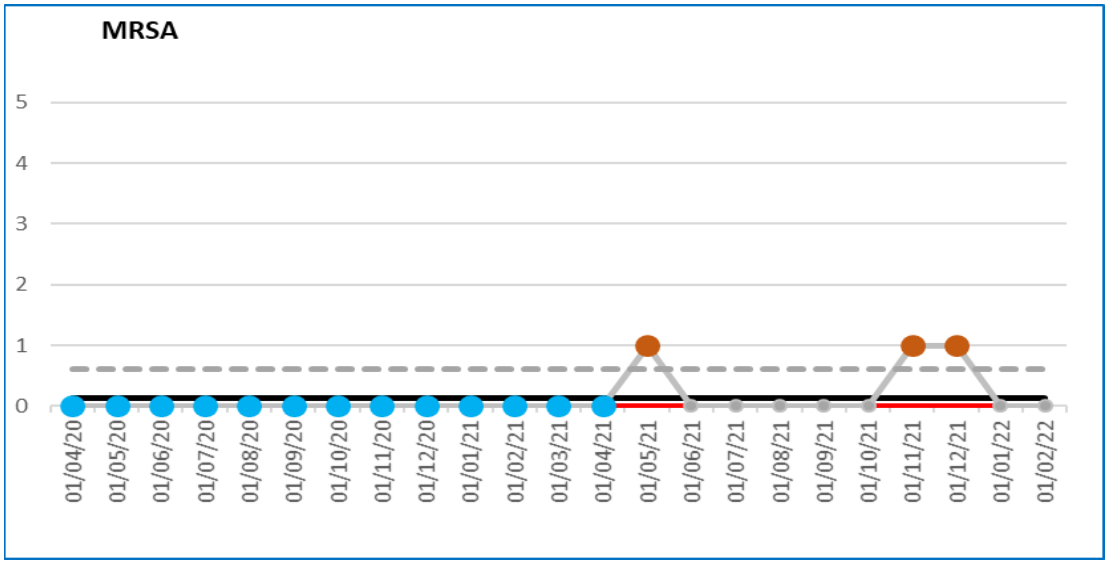
Feb-22
35
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

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	The Trust's falls action plan aim is to reduce falls with harm by 50% by the end of March 2022	1. Strategic falls action plan is in place and actions continue to be implemented	1. Nursing/care staff levels continue to be challenging across the trust and this will be having a direct impact on falls numbers



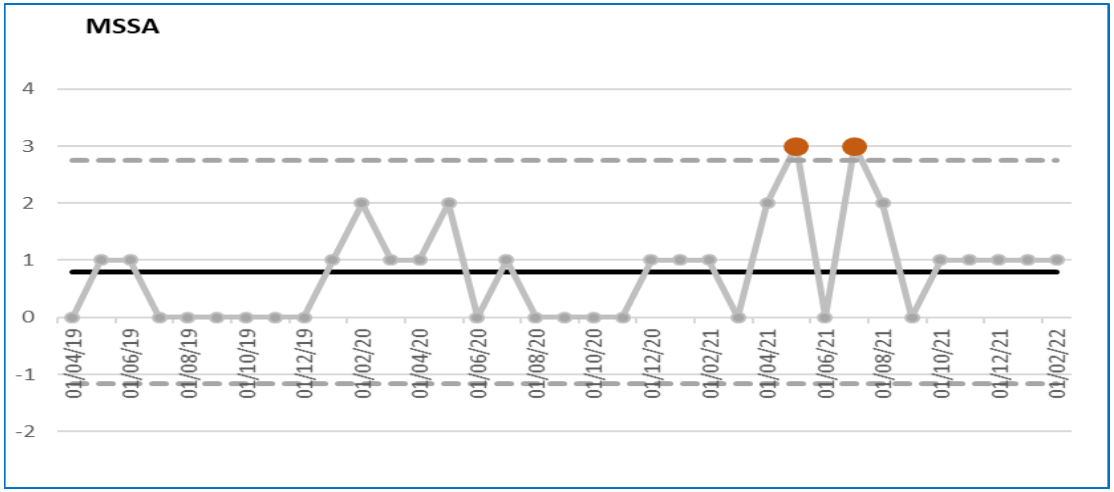
Feb-22
9.21
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

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	



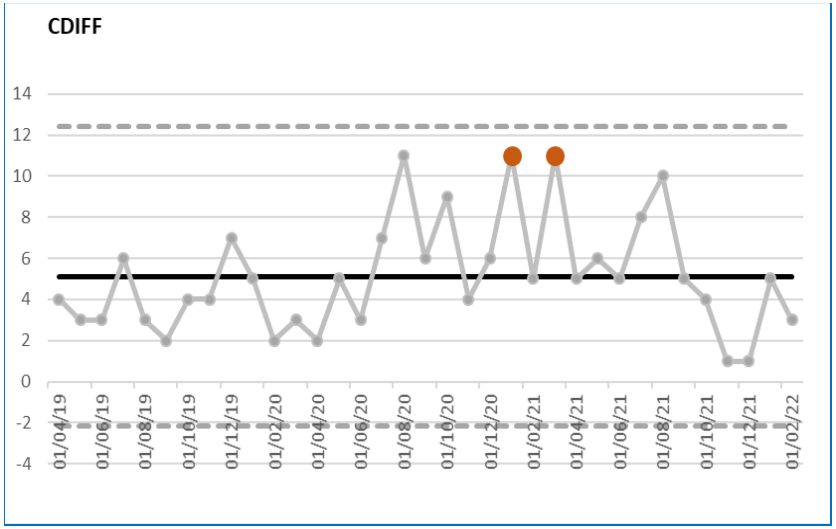
Feb-22
0
Variance Type
Special cause variation
Target
0
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
MRSA	Special cause concerning variation	Three cases of MRSA bacteraemia in 2021-22 (zero cases in January). This is an increase in cases for the Trust.	1. RCA and incident meetings held for all MRSA bacteraemia cases. 2. Action plan developed to manage increase in MRSA and MSSA bacteraemia infection, with a particular focus on management of intravenous devices. Task and finish group formed to drive and oversee the implementation of actions. 3. Actions and learning overseen by the Infection Prevention and Control Committee.	1. All patients screened for MRSA on admisison 2. All patients commenced on Octenisan decolonisation wash 3. Patients are commenced on MRSA protocol when MRSA isolated 4. Infection prevention and control precautions are initiated 5. Enhanced cleaning precaautions Increased environmental and IPC auditing



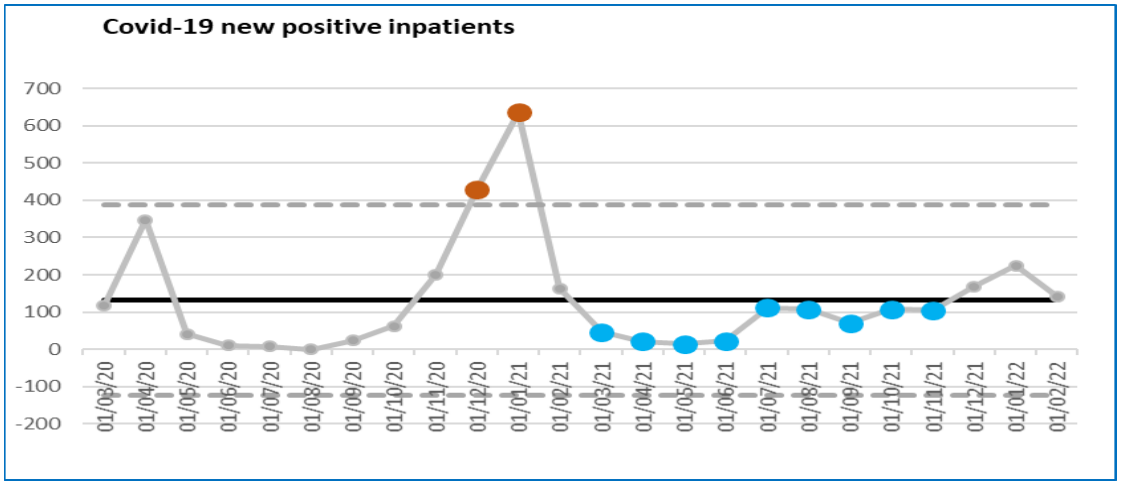
Feb-22
1
Variance Type
Common cause variation
Target
None
Target Achievement
N/A

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



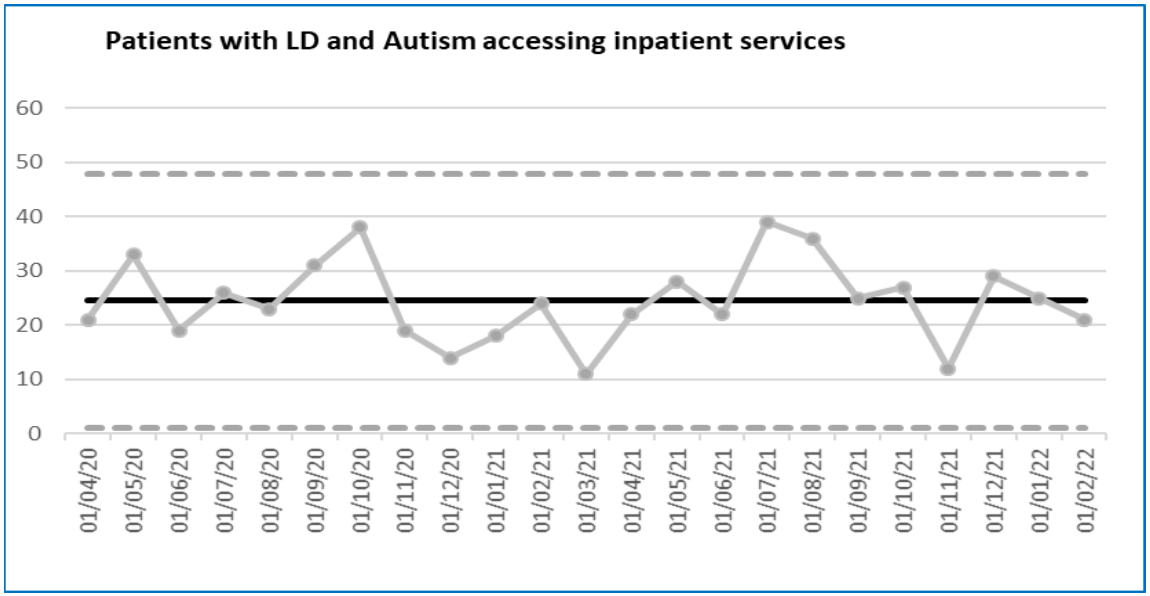
Feb-22
3
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

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



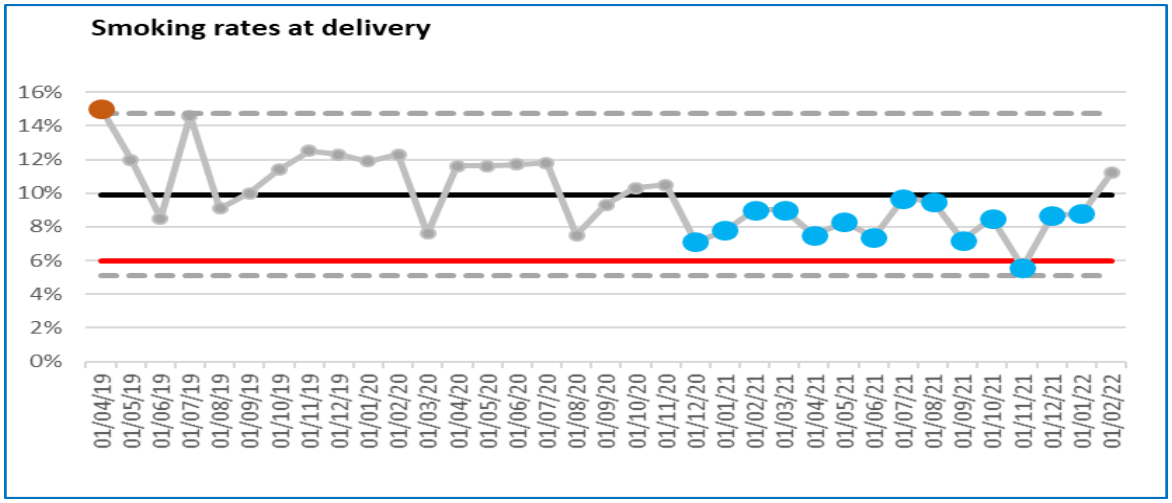
Feb-22
142
Variance Type
Common cause variation
Target
Target Achievement
Hit & miss target subject to random variation

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.



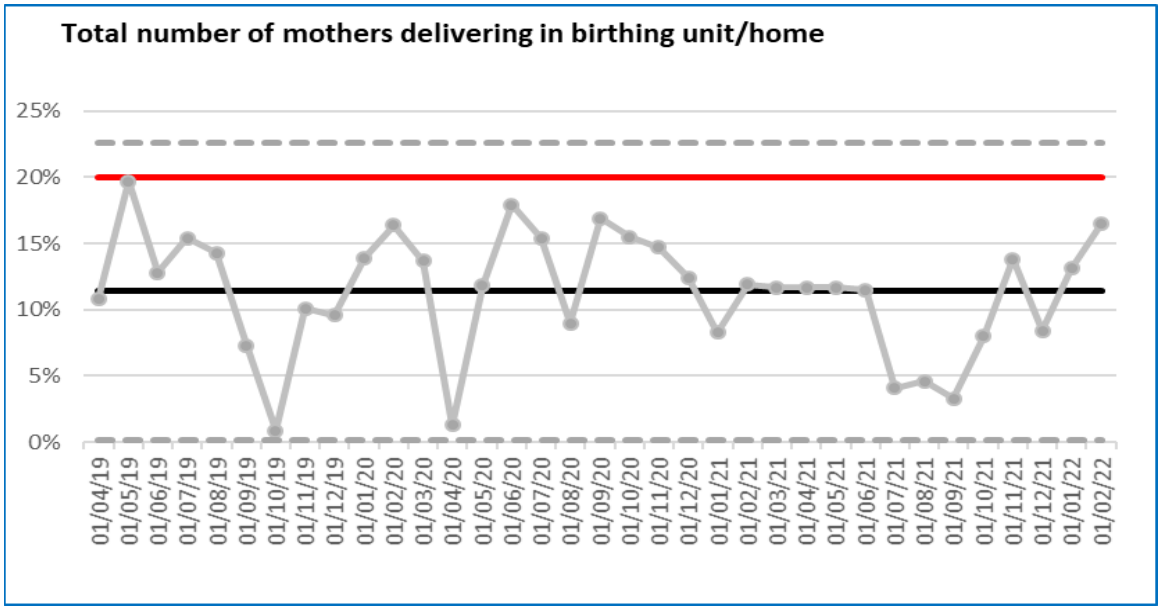
Feb-22
21
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
Patients with learning disabilities & autism accessing inpatient services	Common cause variation	The number of patients with LD will continue to fluctuate especially as the recovery programme continues. Work continues to ensure LD patients are able to access services & provide feedback on their experience.	LD steering plan in place supporting the work of the Learning Disability Nurse. LD nurse supporting with upskilling of enhanced care team	Nil required



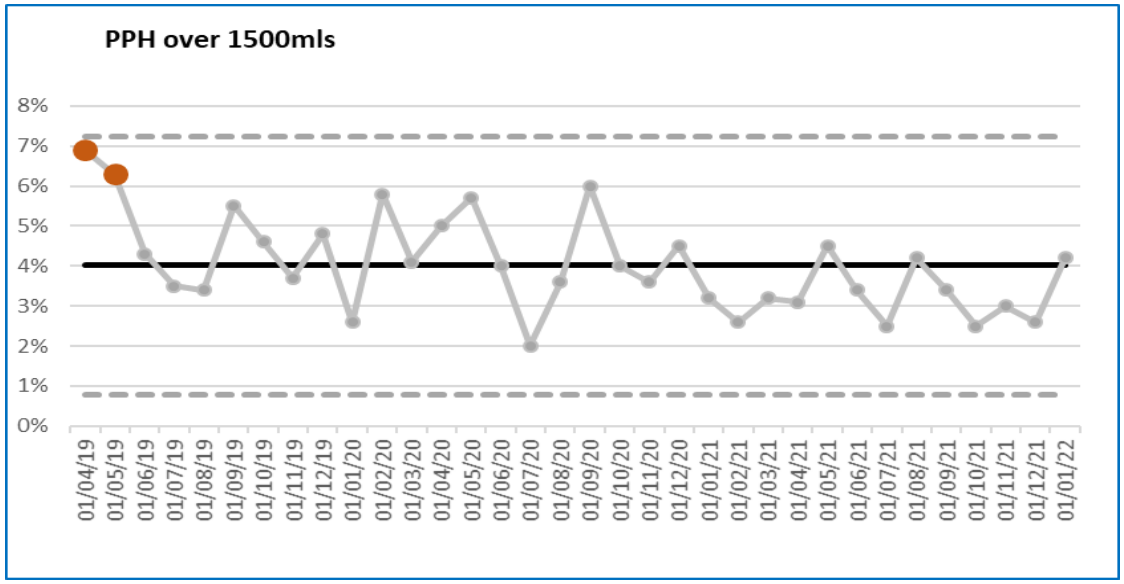
Feb-22
11.2%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

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 February 22 was 8.0%, compared to the target of <6% set by the LMNS	A Healthy Lifestyles midwife is in post, with the remit, of improving services and pathways for smoking in pregnancy. We have recently added a new field to COSMIC to electronically document women's smoking status at around 36 weeks gestation. We are also increasing the number of appointments where a smokerlyser test is offered, regardless of smoking status. 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. PAH have recently received funding 12 months of funding to provide an in house stop smoking service rather than to refer all women externally to PROVIDE.



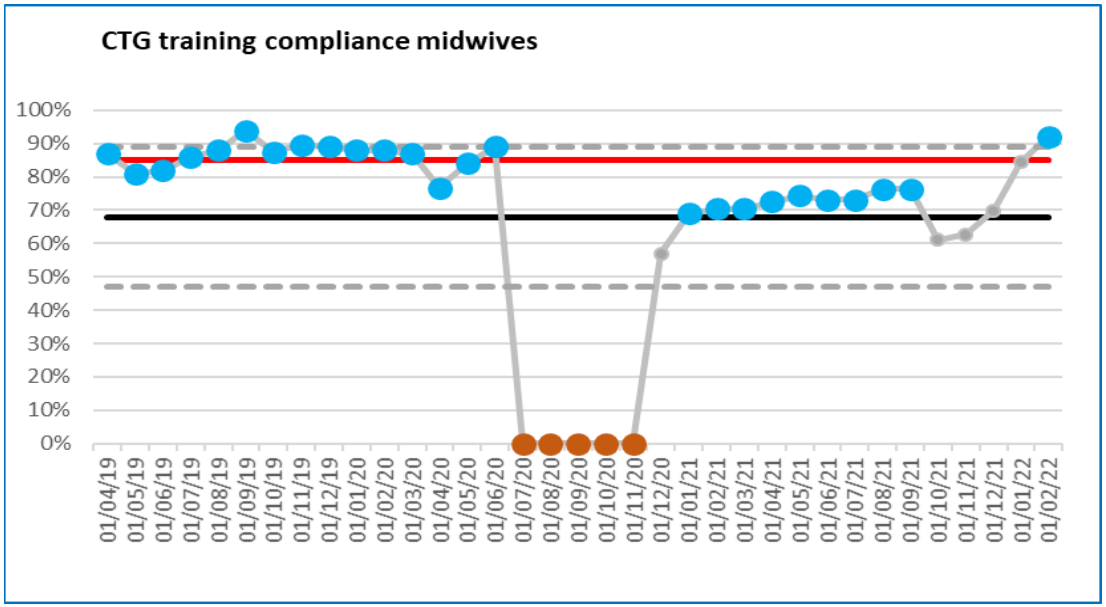
Feb-22
16.5%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

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	3.1% of women were recorded as having had a home birth in February, compared to the latest National average of 2.0% Birth Unit deliveries have increased to 13.4% for February, compared to 13.1% in January 22	Midwives are being re-deployed to the most appropriate area in terms of maintaining safe staffing levels – resulting in periodic closure of the Birth Unit to maintain safe staffing



Feb-22
3.40%
Variance Type
Common cause variation
Target
Not set
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	PPH over 1500mls The massive PPH rate for February was 3.4%, compared to the target of <2.9%.set by the LMNS .	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 identified and any concerns are escalated to the risk consultant for a harm review.



Feb-22
92.2%
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.

Total C-Sections

NEW GRAPH UNDER DEVELOPEMENT TO MATCH CHANGES IN REPORTING

Performance for February is 35% up from 32% for January

Feb-22
35%
Variance Type
Special cause variation
Target
None
Target Achievement

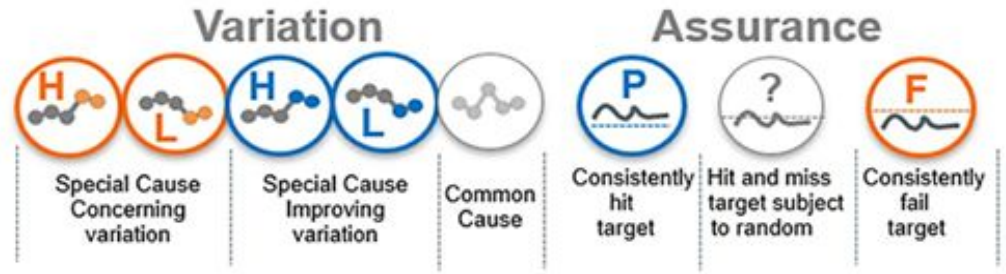
Background	What the chart tells us	Issues	Actions	Mitigation
Total C-Sections	Special cause variation	There has been an increase in elective caesarean sections in month	No longer collected for the IPR	PAH are moving away from looking at planned, unplanned and total C Section rates. These will be replaced by Robson groups as per recent guidance. The House of Commons Health & Social Care committee has recommended an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and advises that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently (Safety of Maternity Services in England 21-22)

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**
Catering	decrease in number of patient meals as the hospital had ward closures and increase in Covid patients, there was also decrease in food wastage, still below the national average.	For information	
Alex Lounge	The lounge is having it being furnished ready for the grand opening 17th March 2022	For information	
Domestics	Improving situation with the recruitment and retension of Housekeepers, weekly interviews taking place and exit interviews being undertaken by HR to understand issues so team are able to address. All new staff now attend Support worker induction.	For information	
Governance	New Quiqcare data base now being populated with all information requested to give assure on PAM's. New processed being identified	For information	
Estates	Agreement for new Cafam system to be purchased for Estates (MICAD)	For information	

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Feb 22	95%	95%			95%	91%	99%
Meals Served	Feb 22	27452	42120			37144	26262	48026
Catering Food Waste	Feb 22	1%	4%	L		5%	-1%	11%
Domestic Services (Cleaning) Very High Risk	Feb 22	98.2%	98.0%			97.6%	94.2%	101.1%
Domestic Services (Cleaning) High Risk	Feb 22	96.7%	95.0%			96.6%	93.2%	100.1%



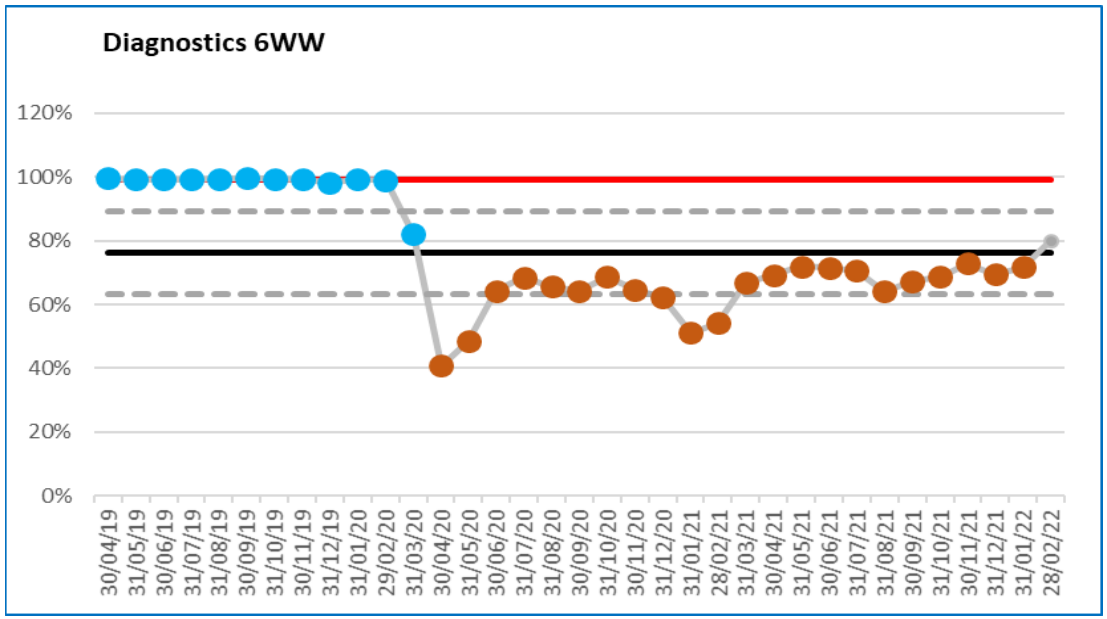
Performance

*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**
RTT - long waiting patients	The Trust continues to have increasing numbers of long waiting patients as anticipated following the 2 years Covid pandemic. Winter reductions in elective capacity and the focus on booking cancer & priority 2 patients further reduced the ability to treat admitted long waiting routine patients. The Trust has implemented twice weekly monitoring of patients over 104 weeks by 31st March and 60% of these patients have a treatment plan and the rest have next steps booked so that we achieve the aim of no patient waiting longer than 2 years by 31st March.	For increased visibility and awareness	
Urgent Care Standards	The Trust has continued to experience significant demand for urgent care services and has improved pathways by implementing streaming for walk in patients through the UTC, reducing the number of patients attending the main ED. Ambulance delays and 4 hour breaches continue to be poor as the flow through the department has been impacted by Covid demand for beds, staffing sickness levels reducing bed capacity and reduced community & social care capacity. Collaborative working across the system has ensured mitigating capacity & flexibility has been implemented wherever possible.	For information	
Stranded Patients	Despite the capacity issues described above the number of stranded patents has remained at a stable level, refecting the additional services that were implemented over December & January such as weekend HIT teams and discharge panel meetings.	For information	
62 day Cancer standard	Continued focus on diagosing & treating the longest waiting patients has created a depressed percentage performance. The number of patients waiting over 62 days decreased until mid December and has risen due to reduced capacity over the year end period. The Trust maintained elective ward capacity which was prioritised for cancer & urgent patients, increased ward capacity from 6 beds to 28 at the end of January.	For information	

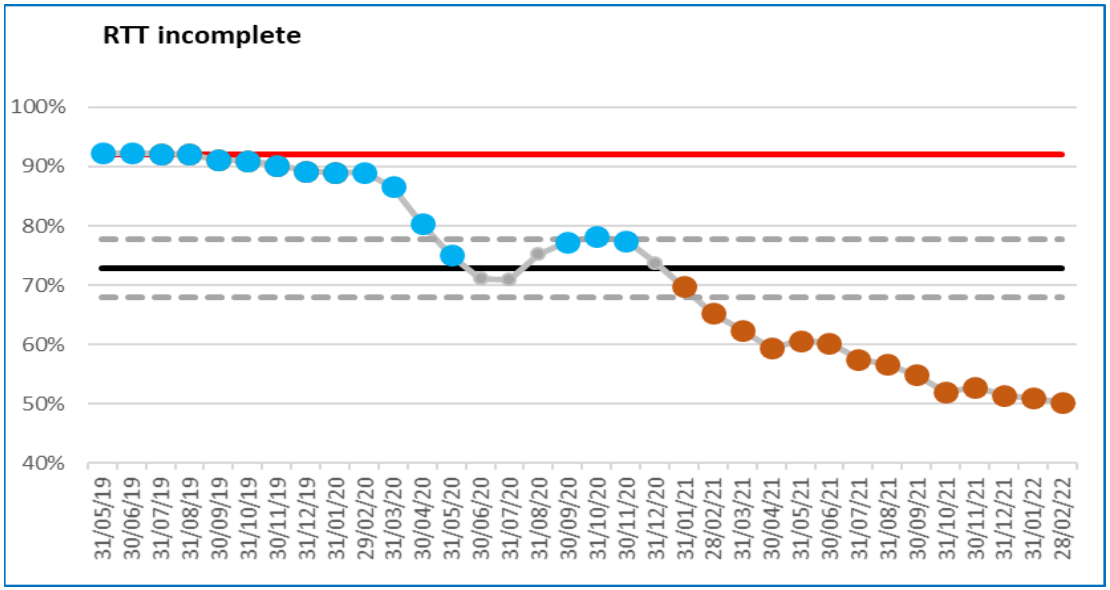
KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Feb 22	50%	92%			73%	68%	78%
RTT admitted	Feb 22	37%	90%			53%	26%	80%
RTT Non admitted	Feb 22	77%	95%			87%	84%	90%
RTT PTL vs RTT PTL & ASIs	Feb 22	85%	none			94%	92%	97%
Cancer 31 days First	Jan 22	92%	96%			94%	87%	101%
Cancer 31 days Subsequent Drugs	Jan 22	78%	98%			98%	91%	106%
Cancer 31 days subsequent surgery	Jan 22	40%	94%			92%	62%	122%
Cancer 2WW	Jan 22	50%	93%			82%	64%	100%
Cancer 62 day shared treatment	Jan 22	48%	85%			69%	50%	89%
Cancer 62 day screening	Jan 22	50%	90%			66%	16%	117%
Cancer 62 Day Consultant Upgrade	Jan 22	69%	90%			85%	65%	105%
Cancer 28 day faster diagnosis	Jan 22	51%	none			66%	50%	82%
4 Hour standard	Feb 22	65%	95%			75%	67%	83%
ED attendances	Feb 22	10184	none			8839	7013	10665
ED Admitted performance	Feb 22	22%	95%			49%	32%	65%
ED non admitted performance	Feb 22	72%	95%			83%	75%	91%
ED Arrival to Triage	Feb 22	61	15			46	29	63
ED Triage to examination	Feb 22	133	60			93	71	116
ED Examination to referral to specialty average wait	Feb 22	129	45			100	88	113
ED referral to be seen average wait	Feb 22	75	30			79	57	102
Seen by specialty to DTA	Feb 22	105	60			96	74	117
DTA to departure	Feb 22	546	30			205	93	317
Ambulance handovers less than 15 minutes	Feb 22	12%	100%			26%	14%	39%
Ambulance handovers between 15 and 30 mins	Feb 22	39%	0%			42%	32%	51%
Ambulance handovers between 30 and 60 mins	Feb 22	36%	0%			22%	12%	33%

KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Feb 22	14%	0%			10%	0%	19%
Diagnostics 6WW	Feb 22	80%	99%			76%	63%	89%
Occupied beds with stranded patients	Feb 22	198	80			148	98	198
Bed occupancy	Feb 22	90%	85%			89%	81%	96%
Discharges between 8am and 5pm	Feb 22	628	none			718	471	964
Discharges between 5pm and 8am	Feb 22	559	none			695	439	951
LOS non elective	Feb 22	4.9	5.1			3.8	2.9	4.8
LOS elective	Feb 22	2.1	4.2			2.3	0.6	3.9
Short Notice clinical cancellations	Feb 22	19	none			44	-29	117
OP new to follow up ratio	Feb 22	2.0	2.3			2.1	1.8	2.5
OP DNA Rate	Feb 22	4.9%	8.0%			4.8%	3.6%	6.0%
52 Week waits	Feb 22	2221	0			734	471	997
Proportion of Majors Patient treated within 4 hours in ED Paeds	Feb 22	70%	95%			81%	65%	97%
Super stranded patients	Feb 22	75	25			43	18	68
12 Hour waits in ED from Arrival	Feb 22	1056	0			475	174	775
12 Hour Trolley waits in ED from DTA	Feb 22	274	0			63	-11	137



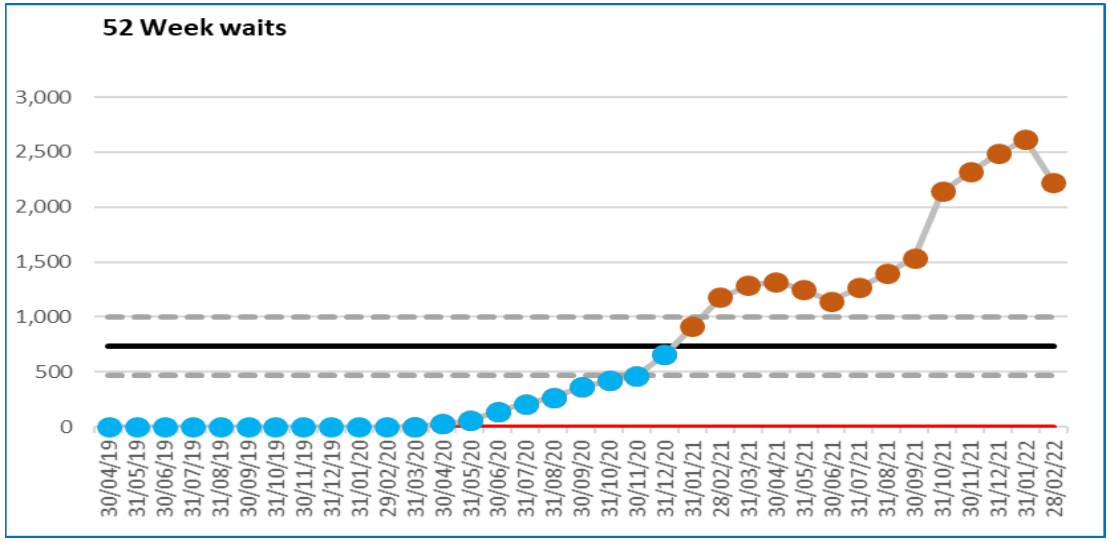
Feb-22
79.87%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

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



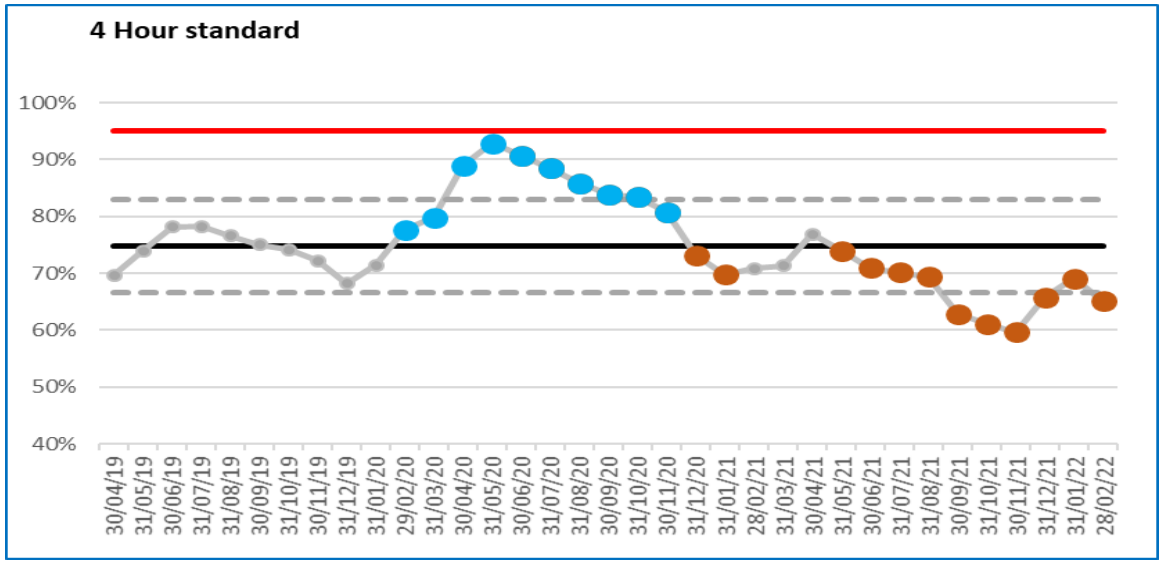
Feb-22
50.3%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

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



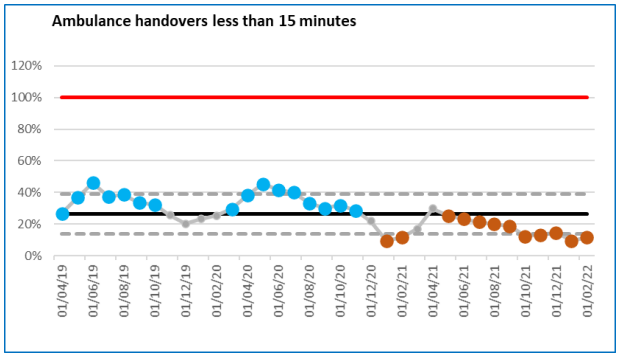
Feb-22
2221
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

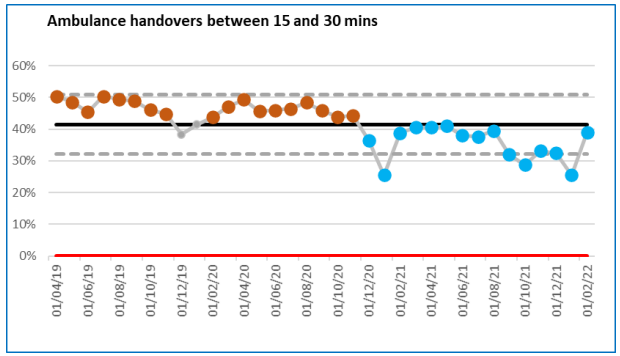
Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Balance between emergency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

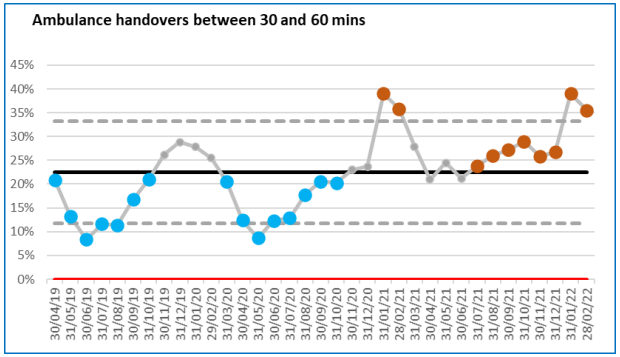


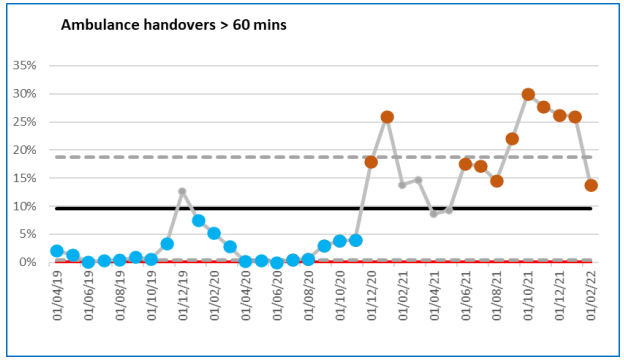
Feb-22
65.10%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

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.



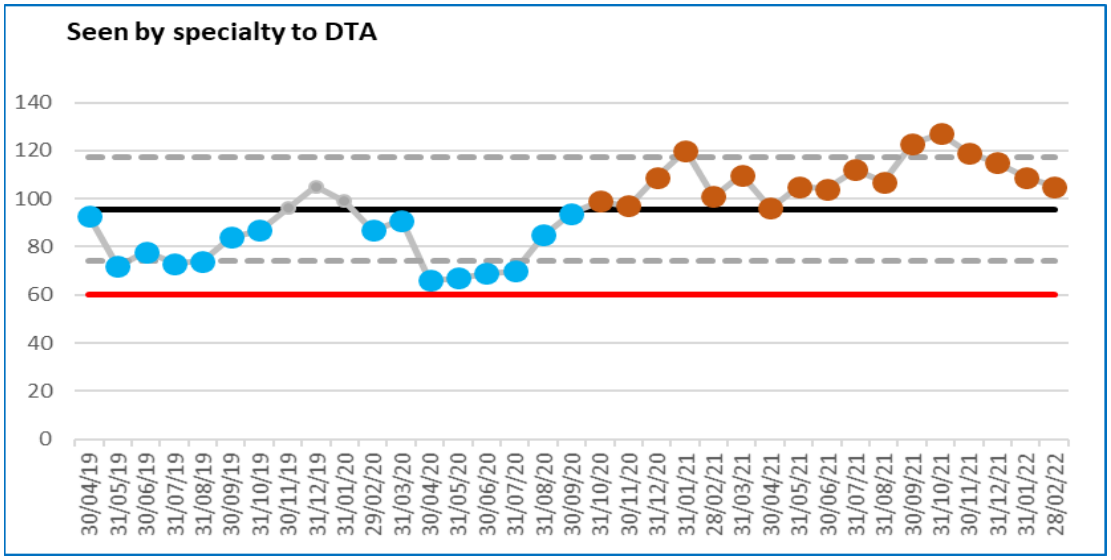






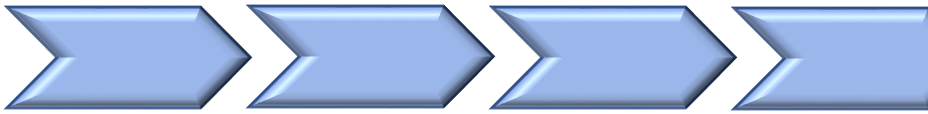
Feb-22
36.00%
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

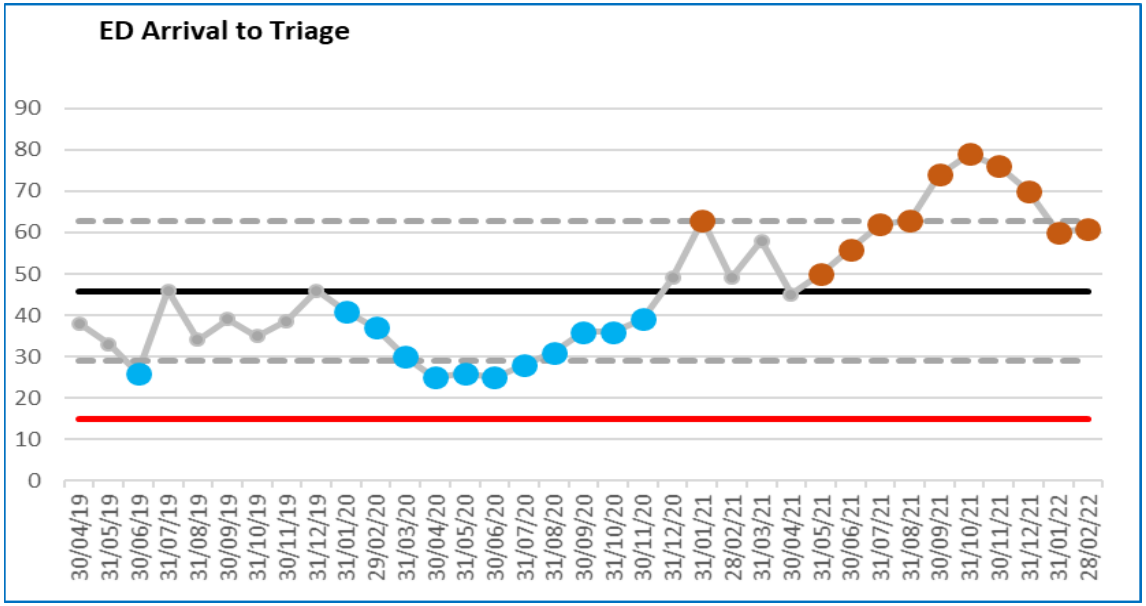
Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average. Increased ambulance activity, delays in bed availability for admissions in emergency department. Increased Covid attendances over the	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	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



Feb-22
105 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

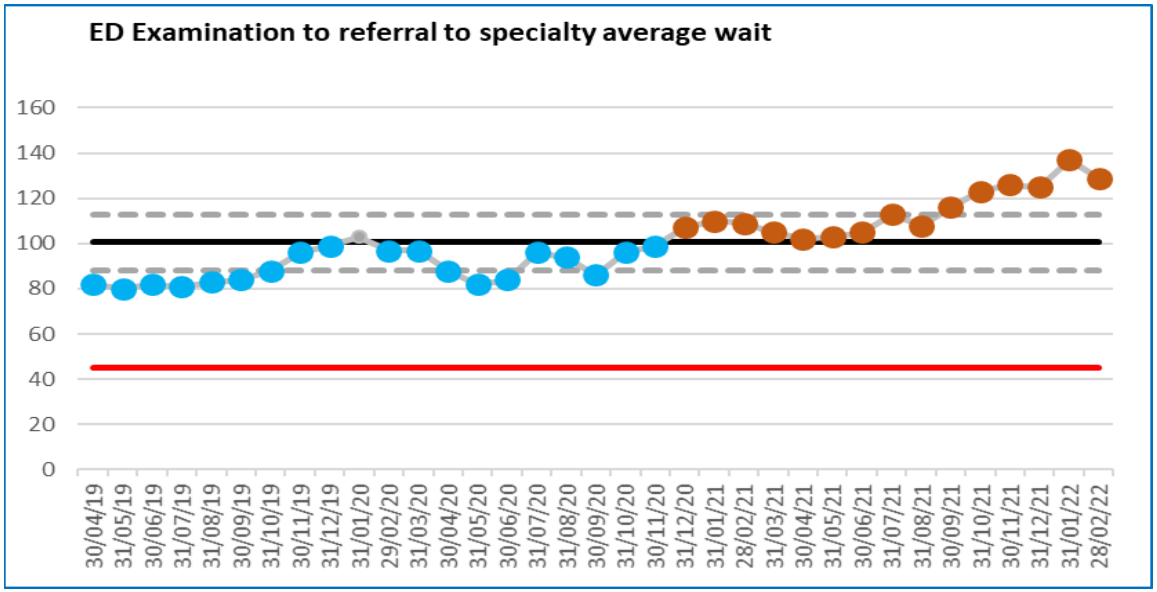
Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	Internal 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





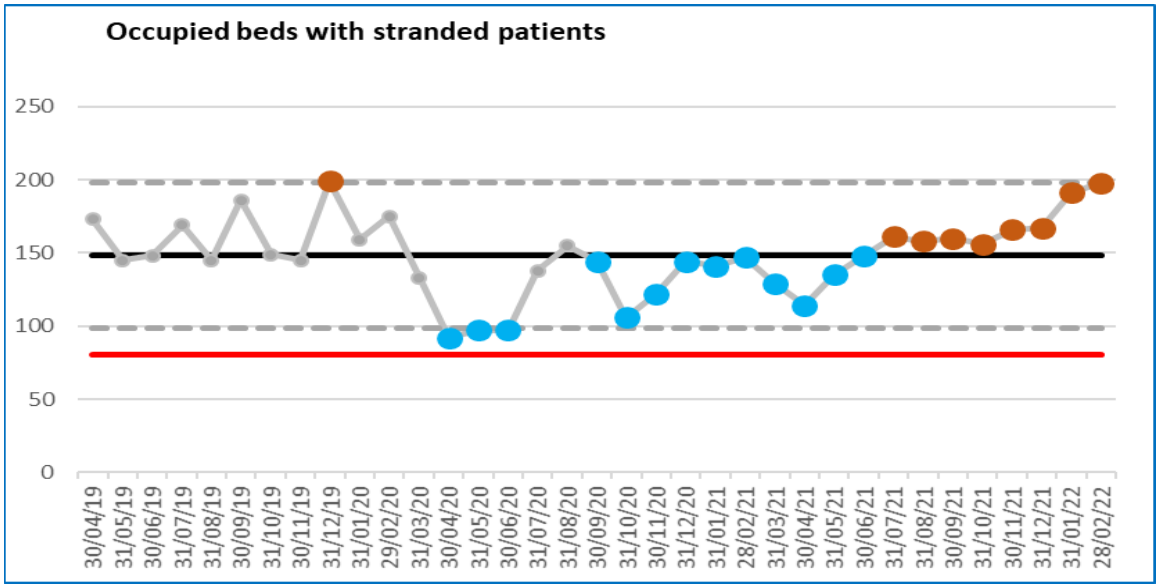
Feb-22
61 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

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 during winter. Two senior nusrses seconded to develop an improvement plan for triage performance.	Close review through breach analysis at Urgent Care Board



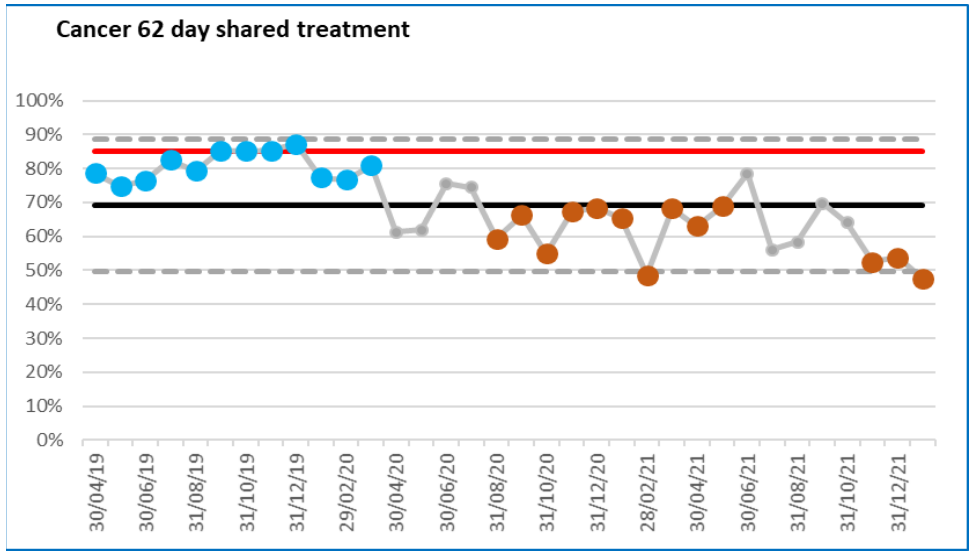
Feb-22
129 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

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



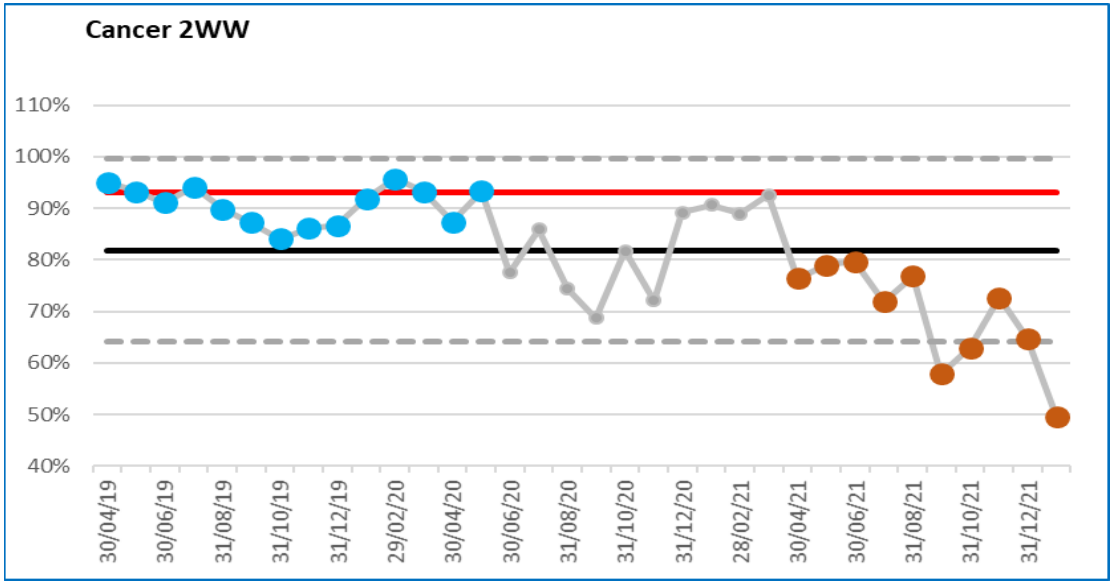
Feb-22
198
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Occupied beds with stranded patients	Special cause concerning variation & consistently failing target	The performance against the target for stranded patients has failed consistently, however, we have shown common cause variation for the last 12 months	Daily patient panel review to understand discharge constraints. HIT Team review of patients appropriate for discharge extended across weekends. Additional community capacity is in place with Gibberd ward as community capacity and additional Covid community capacity opened. External senior national consultant support working alongside consultant & nursing teams on the inpatient wards. Joined national improvement programme	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.



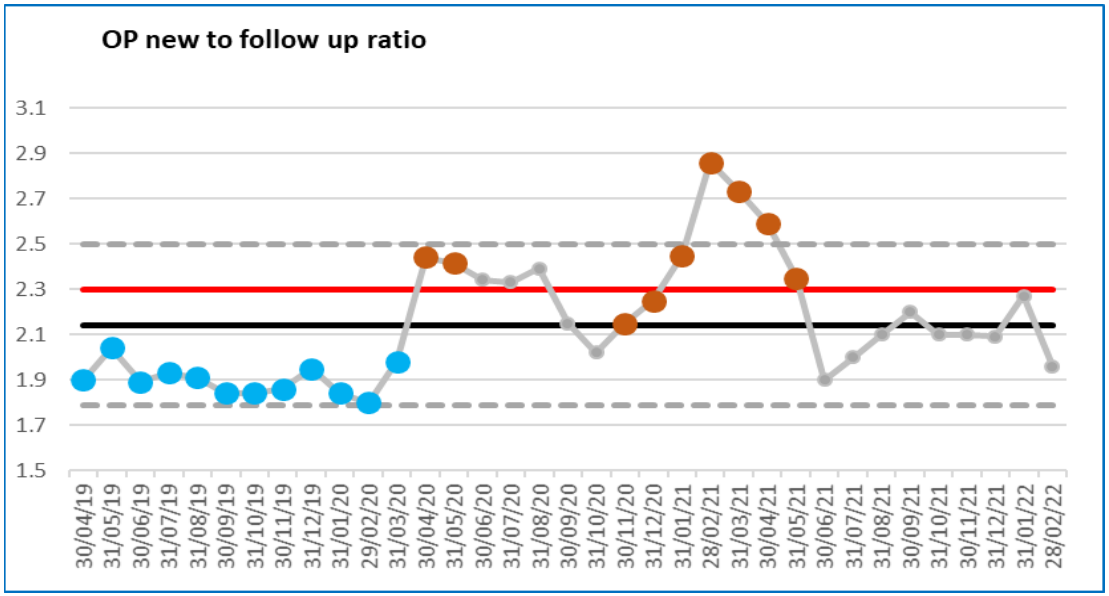
Jan-22
53.80%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

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 is being refreshed following the reduced operating capacity Dec - Feb 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.



Jan-22
50.00%
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 and capacity issues due to staff absence in conjunction with clinic booking issues. Dermatology has seen significant increases in 2ww referrals and has staffing issues. Breat referrals remained high in December following national	Dermatology routine slots utilised for 2ww capacity, reduced 2ww ASIs in February 2022. Colorectal pathway improvements in place. Breast additional capacity in place & returned to 14 day booking mid January.	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.



Feb-22
1.96
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

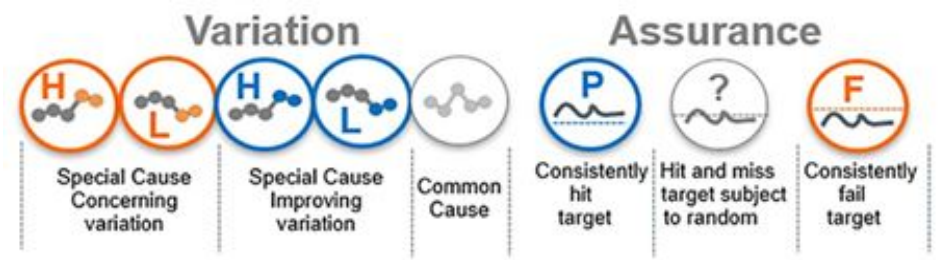
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	Additional insourcing to clear the overdue follow-up appointments is impacting the ratio.	Ongoing monitoring & increased volumes of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

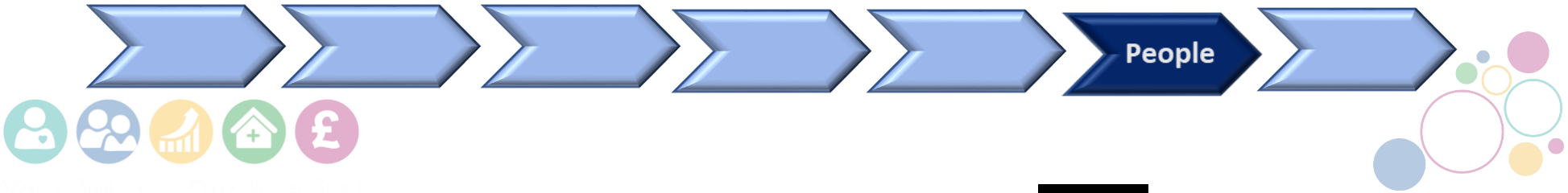
People

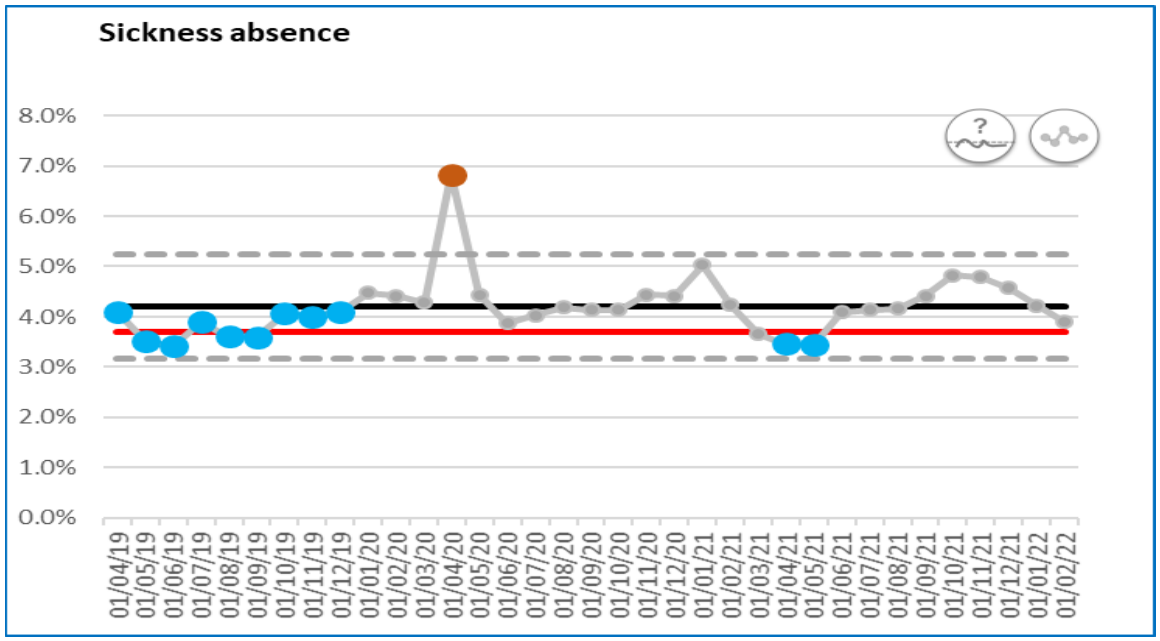
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Vacancy	Vacancy rate for February continues to decrease and is within target. Key areas include domestic, housekeeping and Finance. Following successful recruitment days 16 domestics and housekeepers are currently in the recruitment pipeline. Recruitment and HRBP teams are working with finance colleagues to recruit to substantive roles	For information	Q1
Appraisal	Feedback indicates that appraisal rates have been impacted by absence rates and pressures on services. Monthly reporting of compliance rates are provided to divisions and presented through PRM packs.	For information	Q1
Statutory and Mandatory training	Reported challenges of protected time to complete training. The new training facility will be open from 21st March. Staff sign posted to training booklet to support completion for some core training. The new training facility based on the main site is due to open in Feb. This should improve face to face training	For information	Q1
Sickness	Absence levels for February have reduced and are within target. Reduction is reflective of the reduction in COVID related sickness during this time. SHaW continue to provide advice and guidance on COVID related absence. Other main absence reasons relate to Mental health and MSK, Here for you and physiomed continue to be supportive interventions	For information	Q1

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Feb 22	78.9%	90.0%		F	81.8%	76.8%	86.8%
Agency staffing spend	Feb 22	5.5%	15.0%		P	5.0%	2.1%	7.9%
Bank staffing spend	Feb 22	13.5%	15.0%	H	P	11.7%	9.2%	14.2%
Vacancy Rate	Feb 22	6.5%	8.0%	L	F	9.5%	8.1%	10.8%
Staff turnover - voluntary	Feb 22	15.0%	12.0%	H	?	11.5%	10.6%	12.3%
Sickness absence	Feb 22	3.9%	3.7%		?	4.2%	3.2%	5.2%
Statutory and Mandatory training	Feb 22	87.0%	90.0%	L	?	88.6%	85.8%	91.3%



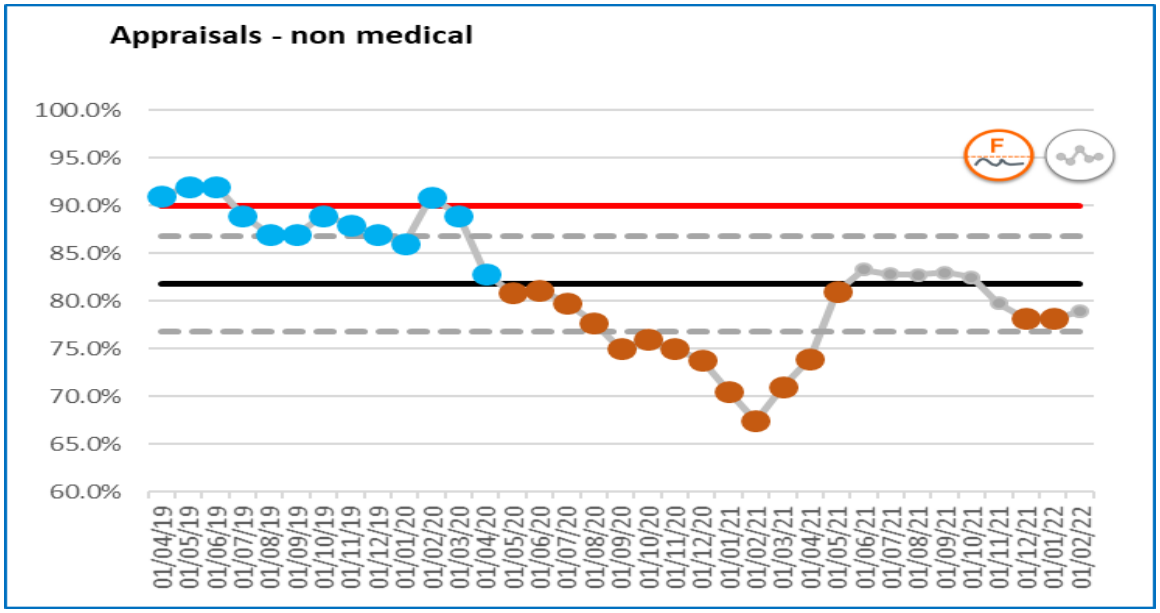




Feb-22
3.90%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Absence levels for February have reduced, this is reflective of the reduction in COVID related sickness during this time	SHaW continue to provide advice and guidance on COVID related absence. Other main absence reasons relate to Mental health and MSK, Here for you and physiomed continue to be supportive interventions	Absences recorded contemporaneously and advice & guidance to managers on COVID & testing guidelines

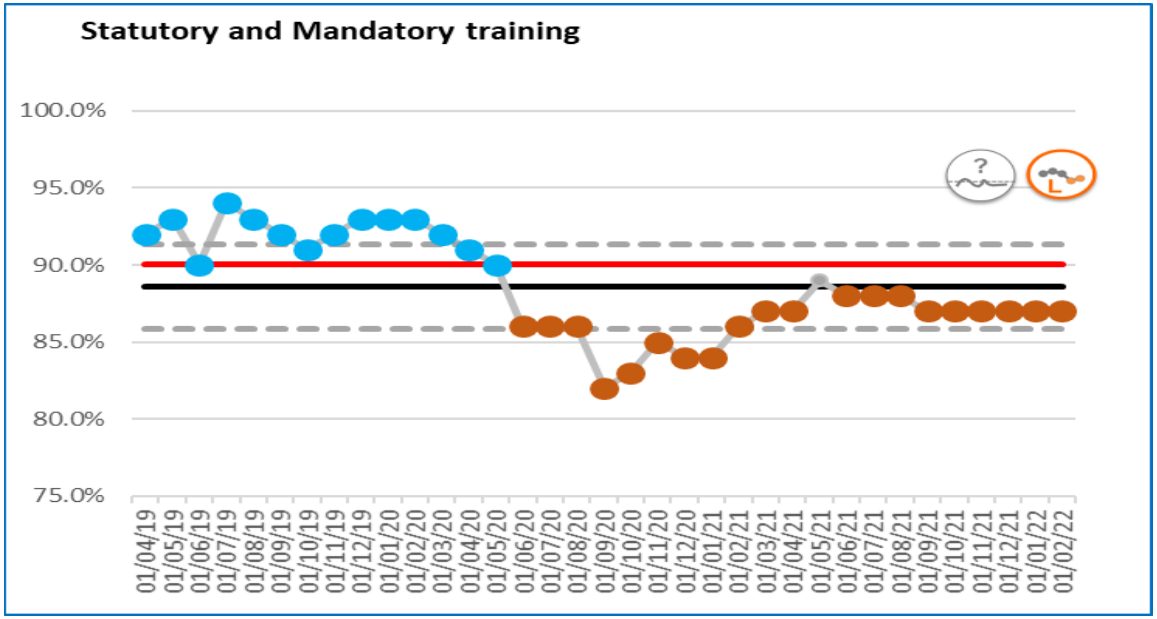
People



Feb-22
78.90%
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	Monthly reporting of compliance rates are provided to divisions and presented through PRM packs.	Compliance rates discussed at monthly divisional board meetings & performance review meetings with actions agreed. People information team able to support any challenges with MyESR

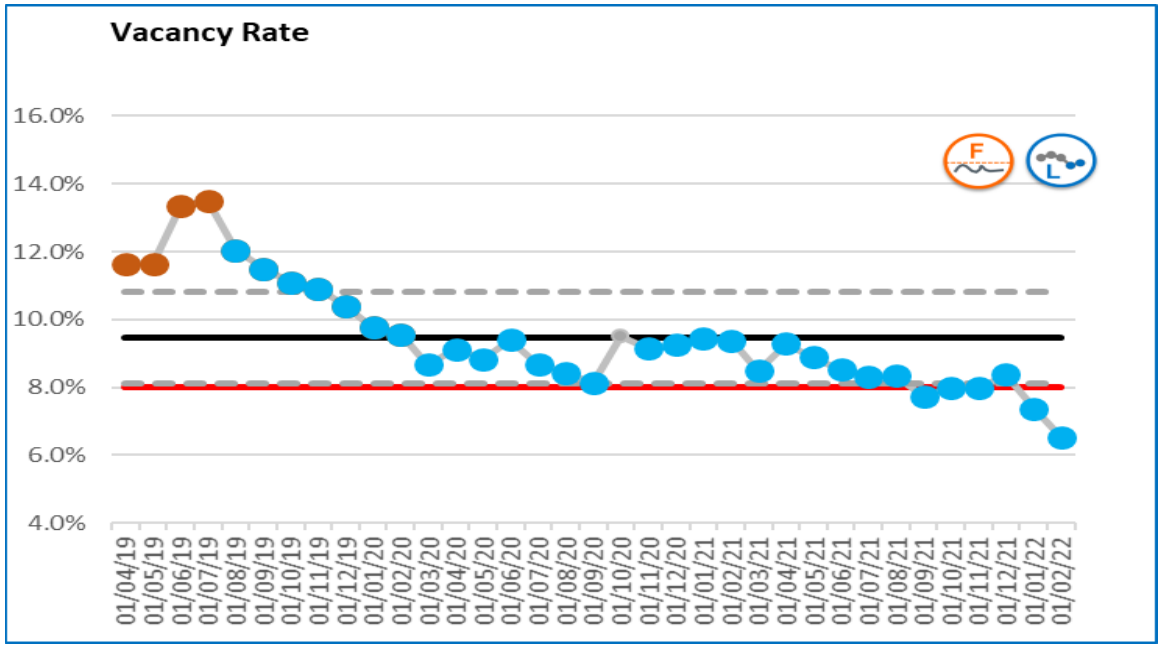
People



Feb-22
87%
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. The new training facility will be open from 21st March	Staff sign posted to training booklet to support completion for some core training. The new training facility based on the main site is due to open in Feb. This should improve face to face training	Compliance rates are discused in monthly divisional meetings and PRMs

People



Feb-22
7.37%
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	Vacancy rate for February continues to decrease, key areas include domestic, housekeeping and Finance	Following successful recruitment days 16 domestics and housekeepers are currently in the recruitment pipeline. Recruitment and HRBP teams are working with finance colleagues to recruit to substantive roles	Recruitment plans for divisions reviewed at divisional board meetings and at monthly performance review meetings. Temporary staff used where appropriate

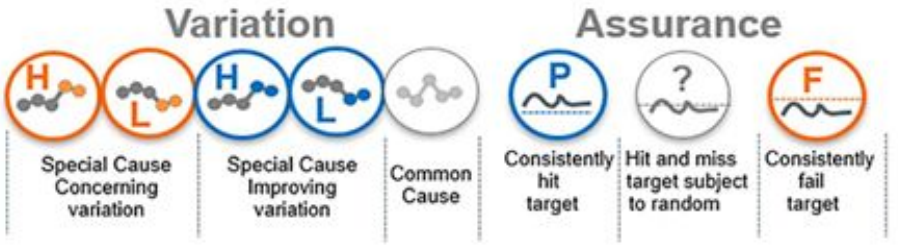
People

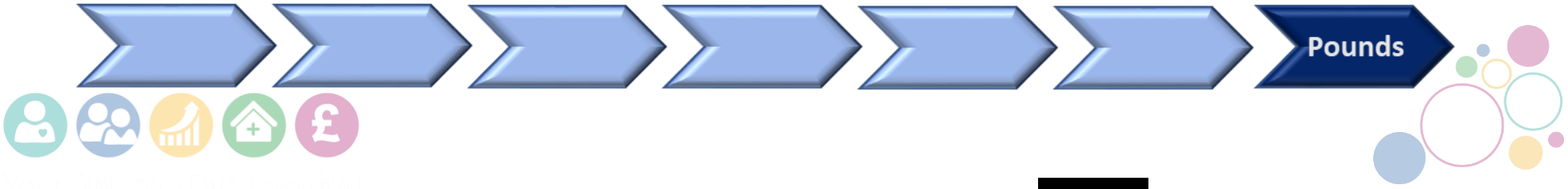
Pounds

*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 recorded a surplus of £1.598m at the end of month 11, against a break even plan.The Trust is currently forecasting to underspend on its winter pressure funding and an surplus of up to £2.998m by year end. The Trust is actively working to reduce the forecast surplus.	For information	
CIP	The Trust has only delivered £4.580m of savings against a year to date plan of £6.251m. The Trust continue to forecast delivery of the CIP target however up to £6.437m of teh arget will be through non recurrent funding against a full year target of £7.052m for the full year.	For information	
Capital Spend	Year-to-date capital spend is £18.230m against a revised capital plan of £18.798m. This under-performance of reflects timing differences and the Trust is expects to achieved spend against its Capital Resource Limit	For information	
Cash	The Trust continues to have a healthy cash balance of £65.800m. There is a continued push to reduce aged payables & improve the 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)	Feb 22	1599	0			173	-5174	5521
EBITDA	Feb 22	2565	0			1330	-4037	6698
CIP	Feb 22	2620	0			592	-385	1569
Income	Feb 22	33071	0			26174	15563	36785
Operating Expenditure	Feb 22	37589	0			25887	19792	31981
Bank Spend	Feb 22	9090	0			2163	1082	3244
Agency Spend	Feb 22	1114	0			845	376	1314
Capital Spend	Feb 22	1450	0			2433	-3295	8161





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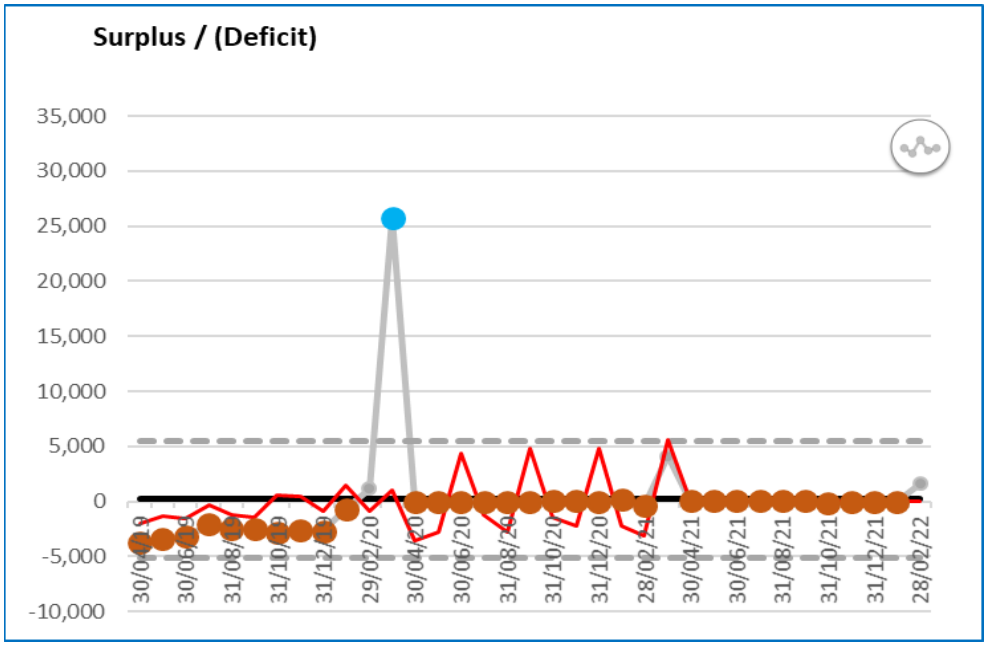
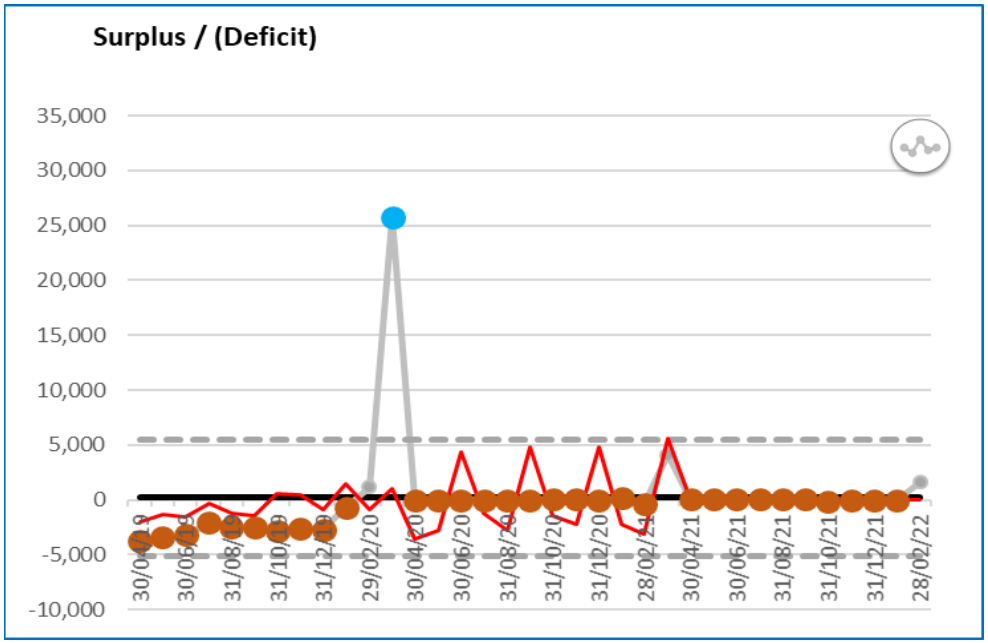


Feb-22
1559
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

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.	Divisions are working to reduce their run rate, while also ensuring spend again the winter funding. The Trust has forecast an underspend and is managing this to ensure a break-even position is achieved at M12.	N/A

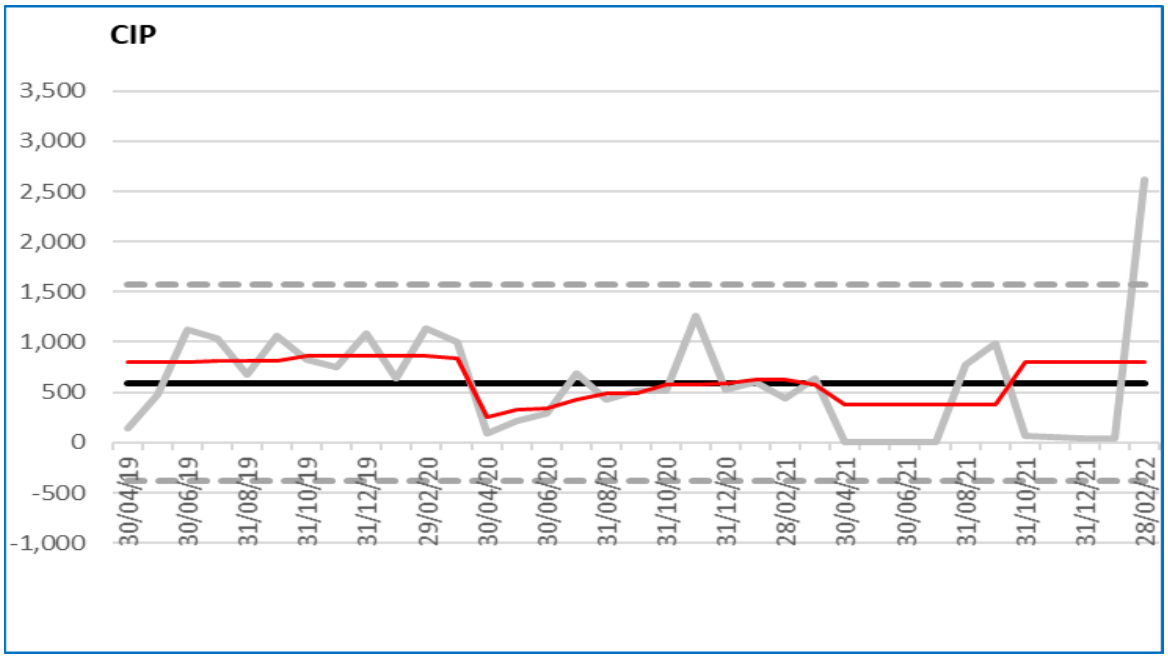
Pounds



Feb-22
1559
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

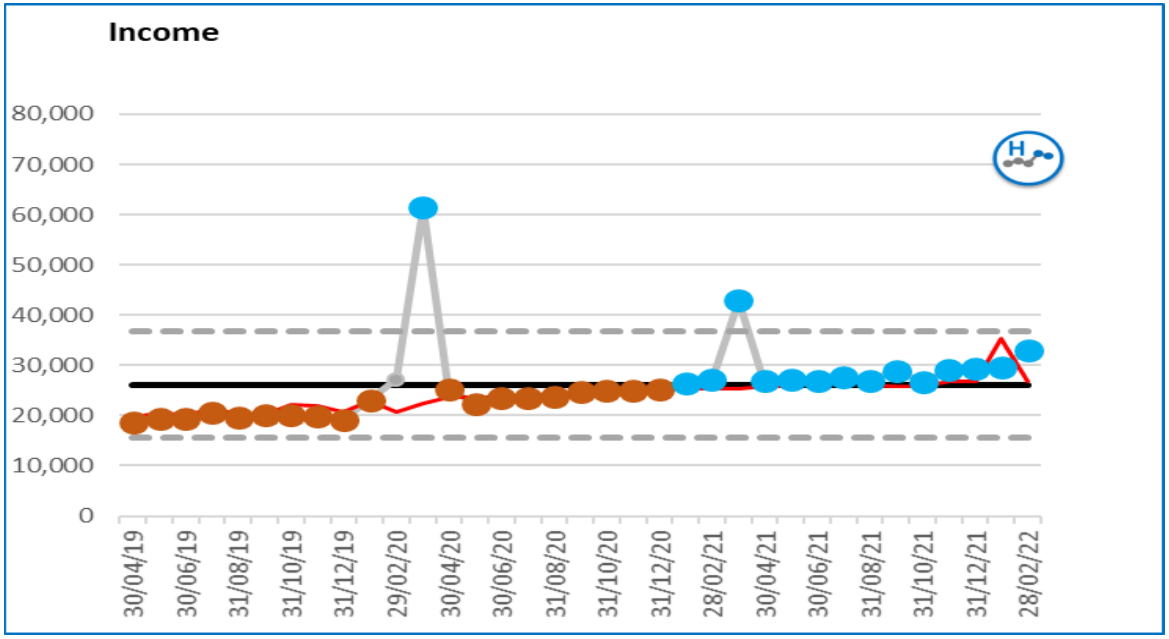
Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target	The Trust has recorded a surplus of £1.6magainst a breakeven finanical plan at M11 as a result of under utilisation of winter funds to date.	Divisions are working to reduce their run rate, while also ensuring spend again the winter funding. The Trust has forecast an underspend and is managing this to ensure a break-even position is achieved at M12.	N/A

Pounds



Feb-22
2620
Variance Type
Common cause variation
Target
801
Target Achievement
Inconsistently passing and falling short of the target

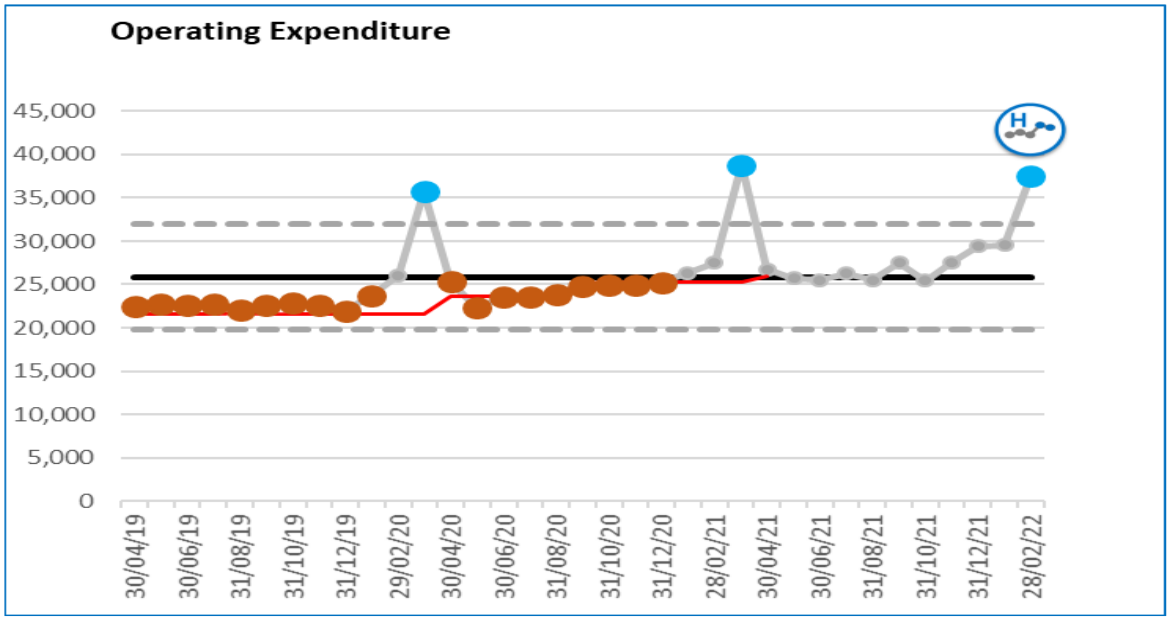
Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target	CIP delivery is behind plan as at M11 (£1.671m).	Divisions are being supported to develop and deliver their cost improvement plans. The CIP programme will be delivered in 21/22 non-recurrently.	N/A



Feb-22
33071
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

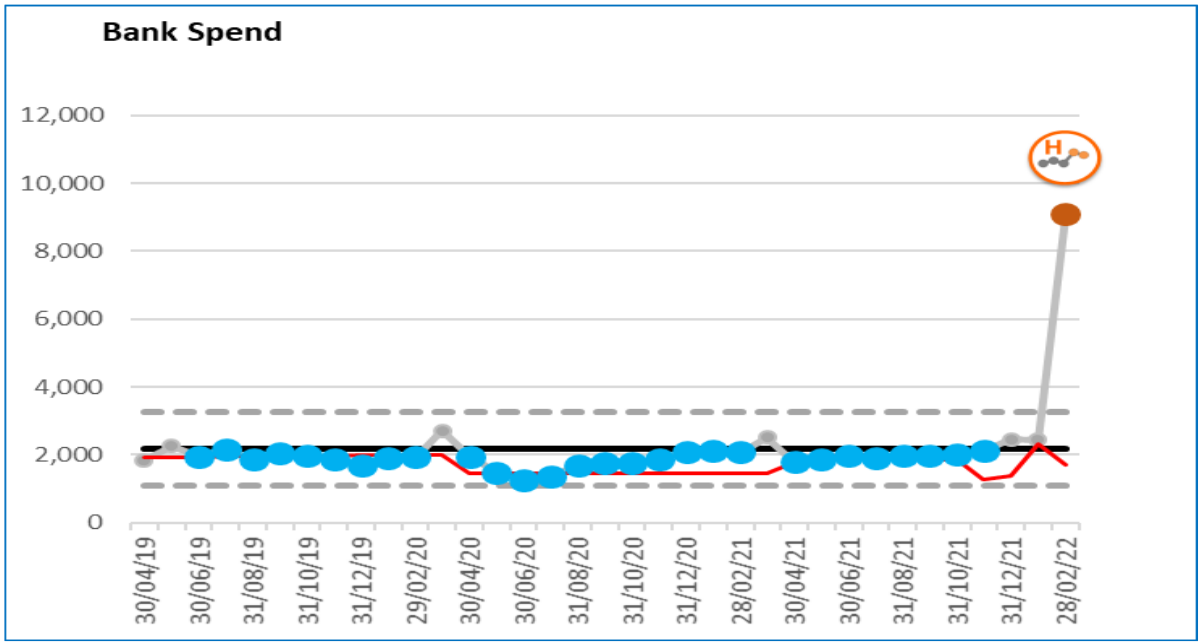
Pounds



Feb-22
37589
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. The Trust is forecasting a M12 underspend. Mitigations are in development.	N/A

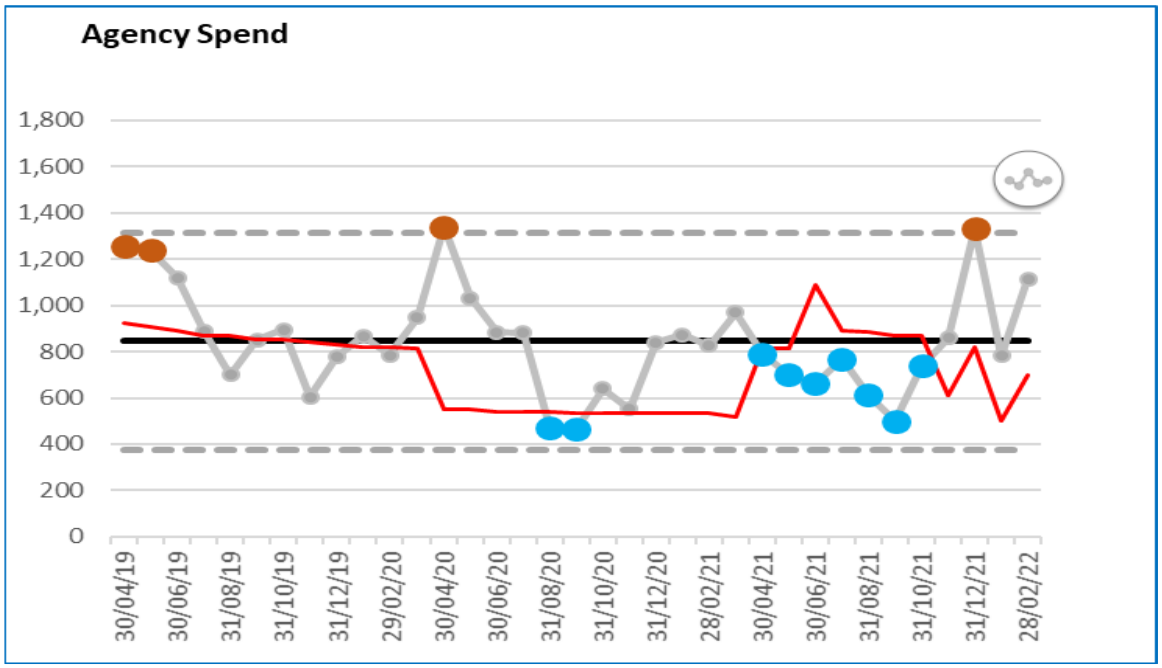
Pounds



Feb-22
9090
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

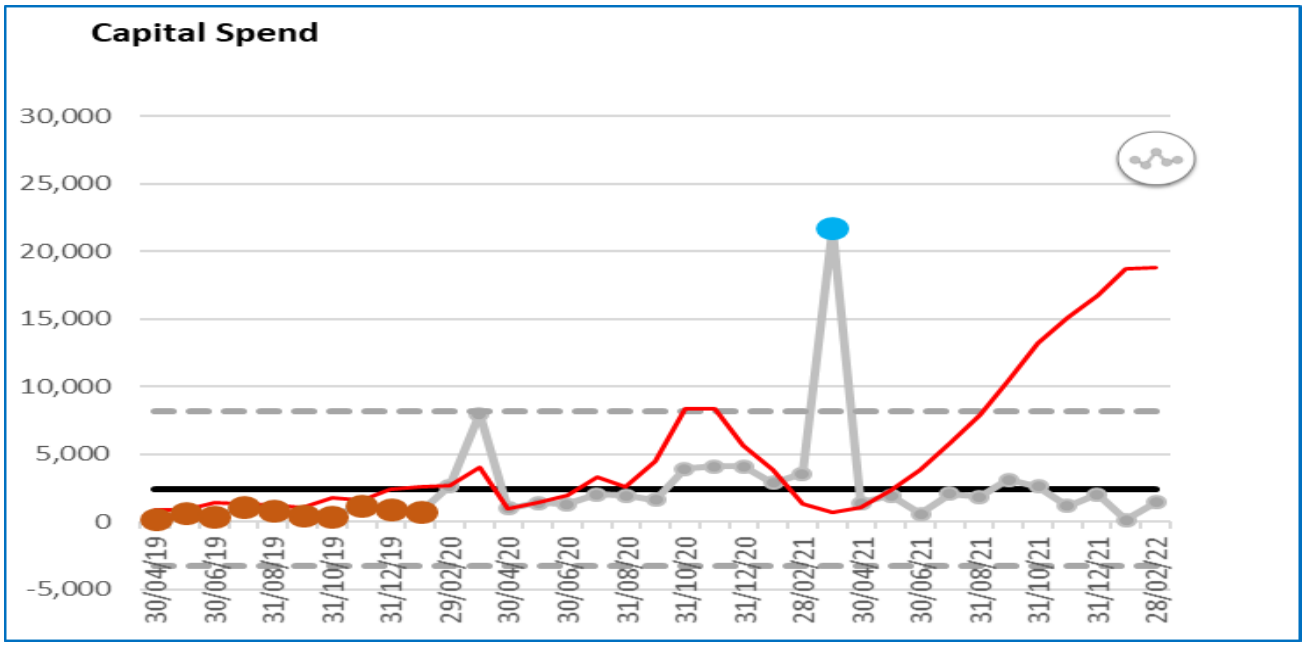
Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation & inconsistently passing and falling short of the target	Bank usage is increasing due to vacancies and winter demand	The bank and agency review meeting is supporting Divisions to reduce this spend. Recruitment plans are being developed to support longer term sustainability of clinical services.	N/A

Pounds



Feb-22
1114
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



Feb-22
1450
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.	The CWG monitors the capital programme. The CWG has identified an underspend and is developing mitigations to land the CRL.	N/A

Pounds

Quality Improvement Plan

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Urgent and Emergency Services					
M1	Apr-19	Urgent Care	The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of reflective of each patient's full clinical pathway	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - Buisness As Usual (BAU) to be completed
M2.N (new)	Apr-19	Urgent Care	The service must ensure that medical staff training meets the compliance target of 90%.	Medical Director	On track for delivery against the set timescales - BAU to be completed
M3.N	Apr-19	Urgent Care	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Skill gap	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M23	Feb-21	Urgent Care	The trust must ensure all appropriate risk assessments for patients attending the department are completed in a timely way to ensure appropriate mitigating actions can be taken	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M24	Feb-21	Urgent Care	The trust must ensure all risk assessments for patients presenting with a mental health crisis are completed in a timely way in order to identify and mitigate any risks to patient and staff safety.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M25	Feb-21	Urgent Care	The trust must ensure all staff comply with all trust infection prevention and control (IPC) guidance in order to minimise the risk of the spread of infection.	Director of Nursing. Midwifery and Allied Health Professionals	BAU form approved Awaiting review by system colleagues Planned April 22
M26	Feb-21	Urgent Care	The trust must ensure that staffing resources are used efficiently throughout the ED to reduce delays to patient	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M27.N	Feb-21	Urgent Care	The trust must ensure that there is robust oversight of the clinical decisions unit (CDU) including that patients cared for there meet the inclusion criteria. / The trust must ensure that there is a clear record and oversight of patients being admitted to clinical decisions unit. (Regulation 17 (1)(2)(a)).	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales. Unit not operational at this current time. Plan for audit cycle when CDU reopens
M28	Feb-21	Urgent Care	The trust must ensure the triage process is robust and accurately identifies those patients who are the most sick.	Chief Operating Officer	Behind on delivery but plan in place
M29	Feb-21	Urgent Care	The trust must ensure the monitoring of the time to specialist review and total time spent in the department is accurate.	Director of Nursing. Midwifery and Allied Health Professionals	BAU form approved Awaiting review by system colleagues April 22
M30.N	Nov-21	Urgent Care	The Registered Provider must operate an effective system which will ensure that every patient attending the Emergency Department has an initial assessment of their condition to enable staff to identify the most clinically urgent patients	Chief Operating Officer	Behind on delivery but plan in place
M31.N	Nov-21	Urgent Care	The Registered Provider must devise a process and undertake a review of current and future patients clinical risk assessments, care planning and physiological observations, and ensure that the level of patients' needs are individualised, recorded and acted upon. This must include, but not limited to skin integrity, falls, and mental health assessments.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M32	Nov-21	Urgent Care	The registered provider must ensure that it implements an effective system with the aim of ensuring all patients who present to the emergency department at the Princess Alexandra Hospital patient observations are completed within 15 minutes of arrival and as appropriately thereafter in line with trust policy.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Urgent and Emergency Services					
M33.N	Feb-21	Urgent Care	The trust should ensure all appropriate staff are familiar with the doffing procedures for personal protective equipment in the aerosol generating procedures room. (Regulation 12)	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
M35.N	Nov-21	Urgent Care	The trust must ensure that there are safe toilet facilities for adult patients presenting with mental ill health. (Regulation 13 (1))	Chief Operating Officer	On track for delivery against the set timescales - BAU to be completed
T4	Mar-20	Urgent Care	The trust must ensure the out of hours endoscopy process is embedded and understood by all appropriate staff in the department.	Medical Director	On track for delivery against the set timescales - BAU to be completed
S25.N	Nov-21	Urgent Care	The trust should ensure they continue to improve safeguarding training compliance for nursing and medical staff. (Regulation 13)	Medical Director	On track for delivery against the set timescales - BAU to be completed
S2.N	Apr-19 / Nov21	Urgent Care	The trust should ensure that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
S21	Nov-21	Urgent Care	The trust should ensure resuscitation equipment in the CDU is checked in line with trust guidelines.	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
S22	Feb-21	Urgent Care	The trust should continue to recruit registered nursing and health care staff in order to meet establishment guidelines	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
S23	Feb-21	Urgent Care	The trust should continue to recruit consultants in order to meet Royal College of Emergency Medicine (RCEM) guidelines.	Medical Director	BAU complete - reviewed and approved by system colleagues
S24	Feb-21	Urgent Care	The trust should ensure the minutes of the Urgent and Emergency Care meetings are detailed.	Director of Quality improvement	On track for delivery against the set timescales - BAU to be completed
Paediatric Urgent and Emergency Services					
M34.N	Nov-21	Paediatric Urgent and Emergency Services	The trust must ensure that the paediatric mental health room is fit for purpose and meets the standards set out in Facing the Future, Standards for Children in Emergency Care Settings. (Regulation 13 (1))	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
S25.N	Nov-21	Paediatric Urgent and Emergency Services	The trust should ensure they continue to improve safeguarding training compliance for nursing and medical staff. (Regulation 13)	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Medical Care					
M2	Apr-19	Medical care (including older people's care)	The service must ensure that medical staff training meets the compliance target of 90%.	Director of people Organisational Development & Communications	On track for delivery against the set timescales - BAU form approved
M4.N	Apr-19	Medical care (including older people's care)	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU form approved
M5.N	Apr-19	Medical care (including older people's care)	The service must ensure that systems and processes to identify risk at ward level are embedded.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M6.N Falls	Apr-19	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient falls	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M6.N Ulcers	Apr-19	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient pressure ulcers.	Associate Director of Nursing	On track for delivery against the set timescales - BAU to be completed
M7	Apr-19	Medical care (including older people's care)	The service must ensure broken crockery and glass is safely disposed of on all wards.	Director of estates and Strategy	BAU complete - reviewed and approved by system colleagues
M8	Apr-19	Medical care (including older people's care)	The service must ensure that medical staff training meets the trust compliance target of 90%.	Associate Medical Director	On track for delivery against the set timescales - BAU form approved
M9	Apr-19	Medical care (including older people's care)	The service must ensure that hazardous chemicals are kept in a locked cupboard.	Director of Strategy and Estates	On track for delivery against the set timescales - BAU form completed
M36.N	Nov-21	Medical care (including older people's care)	The trust must ensure that records of patients' care and treatment are completed with appropriate detail and contemporaneously. (Regulation 17 (1)(2)(a)).	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
M37.N	Nov-21	Medical care (including older people's care)	The trust must ensure staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (1)(2)(a))	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
M37b.N	Nov-21	Medical care (including older people's care)	The trust must ensure staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (1)(2)(a))	Medical Director	On track for delivery against the set timescales - BAU form to be completed
S3.N	Nov-21	Medical care (including older people's care)	The service should ensure all staff complete safeguarding training in line with national guidance.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
S27.N	Nov-21	Medical care (including older people's care)	The trust should ensure that all ward areas are free from clutter and relative rooms are fit for purpose at all times. (Regulation 15).	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
S28.N	Nov-21	Medical care (including older people's care)	The trust should ensure that all ward areas display information on how to make complaints, performance data and information relevant to patients and families on health promotion. (Regulation 17).	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Surgery					
M10	Apr-19	Surgery	The service must ensure that actions to protect patient safety are put in place in a timely manner.	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
M11	Apr-19	Surgery	The service must continue to monitor and actively recruit to ensure staffing with the appropriate skill mix is in line with national guidance	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
M12	Apr-19	Surgery	The service must ensure that assessments are updated in patient records and that there is oversight of NEWS2 observation timeliness for deteriorating patients.	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
M13	Apr-19	Surgery	The service must ensure that policies are reviewed in a timely manner and that they are shared with staff	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
S5	Apr-19	Surgery	The service should consider revising the consenting of patients on the day of surgery in line with best practice. ***(Looking at eConsent)***	Medical Director	On track for delivery against the set timescales - BAU form to be completed

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Family and Women's Services					
M14	Apr-19	Maternity	The service must ensure staff accurately complete women's care records with all necessary assessments required to safely monitor mothers and their babies.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU approved for review with system partners 28.4.22
M15	Apr-19	Maternity	The service must ensure staff complete fetal growth charts at each appointment.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
M16	Apr-19	Maternity	The service must ensure staff complete and annotate cardiotocograph traces in line with national guidance	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
M17	Nov-21	Maternity	The service must ensure policy and guidance documents are reviewed in a timely way and reflect current working practices to enable staff to be able to give women the most up to date information.	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
M18	Apr-19	Maternity	The service must ensure staff compliance with basic life support training meets the trust's compliance target of 90%.	Director Of People Organisational Development & Communications	On track for delivery against the set timescales
M19	Apr-19	Maternity	The service must ensure medicines and hazardous substances are stored securely.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
M20	Apr-19	Maternity	The service must ensure all incidents are reviewed in a timely way to promote learning and service improvement	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
M21	Apr-19	Maternity	The service must ensure risk registers accurate reflect the risks identified, are updated in a timely way and risks are closed appropriately once all actions are completed.	Medical Director	On track for delivery against the set timescales - BAU approved for review with system partners April 22
M22.N	Apr-19	Maternity	The service must ensure that staff complete mandatory training to meet the trust's compliance target.	Director Of People Organisational Development & Communications	On track for delivery against the set timescales - BAU approved for review with system partners April 22
M38.N	Nov-21	Maternity	The service must implement an effective governance system and ensure systems to manage risk and quality performance are effective. Regulation 17 (1)(2)(a)	Medical Director	On track for delivery against the set timescales
M39.N	Nov-21	Maternity	The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU approved for review with system partners April 22
M40.N	Nov-21	Maternity	The service must ensure a robust, embedded and audited maternity triage system with appropriate guidance and training to help keep women and babies safe. Regulation 17 (1)(2)(a)	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU form to be amended
S6	Apr-19	Maternity	The service should ensure there is an arrangement in place for a dirty utility in the antenatal clinic.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU approved for review with system partners 28.4.22
S7	Apr-19	Maternity	The trust should ensure staff circulating in theatres wear personal protective equipment in line with national guidance to prevent health care associated infections.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU submitted Plan for Peer Review with System Colleagues April 22

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Family and Women's Services					
S8	Apr-19	Maternity	The trust should ensure reusable equipment is cleaned appropriately after its use.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU approved for review with system partners April 22
S9	Apr-19	Maternity	The trust should ensure that electrical equipment is up-to-date with safety testing.	Director of Strategy and Estates	On track for delivery against the set timescales - BAU submitted Plan for Peer Review with System Colleagues April 22
S10	Apr-19	Maternity	The trust should ensure senior midwives and consultants participate in skill simulation training.	Director Of People Organisational Development & Communications	On track for delivery against the set timescales - BAU submitted Plan for Peer Review with System Colleagues April 22
S11	Apr-19	Maternity	The trust should ensure maternity services have access to designated maternity physiotherapy practitioners.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU submitted Plan for Peer Review with System Colleagues due 9/3/22
S12	Apr-19	Maternity	The trust should ensure improved sustainability and transformation partnership working in maternity services.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU submitted Plan for Peer Review with System Colleagues April 22
S13	Apr-19	Maternity	The trust should ensure managers use effective change management processes to facilitate required improvements in a timely way.	Director of quality improvement	On track for delivery against the set timescales - BAU submitted Plan for Peer Review with System Colleagues April 22
S17	Apr-19	Services for children and young people	The service should ensure discharge summaries are sent to GPs within 72 hours of discharge.	Chief Operating Officer	BAU complete - reviewed and approved by system colleagues
S19	Apr-19	Services for children and young people	The service should improve access to allied health professionals, specifically in the Neonatal Intensive Care Unit.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU submitted
S29.N	Nov-21	Maternity	The service should ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process. (Regulation 17)	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
S30.N	Nov-21	Maternity	The service should ensure they are infection prevention control compliant. (Regulation 12)	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
S31.N	Nov-21	Maternity	The service should ensure staff have access to the right equipment at the right time at important points in a woman's treatment. (Regulation 12)	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
S32.N	Nov-21	Maternity	The service should consider internal security access between labour and post natal wards	Director of Strategy and Estates	On track for delivery against the set timescales

Quality Improvement Project Reference	CQC Inspection Year	Quality Programme	Quality Improvement Action	Project Owner	Quality Project Management Office Update
Trust					
S1	Apr-19	Trust	The trust should ensure that structures and processes for governance are fully embedded at all levels throughout the trust to enable a timely response to risk and safety issues.	Director of Nursing. Midwifery and Allied Health Professionals	BAU complete - reviewed and approved by system colleagues
S4	Apr-19	Trust	The service should monitor national audits and use the results to improve outcomes for patients	Medical Director	Behind delivery but plan in place
Services for Children and Young people					
S15	Apr-19	Services for children and young people	The service should continue to ensure staff complete safeguarding training, in line with national guidance	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales
S16	Apr-19	Services for children and young people	The service should ensure there is a nurse trained in advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on every shift, in line with guidelines from the Royal College of Nursing.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
S18	Apr-19	Services for children and young people	The service should continue to improve transitional arrangements for young people moving to adult services – QI team supporting update project	Chief Operating Officer	Behind delivery date but plan in place to progress
S19	Apr-19	Services for children and young people	The service should improve access to allied health professionals, specifically in the Neonatal Intensive Care Unit.	Director of Nursing. Midwifery and Allied Health Professionals	On track for delivery against the set timescales - BAU to be completed
End of Life Care					
S20	Apr-19	End of life Care	Continue to work towards a 7 day service to support patients at end of life	Medica Director	BAU complete - reviewed and approved by system colleagues

The Princess Alexandra Hospital NHS Trust

Trust Board – 7th April 2022

Agenda item:	6.3
Presented by:	Saba Sadiq – Director of Finance
Prepared by:	Saba Sadiq – Director of Finance
Date prepared:	25th March 2022
Subject / title:	Standing Financial Instructions Update

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Trust's current Standing Financial Instructions (SFIs) require our people to obtain 3 quotes for goods or services for £500 to £4,999. If 3 quotes are not obtained then a waiver must be completed for each good or service. The DoF proposed making a change to this element of the SFIs with the Audit Committee Chair and Audit Committee members. This change involved increasing the limit from £500 to £10,000. This change was introduced earlier than the annual SFIs as it enabled the Trust to address its underspend whilst managing the number of waivers that were required to support this expenditure in a tight timeframe. This revision has made PAH consistent with other ICS providers and their SFIs. This revision was agreed on 3rd March 2022 by the Audit Committee Chair and was ratified by the Audit Committee on 7th March 2022.
Recommendation:	The Trust Board is asked to approve this change to the SFIs.

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:	AC.07.03.22
Risk / links with the BAF:	BAF 5.1 requires the Trust to breakeven and ensure sufficient cash
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	n/a

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**Trust Board 7 April 2022**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee**			
REPORT FROM:	**John Hogan – Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 March 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
1.6 STC revised terms of reference	For discussion			The committee approved and recommended the revised terms of reference to the Board for approval (Appendix 1).
2.1 PAHT 2030 update	Yes	Yes	DoQI/DoS	The committee was assured on the process of oversight and noted the work in progress and development of an outcomes framework to measure successes.
2.2 Corporate Transformation report	Yes (partially as timelines are required)	Yes	DoF	Assurance was provided that a process is in place to monitor delivery of the 13 strategic priorities and requested timelines for delivery of the 3 red rated objectives.
2.3 EHR and BAF risk 1.2 EPR	Yes	No	N/A	The committee was assured that the programme is on track and the Board will receive an update on 7 April 2022. It is recommended that the BAF risk score for the current EPR remains at 16.
2.5 New Hospital Programme and BAF risk 3.5 New Hospital	Yes	No	No	The current position was noted; further clarification on the commercial strategy is awaited from the national New Hospital Programme. It is recommended that the BAF risk score remains at 20.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**Trust Board 7 April 2022**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee**			
REPORT FROM:	**John Hogan – Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 March 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.7 OHCP System transformation: Children and Young People and Adult Mental Health	Yes (partially)	Yes	DoQI/System partners	The committee was assured that work streams are in place and noted the challenges presented by the different models of operation currently in place across Essex compared to Hertfordshire.
3.1 System update	Information item.	N	N	The committee noted the external system update. The Board will receive an update in the private session.
4.1 Summary of enabling strategies	Yes (partially)	N	N	An update on the development of the strategies underpinning delivery of PAHT2030 was noted. Next steps include alignment of the strategies and development of an outcomes framework.
4.2 Digital Transformation Strategy	Yes	N	Board approval required	The committee recommended the strategy to Board for approval.

The Princess Alexandra Hospital NHS
NHS Trust

STRATEGIC TRANSFORMATION COMMITTEE 2022/23

TERMS OF REFERENCE

PURPOSE:

The Strategic Transformation Committee ("the Committee") is responsible for overseeing the delivery of the Trust's strategy (PAHT2030) and transformation programmes.

The Committee will monitor the external strategic environment and developments across the Integrated Care System.

DUTIES:

1. To review and monitor the delivery of the Trust's strategy/PAHT 2030 including the Trust's vision, goals, objectives and values.

2. To monitor progress of the work streams underpinning the strategic priorities of PAHT2030 including:

- Digital Health
- Our New Hospital
- Transforming our Care
- Our culture
- Corporate Transformation

3. To monitor the development and implementation of the strategies that enable delivery of PAHT2030.

4. To monitor the external strategic environment and developments in the Integrated Care System.

5. Maintain oversight of the risks and mitigations associated with these programmes of work, review the associated Board Assurance Framework risks and provide assurance to the Board on the management of these risks.

6. Receive reports from other feeder groups/programme Boards.

ACCOUNTABLE TO:

Trust Board.

REPORTING ARRANGEMENTS:

Following each meeting of the Committee a report shall be produced for the Board of Directors by the Committee Chairman and Lead Executive.

CHAIRMAN:

Non-Executive Director

COMPOSITION OF MEMBERSHIP:

- Non-Executive Directors/Associate Non-Executive Directors
- Director of Strategy,
- Medical Director,
- Director of Quality Improvement,
- Chief Information Officer,
- Director of Finance.

In addition to the members of the Committee, the following shall be expected to attend each meeting as attendees:

- Director of Information & IT
- Deputy Medical Director (Strategy)

ATTENDANCE: Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record shall be taken at each meeting.

The Trust Chair and Chief Executive of the Board reserve the right to attend meetings.

INVITED TO ATTEND: The Committee may invite internal and external attendees to attend the Committee to provide advice, support and information.

DEPUTISING ARRANGEMENTS: In the absence of the Chairman of the Committee, another Non-Executive Director member shall chair the meeting.

QUORUM: The quorum for any meeting of the Committee shall be two members, one of which must be a Non-Executive member and the other an 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 EXECUTIVE: Director of Strategy/Director of Quality Improvement

MEETING FREQUENCY: Meetings shall be held monthly

MEETING ORGANISATION:

- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- A draft agenda shall be developed by the Head of Corporate affairs and the Lead Executive and agreed by the Committee Chairman at least ten clear days*
- 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' means any day which is not a Saturday or Sunday or a public or bank holiday.

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

The Committee 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

The terms of reference of the Committee shall be reviewed annually and approved by the Trust Board.

The Princess Alexandra Hospital NHS
NHS Trust

TERMS OF REFERENCE:

DATE APPROVED: By Committee: 25 March 2022
By Trust Board:

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 April 2022

Agenda item:	7.2
Presented by:	Phil Holland, Chief Information Officer
Prepared by:	Phil Holland, Chief Information Officer
Date prepared:	18th March 2022
Subject / title:	Digital Strategy

Purpose:	**Approval**	**X**	**Decision**		**Information**		**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	Our digital strategy looks beyond the new hospital build through to 2030, considering how digital can enable our PAHT2030 goals. Our strategy has been developed collaboratively with our patients, staff and partners, and has been informed by insights from advanced digital hospitals and health systems around the world. This has been to ensure we have taken into account health and social inequalities as well as equality and diversity, and in particular digital exclusion. Our overarching digital strategy brings together and aligns the significant amount of work done to date by PAHT on digital transformation.							
Recommendation:	The Board is asked to considering approving the Digital Strategy							

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:	Senior Management Team / STC.28.03.22
Risk / links with the BAF:	1.2 The current EPR has limited functionality resulting in risks relating to the delivery of safe and quality patient care
Legislation, regulatory, equality, diversity and dignity implications:	Joining up care for people places and populations white paper; What good looks like, people at the heart of care white paper
Appendices:	The full strategy can be viewed in the resources section of Diligent

7.2

Introduction

Our digital strategy looks beyond the new hospital build through to 2030, considering how digital can enable our PAHT2030 goals. Our strategy has been developed collaboratively with our patients, staff and partners, and has been informed by insights from advanced digital hospitals and health systems around the world. This has been to ensure we have taken into account health and social inequalities as well as equality and diversity, and in particular digital exclusion.

Our overarching digital strategy brings together and aligns the significant amount of work done to date by PAHT on digital transformation.

Strategy Principles

The digital strategy is anchored by the following guiding principles: patient co-design; digitally-confident workforce; inclusivity and reduction of health inequalities; intuitive, user-friendly design; and partnership working.

Our strategic ambitions require significant transformation and investments in digital capabilities. We need to develop and embed digital capabilities in our organisation to deliver the transformation we set out in our strategic priorities. These digital capabilities will be implemented logically and built on over time and, when grouped together, will provide cohesive functionality for our patients, staff and partners.

Delivering the Strategy

Our digital strategy is brought to life through the fictional Willow Road neighbours and our future office – A47. The future journeys describe the vision from our front-line clinicians, staff and patients on how digital will improve their experiences and outcomes.

Achieving our digital strategy will take more than technology. We will need aligned, brave leaders to support staff to recognise the importance of digital and support them to embrace the strategy, effective communication, sustained engagement, robust change management, training, programme management, improvements in our technical infrastructure, and continued focus on partnership working.

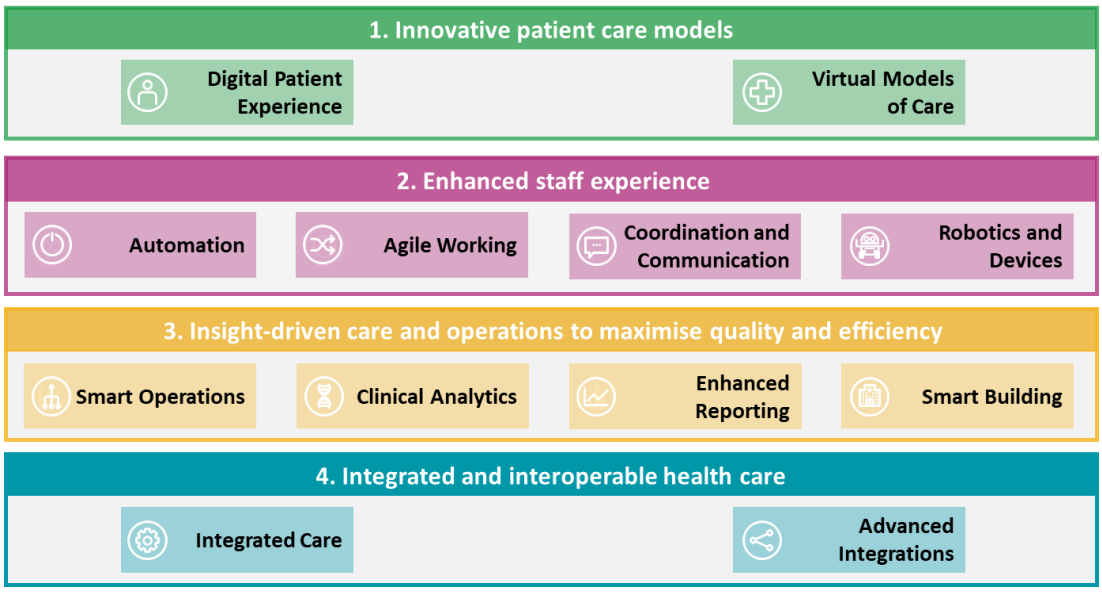
The digital capabilities that will deliver the strategic priorities and themes for the overarching vision for PAHT are set out in a roadmap and organised into 3 phases. The 3 phases represent groupings of time-bound activities punctuated by a transformation catalyst: the period in preparation for the go live of the new EHR, the hospital building and building on and optimising digital healthcare once the foundational transformation from the EHR and new hospital building has been completed.

Four Priorities

Our strategy will be realised through four priorities:

- Innovative patient care models
- Enhanced staff experience
- Insight driven care and operations to maximise quality and efficiency, and
- Integrated and interoperable healthcare

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

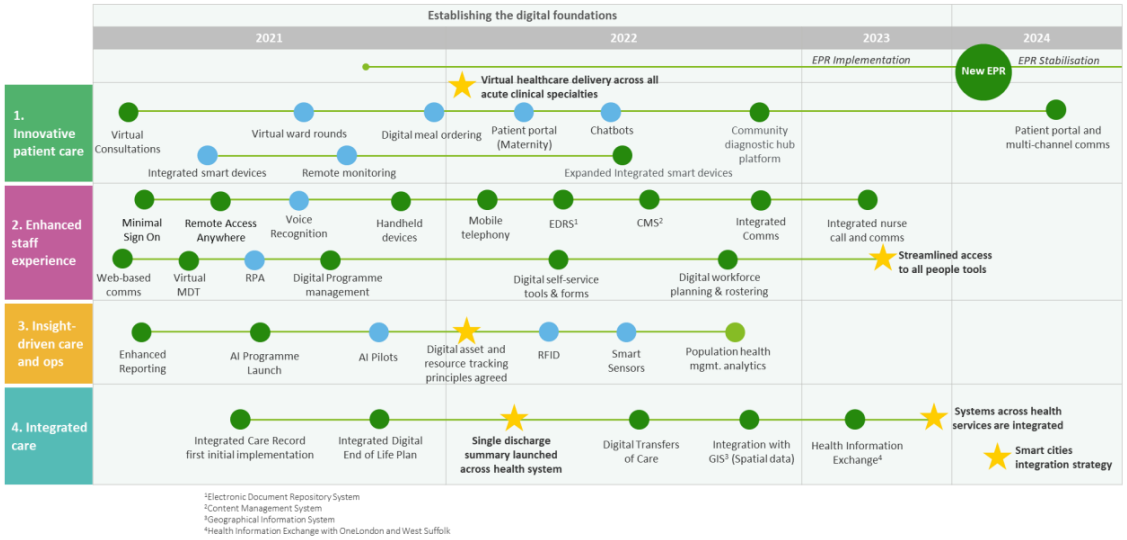


Resourcing the Strategy

To ensure successful delivery of the strategy, we need to ensure we have the right resources, and right people making it happen. To do this we will need to build digital teams that are the cornerstone of building a digital organisation. The digital workforce will be supported by effective governance, which enables them to be responsive, open, efficient and work in an agile fashion, and to successfully deliver service transformation. The team will

focus on user centred design, agile ways of working, and a knowledge of how to build and operate modern digital technologies.

Projected Timeline (to end of 2024)



Conclusion

The Digital Strategy is support by the Executive Team, and approved by the Senior Management Team. The Strategic Transformation Committee is requested to consider the approval of the strategy to enable it to be further considered by the Trust Board.

Phil Holland

Chief Information Officer

NHS
The Princess Alexandra Hospital
NHS Trust

7.2

The Princess Alexandra Hospital NHS Trust

2022 – 2030 Digital Strategy

Table of Contents

Executive summary

We are embarking on a digital transformation journey to reimagine patient care and experiences. Our new hospital, due to open within the period of this strategy, provides us with a catalyst to rethink how we work, enabled by advanced digital technologies supporting care integrated with our system partners.

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

Our digital strategy looks beyond the new hospital build through to 2030, considering how digital can enable our PAHT2030 goals. Our strategy has been developed collaboratively with our patients, staff and partners, and has been informed by insights from advanced digital hospitals and health systems around the world. Our overarching digital strategy brings together and aligns the significant amount of work done to date by PAHT on digital transformation.

Our digital strategy is organised in four themes, with defined priorities to outline the areas we will focus on to achieve our vision, as described below in Figure 1.

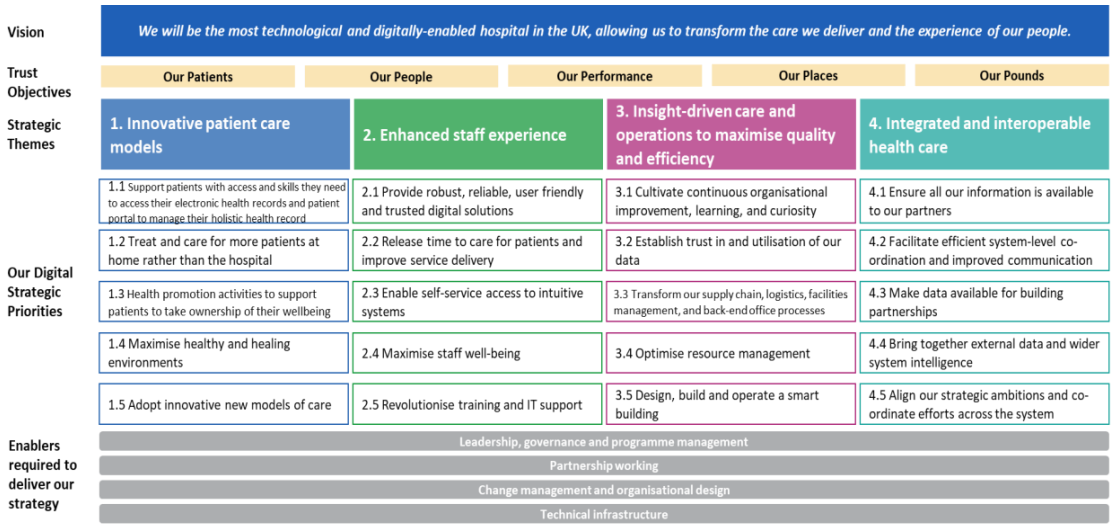


Figure 1 Digital Strategy Overview

7.2

The digital strategy is anchored by the following guiding principles: patient co-design; digitally-confident workforce; inclusivity and reduction of health inequalities; intuitive, user-friendly design; and partnership working. Our strategic ambitions require significant transformation and investments in digital capabilities. We need to develop and embed digital capabilities in our organisation to deliver the transformation we set out in our strategic priorities. These digital capabilities will be implemented logically and built on over time and, when grouped together, will provide cohesive functionality for our patients, staff and partners.

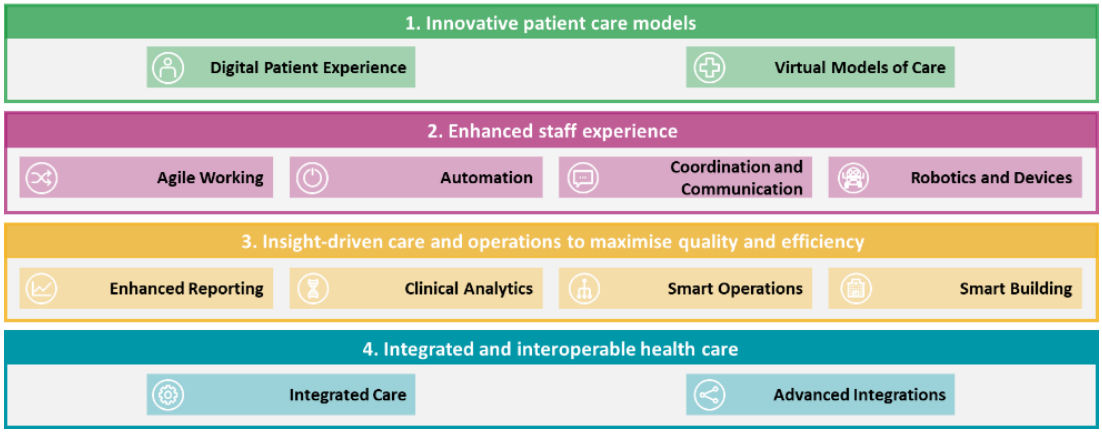


Figure 2 Digital capabilities overview

Our digital strategy is brought to life through the fictional Willow Road neighbours. The future journeys describe the vision from our front-line clinicians, staff and patients on how digital will improve their experiences and outcomes.

Achieving our digital strategy will take more than technology. We will need aligned, brave leaders to support staff to recognise the importance of digital and support them to embrace the strategy, effective communication, sustained engagement, robust change management, training, programme management, improvements in our technical infrastructure, and continued focus on partnership working.

The digital capabilities that will deliver the strategic priorities and themes for the overarching vision for PAHT are set out in a roadmap and organised into 3 phases. The 3 phases rEHResent groupings of time-bound activities punctuated by a transformation catalyst: the period in preparation for the go live of the new Electronic Health Record, the hospital building and building on and optimising digital healthcare once the foundational transformation from the Electronic Health Record (EHR) and new hospital building has been completed.

Thank you to our stakeholders for taking the time to provide their input to the development of the digital strategy. We look forward to your continued collaboration as we deliver our digital strategy.

Phil Holland

Chief Information Officer

1. Our strategic context

We are undertaking a digital transformation journey to deliver outstanding healthcare to the community. Our digital strategy looks beyond the new hospital build through to 2030 towards our aspiration to be the most digitally-enabled hospital in the UK. A significant amount of work has been conducted to date, including transformation projects and initiatives over the past 5 years, planning for the new hospital and strategies to develop a vision for the future. The new hospital, due to open with the period of this strategy as part of the New Hospital Programme, provides us the opportunity to transform models of care radically in line with the NHS Long Term Plan and the New Hospital Programme ambitions. The new hospital will provide the catalyst to re-imagine care delivery, enabled by advanced digital technologies and integrated care with our system partners.

"When we open, we want to be the most technological and digitally-enabled hospital in the UK, allowing us to transform the care we deliver and the experience of our people" – Lance McCarthy, Chief Executive Officer, Princess Alexandra Hospital

Our overarching digital strategy brings together and aligns the previous strategic work completed, feedback from staff and patients, insights from advanced digital hospitals and health systems around the world, as well as the local and national strategic context in which we deliver care to provide an overarching vision and strategy to achieve our ambitions for 2030.

Trust Strategy

Our digital strategy supports PAHT2030, our Trust strategy, and articulates the digital capabilities required to achieve our Trust vision. The 2030 Trust strategy includes 5 interlinked areas of focus for how the Trust will operate both inside and outside of the hospital:

- **eHealth** - using technology in all that we do and digitising everything that we do in the hospital and the community
- **New hospital** - building a brand-new state of the art hospital that is net carbon zero and the most technology enabled hospital in the country
- **Culture and OD** - all behaviours are aligned with inclusion, equality, improving patient safety and a learning organisation
- **Integrated care** - joining up primary, secondary, community and mental health care for the benefit of all patients
- **Corporate services modernisation** – ensuring we have fit for purpose, efficient corporate services to support our clinical teams

NHS Long Term Plan

National Policy

The NHS Long Term Plan (LTP) addresses concerns around funding, staffing, increasing inequalities and pressures from a growing and ageing population. The LTP focuses on delivering new service models in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting, with emphasis on prevention, health inequalities, care quality and outcomes improvement.

The *NHS Long-Term Plan articulates the role of digital in enabling future models of care, opening up new possibilities for prevention, care and treatment, and improving access to services*. Our digital strategy is aligned with the national NHS direction of travel, including:

- Decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition;
- Predictive techniques to support local health systems to plan care for populations;
- Intuitive tools to capture data as a by-product of care, reducing the administrative burden for clinicians;
- Protecting patients' privacy and providing them with access to their interactive medical record;
- Contributing to the linking of clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services;
- Ensuring NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education; and
- Mandating and rigorously enforcing technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible[1].

Impact of COVID-19

The COVID-19 pandemic has impacted on all of our lives and all of our services. As a result of the unprecedented demand for intensive care and other inpatient capacity during the pandemic, non-COVID services at PAHT were severely disrupted. Our digital strategy aims to leverage digital technologies to increase the accessibility of our services, reduce wait times for the long backlogs of services that were disrupted, optimise efficiencies and improve our recovery.

[1] NHS Long Term Plan » Chapter 5: Digitally-enabled care will go mainstream across the NHS

Complex local landscape

We are also faced with a growing population with diverse care needs and an ageing population that requires support. There are significant health inequalities across West Essex and East Hertfordshire. To support our patients' complex, holistic needs and improve their well-being, we will work closely with our partners to address the wider determinants of health (housing, employment, education etc). Digital will improve how we collaborate with our partners; advanced analytics will ensure we are targeting resources to our most at-risk populations. We strive to continuously put the patient at the centre of our working, using digital to improve experiences across care settings and manage care across pathways.

2. How digital supports our Trust objectives

Our overarching digital strategy will enable us to achieve our Five Trust objectives for 2030. The digital strategy will provide opportunities and tools to support patients and our people, improve our performance, launch our digitally-enabled hospital and help us manage our funds effectively.

Table 1 Trust Objectives

Trust Objectives (Five Ps)		How digital enables the Five Ps
	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.	✓ Digital capabilities will provide patients with innovative ways to access holistic services. ✓ Patients will be supported to own and manage their interactive health records. ✓ Care journeys will be personalised and seamlessly integrated across our system.
	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.	✓ Automation and advanced digital capabilities will release staff time to spend on valuable, patient-facing activities, ensuring care is compassionate and patient-centric. ✓ The wellbeing of our workforce will be enhanced with easy-to-use, reliable systems and streamlined access to information. ✓ Staff will be supported to continuously learn and enhance competence with high quality digital

		learning, develop professionally, and perform 'at the top of their licence'.
	Our performance We will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators.	✓ System insight and analytics will enable efficient, targeted reporting and performance management. ✓ Digital will optimise quality by embedding best practice and supporting our staff towards the safest delivery of care.
	Our places We will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Integrated Care Partnership.	✓ System insight and analytics will enable efficient, targeted reporting and performance management. ✓ Digital will optimise quality by embedding best practice and nudging our staff towards the safest delivery of care.
	Our pounds We will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.	✓ System insight and analytics will enable efficient, targeted reporting and performance management. ✓ Digital will optimise quality by embedding best practice and nudging our staff towards the safest delivery of care.

3. How our digital strategy was developed

Our digital strategy has been developed collaboratively with senior stakeholders from within and outside of the Trust, front-line clinical, operational, and administrative staff, and with our patients. Our digital strategy has also been informed by global healthcare trends and digitally advanced health systems in the UK and abroad. The strategy development process allowed us to understand the 'art of the possible', as well as how to achieve it within the next years.

We have carefully reviewed and analysed PAHT's previous strategies, as well as regional and national guidelines, to ensure we head towards a common future vision. Our strategy aligns and brings together the following Trust strategic documents:

- PAHT Clinical Digital Strategy;
- PAHT ICT Strategy;
- PAHT New Build Digital Technology and Partnering Strategy;
- PAH Digital Hospital Update;
- Data Quality Policy;
- Nursing Midwifery and AHP Strategy;
- PAHT Quality Improvement Strategy; and
- People Strategy.

To gain input and perspectives into our digital strategy, we engaged with our people, partners and patients via:

- A digital strategy working group of multi-disciplinary senior stakeholders;
- Over 50 stakeholder interviews with our staff and partner organisations (e.g. GPs, Essex Partnership University Trust (EPUT), West Essex CCG, ICP Development & Transformation);
- Patient journey workshops with front line staff from clinical and corporate areas; and
- Panels, focus groups and interviews with patients through our Patient Panel and Maternity Voices Partnership.

4. Digital Strategy Guiding Principles

Our guiding principles anchor our digital strategy by centring on what matters most. The guiding principles are mapped to the strategic objectives we have set in pursuit of being the most digitally-enabled hospital in the UK and will ensure investment priorities are aligned with our strategic ambitions.

Patient co-design

Our patients and their carers will be placed at the heart of the selection, design, and optimisation of our digital solutions.

Digitally confident workforce

We will support our staff in embracing digital to improve their working lives.

Inclusivity and reduction of health inequalities

We will drive inclusivity by leveraging opportunities enabled by digital technology to reduce, not further exacerbate, inequalities.

Intuitive, user-friendly design

We will ensure digital solutions adopted will be simple and easy to use.

Working together with our partners

As a population-focussed organisation, we will collaborate with our partners to develop joint solutions to address system challenges.

5. Our digital vision and strategy

Our digital strategy is organised into four strategic themes, with defined priorities and supporting enablers. These themes outline the activities we will target to achieve our vision of being the most digitally-enabled hospital in the UK. The strategic priorities describe the experiences we want to deliver, enabled by advanced digital capabilities. To deliver our strategy, we will also need to focus on several categories of enablers, including leadership, governance, programme management, partnership working, change management, training, communication, engagement, organisational design, and technical infrastructure.

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

Figure 3 Digital Strategy Overview

Our strategic priorities for each of the four strategic themes are described in the following section.

5.1 Innovative patient care models

We will support safe, high-quality patient care, improve health outcomes and enhance the patient experience by embracing digitally enabled modern medicine and supporting patients to be active participants in their own healthcare journeys. We will use digital technologies to educate, improve access, and reduce barriers between the hospital, patients and caregivers, contributing to a reduction in health inequalities.

Strategic Priorities:

1. Innovative patient care models	2. Enhanced staff experience	3. Insight-driven care and operations to maximise quality and efficiency	4. Integrated and interoperable health care

1.1 **Support patients with access and skills to manage their holistic health record and jointly-build evidence-based digital care plans, fostering ownership of their care across the system and greater self-care**.

We will support and equip patients with the skills to access and interact with their health record, ensuring information is accessible to all and they no longer need to repeat their story. This way, our patients will be in control of their information and their care journey.

1.2 **Treat more patients at home rather than the hospital**.

We will leverage digital solutions to enable care outside the hospital environment and proactive early intervention. We will expand our remote monitoring capabilities and take advantage of emerging technologies to provide integrated care to patients at home. Healthcare by multidisciplinary teams will provide a seamless care experience from outpatient check-ins to physiotherapy / mental health services to social services.

1.3 **Target health promotion activities, especially to at-risk patients, for a greater focus on prevention**.

Population health analytics will be used to understand the risk profiles and needs of our patients and use targeted education programmes and communication campaigns capability to drive a health promotion agenda through all patient contact channels.

1.4 **Maximise healing environments, personalised to our patients' needs and enabled by digital.**

We will optimise patients' immediate surroundings to support their care, whether that is at home supported by virtual assistants or at the hospital in customisable rooms where patients can personalise their hospital room to their preferences for comfort.

1.5 **Adopt innovative new models of care driven by advances in modern medicine and digital technology for patient-centred care.**

We will design new models of care centred around patients' needs. We will work with our patients to deliver innovative care models, supported by digital capabilities for patients to easily and effectively manage their care and for care providers to efficiently deliver the best quality of care. Leveraging AI, precision medicine and genomics, we will personalise treatment in the future to achieve the best outcomes for our patients.

5.2 Enhanced staff experience

We will use digital technologies to support staff to work efficiently and seamlessly, freeing up more time to care for patients. Reliable systems, access to information and ease of use will improve wellbeing, relieve workforce pressures and improve job satisfaction.

Strategic Priorities:

1. Innovative patient care models	2. Enhanced staff experience	3. Insight-driven care and operations to maximise quality and efficiency	4. Integrated and interoperable health care

2.1 **Provide robust, reliable, user-friendly and trusted IT and hardware.**

We will support daily activities with reliable infrastructure that is readily available when needed, functions appropriately for the task at hand and provides simple interactions with systems that are modern and fast.

2.2 **Release time to care and service delivery by automating processes and streamlining access to information, wherever staff are working.**

Our staff will have access to user-friendly systems with quick access from anywhere at any time, in a paper-lite environment. There will be robotic process automation of simple tasks to save our people time in doing repetitive tasks so they can spend more time on valuable activities.

2.3 **Enable self-service access to intuitive systems with a single source of truth.**

We will inspire trust in our information, knowing that our technology infrastructure supports the management of data to provide a single source of truth to the user. We will provide staff with access to user-friendly systems to request reports and query information proactively without the bottleneck of an information or system specialist to consolidate and cleanse data from multiple sources.

2.4 **Maximise staff well-being by eradicating the need to record information more than once and enabling seamless staff communication.**

We will leverage digital technologies to provide our people with peace of mind, as well as trust and confidence in technology. We will prevent the duplication of information via an integrated EHR, voice recognition and integration of systems across the Trust, as well as partner organisations. Seamless communication will be enabled by unified communications and workflow automation.

2.5 **Revolutionise training with innovative digital solutions and techniques.**

We will support our workforce to embrace change and feel prepared to be the workforce of the future, with access to tailored, digitally enabled training programmes. Our workforce will have access to ongoing learning innovative, tailored digital solutions, improving retention and commitment to our organisation.

5.3 Insight-driven care and operations

We will use data and insight to guide clinical and operational decision-making and enhance patient outcomes. We will streamline and optimise our processes and operations, supported by digital technologies, to gain efficiencies and make the best use of our resources. The new hospital will be a state-of-the-art building embedded with technology to manage the building and operations efficiently. Our staff will feel confident driving improvement through the use of digital technology.

Strategic Priorities:

1. Innovative patient care models	2. Enhanced staff experience	3. Insight-driven care and operations to maximise quality and efficiency	4. Integrated and interoperable health care

3.1 **Cultivate continuous improvement, organisational learning, and professional curiosity by improving the ease of using data to support clinical decision-making, improvement, and research. Embed decision support, analytics and AI to make to it easier to consistently deliver the right care**.

We will have population health, as well as predictive and prescriptive analytics to help guide decision making for our population in collaboration with our partners. Our workforce will be supported in providing the highest level of quality and safety to our patients, with systems that have embedded clinical decision support and best practice guidelines with safety nudges to make it easier for our staff to do the right thing.

3.2 **Establish trust in our data by automating data validation on entry and enhancing data quality**.

We will create confidence in the integrity of clinical data, enabled by system checks for data accuracy and automated validation. This will greatly improve patient safety and allow insights from data analytics to have a high level of accuracy.

3.3 Transform our supply chain, logistics, facilitates management and back-end office processes

We will modernise and digitise our back-end office processes, ensuring they are efficient, integrated and user friendly. We will manage our hospital, operations and assets effectively through a digital command control centre, digital twin and assets management systems for beds, devices, stock etc. saving staff time in tracking items, reducing waste and using insights to make decisions.

3.4 **Optimise resource management with intelligent, dynamic workforce planning, ensuring efficient staffing**.

We will optimise workforce planning with advanced, integrated digital solutions, such as digital workforce recruiting and rostering, as well as human resources tools to manage day-to-day staffing needs.

3.5 **Design, build and operate a smart building for a digitally-enhanced therapeutic environment and efficient use of our space**.

We will optimise experiences and operations through integrated systems, devices and sensors in our state-of-the-art new hospital building. We will also provide an agile and flexible physical space, allowing us to easily customise environments to suit patient, medical and therapeutic needs.

5.4 Integrated and interoperable health care

We will continue to work closely will our partner organisations to align strategic ambitions and collaborate on holistic care management across patient pathways.

Strategic Priorities:

1. Innovative patient care models	2. Enhanced staff experience	3. Insight-driven care and operations to maximise quality and efficiency	4. Integrated and interoperable health care

4.1 **Ensure all of our information is available to our partners.**

We will make our information available to our partners whenever they need it, by promoting inter-operability and adopting standards to ensure data integrity and that our data can be shared in a meaningful way.

4.2 **Facilitate efficient system-level co-ordination and improved communication for improved visibility and management of end-to-end pathways**.

We will work closely with our partners through streamlined processes and digital technologies, such as virtual multi-disciplinary team meetings and digital transfers of care.

4.3 **Make data available for building partnerships in research and the wider health economy**.

We will use interoperable, open solutions and platforms to share data with research partners, across our Integrated Care System and with our partner Trusts.

4.4 **Bring together external data and wider system intelligence for holistic, proactive health planning**.

Our goal will be to collaborate with our system partners to contribute to a longitudinal care record, as well as non-health system data integration (e.g. air quality, weather) to plan for care needs and manage system capacity.

4.5 **Align our strategic ambitions and co-ordinate efforts across the system**.

We will continue to work with our partners and align strategically on how we coordinate our workforce, system-wide technology solutions and policies so all future investments consider inter-operability e.g. system-level vendor neutral archive for image sharing. Our leadership will work towards strategic collaboration with our partners, in order to co-ordinate our workforce, invest in system-wide technology solutions and standardise policies.

6. Bringing our digital strategy to life

6.1 Bringing the digital strategy to life through the Willow Road Neighbours

To bring our digital vision to life, we have collectively imagined five illustrative patient journeys with front-line clinicians, staff and patients to articulate *how digital will enable improved patient and staff experiences, health outcomes, and efficiency*. The future journeys are centred on a year in the life of the Willow Road residents, as described in figures 4 and 5 below.

Figure 4 Willow Road neighbours

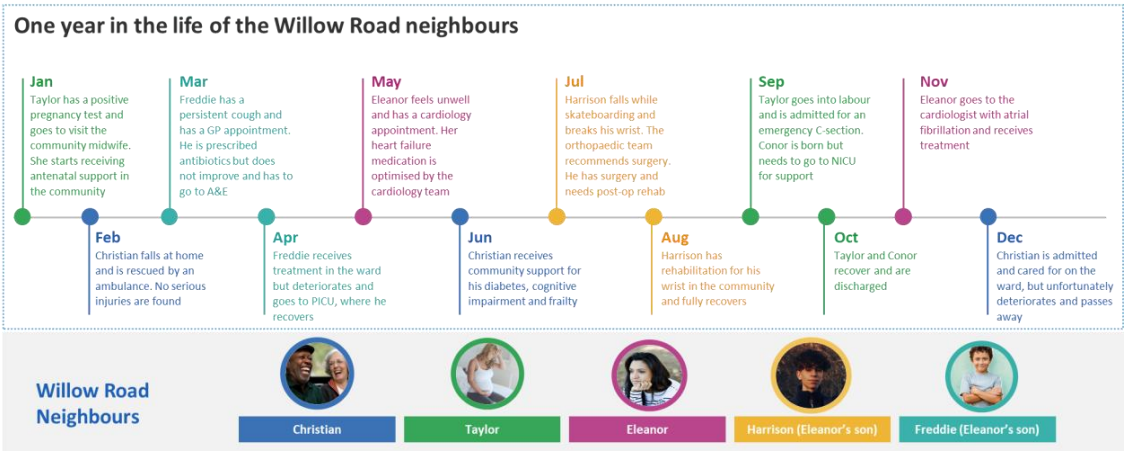


Figure 5 One year in the life of the Willow Road neighbours

The digital strategy incorporates the feedback from our front-line clinicians, staff and patients on the digital capabilities that will support the future patient journeys for the Willow Road neighbours and, in turn, improve the experiences and health outcomes for all of our patients. The digital capabilities and enablers required to make the experiences described in the future patient journeys have contributed to the development of the digital strategy. The full patient journeys can be found at Appendix section A.5 Willow Road Neighbours Journeys.

6.2 Bringing the digital strategy to life through the workers of Office A47

To bring our digital vision to life, we have also imagined the experiences of a fictional office of the future to describe how digital will support our staff. The future Office A47, shown below in Figure 6, was developed collaboratively with our workforce, finance, administrative and management staff.

Figure 6 The workers of Office A47

Details of how digital will support the day-to-day experiences of our staff may be found at Appendix section A.6. Please note these staff members are fictional.

6.2 What our digital vision means for our staff and partners

Our clinically-facing staff will benefit from PAHT's digital innovation in different ways, as articulated below.

Jessica

- As a ward nurse, I can quickly access all key data from my patients using a personalised dashboard solution at the nursing station. This allows me to safely look after patients staying in single rooms.
- I only need to input clinical notes once, which gives me the ability to spend more face-to-face time with my patients, improving the quality of care given .
- I can access my patient's information from their bedside, using the mobile tablet or the workstation on wheels, which gives me flexibility and allows accurate and timely clinical documentation.

Mary

- As a doctor, I am more confident, as I get decision support from the system, confirming I am always following best practice.
- I can work flexibly by accessing PAHT's integrated clinical systems remotely and with single sign on, which allows me to conduct part of my workload in a mobile way, from home or at my main office.
- Personalised predictive analytics and AI support our clinical practice by automating clinical tasks and giving back time to focus on what only humans can do.

Ravi

- In the operations team, we can track, register and analyse live performance via a trackboard screen integrated with the system.
- We have access to accurate, real-time information and insights, which enables me to address problems proactively and better manage business operations.
- We can better predict where staff will be needed via the integrated HR system, allowing us to roster our staff accordingly. It reduces gaps in staffing and costs with locum professionals.

Mark

- As an outpatient receptionist, I can easily manage bookings via the automated booking system, which gives me automatic dashboards with the latest information on demand.
- I have more available time to ensure the service is running well, as most patients can now self check into the clinic when they arrive.
- The process of merging daily data from different clinics is now automated and displayed via an interactive dashboard with graphs for different metrics, which is used by management for service improvement.

George

- As a partner of PAHT, I can easily access the information I need to manage our patient pathways. The trust has its data available to the integrated care system, allowing all levels of care to work together on improving patient care.
- Our staff are able to conduct multi-disciplinary virtual meetings with PAHT easily, greatly improving patient care, avoiding unnecessary referrals and saving patient time.
- We manage part of our healthcare efforts based on PAHT's insightful population health data analysis, proactively caring for the community.

7. Delivering our digital strategy

Our strategic ambitions require significant transformation and investments in digital capabilities. Implementing an integrated EHR is the beginning of our 10+ year journey to be the most digitally-enabled hospital in the UK. We will develop and embed digital capabilities to deliver the transformation we set out in our strategic priorities.

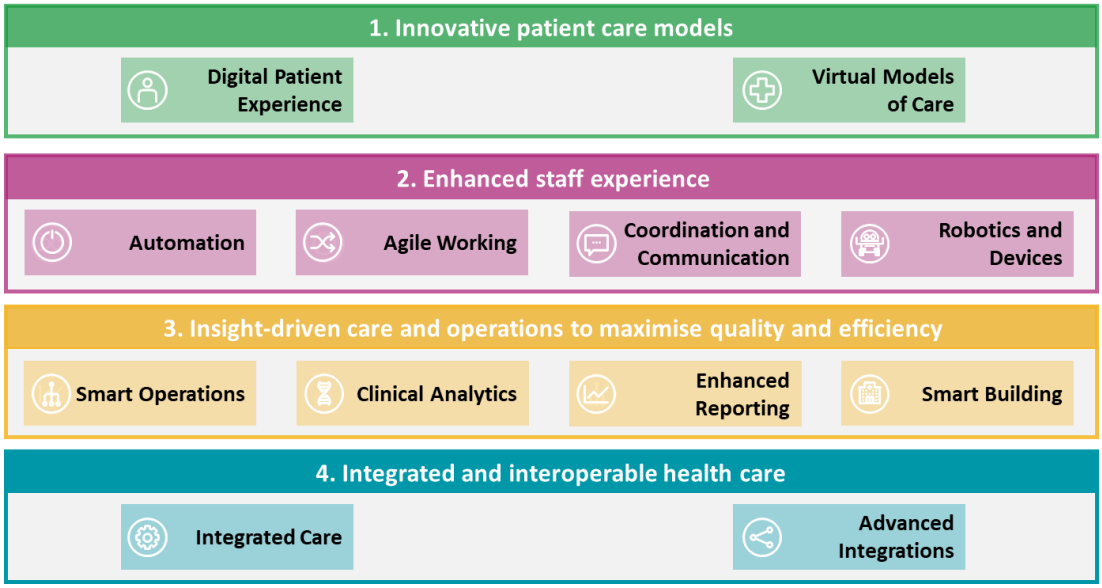


Figure 7 Digital capabilities overview

The diagram above describes the categories of digital capabilities required to achieve our strategic aspirations. These digital capabilities will be implemented logically and built on over time, and, when grouped together, will provide cohesive functionality for patients, staff and partners.

As mentioned before, we have collectively imagined five illustrative patient journeys with front-line clinicians, staff and patients to articulate *how digital will enable improved patient and staff experiences, health outcomes, and efficiency*. The future journeys are centred on a year in the life of the Willow Road neighbours and helps illustrate how digital will impact the lives of our patients in the future. We have also described how digital will support the day-to-day working of our staff in Office A47, our office of the future.

For full definitions of each digital capability please refer to the glossary of terms in the appendix.

1. The digital and technology capabilities required to provide our patients with experiences customised to their individual needs and preferences, with a focus on proactive support both inside and outside our hospital walls, are outlined below. The digital capabilities for each theme are grouped into strategic priority categories as displayed in the figure below.

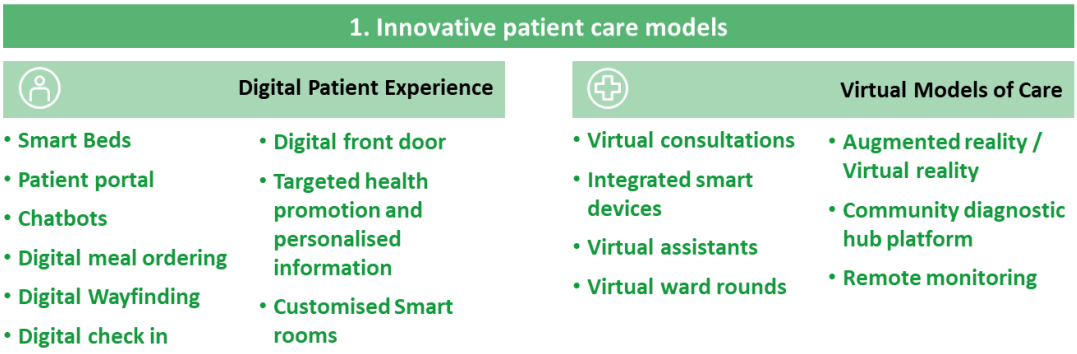


Figure 8 Innovative patient care models digital capabilities

2. To enhance experiences, staff will be supported to adopt digital solutions for efficient working.

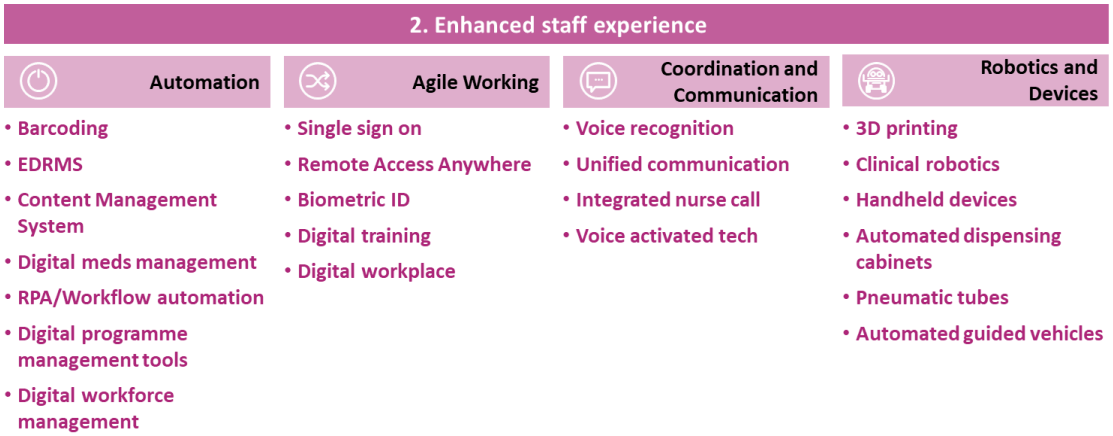


Figure 9 Enhanced staff experience digital capabilities

3. Clinical care, operations and building management will be enabled by intelligent automation and advanced analytics to maximise quality and efficiency.

Figure 10 Insight-driven care and operations digital capabilities

4. Integrated and interoperable health care will be achieved with a continued focus on seamless information sharing and digital collaboration with our system partners.

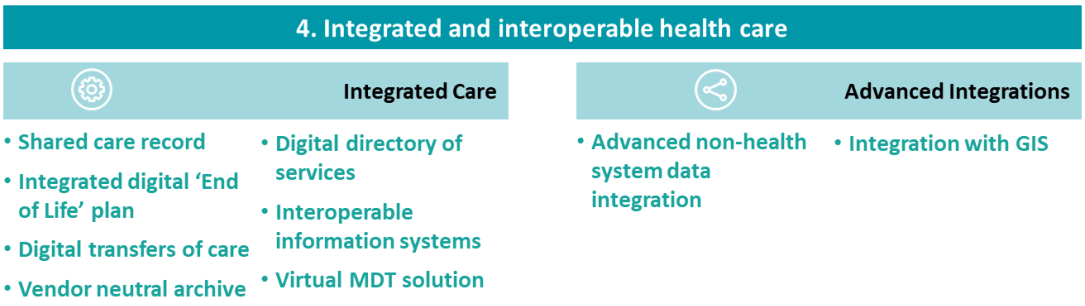


Figure 11 Integrated and interoperable health care digital capabilities

8. Digital strategy roadmap

The digital capabilities that will deliver the strategic priorities and themes for the overarching vision for PAHT are set out in a roadmap and organised into three phases. The three phases rEHResent groupings of time-bound activities punctuated by transformation catalysts:

1. The period in preparation for the go-live of the new EHR and becoming a paper lite trust;
2. The period leading to the opening of our new hospital facility and optimising digital healthcare; and
3. The period once the foundational transformation from the EHR and new hospital building have been completed.

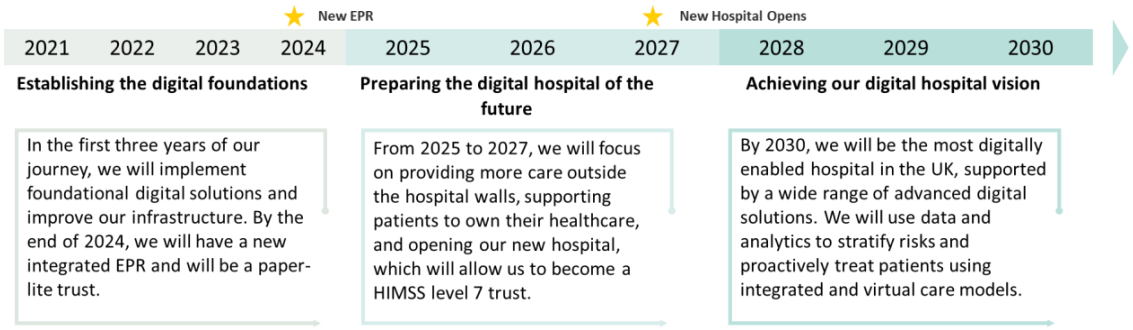


Figure 12 Roadmap phases

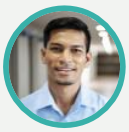
The following section describes how our patients' and our people's experiences will change with the launch of digital capabilities and enablers in every phase, and how the innovations in each phase help us achieve the themes of our strategy.

8.1 Phase 1

2021-2024: Establishing the digital foundations

By 2024, we will have implemented a new integrated EHR system and will become a paper-lite trust.

Innovative patient care models	• Our patients will have access to a seamless patient portal for digital access to their health records, appointment management, and communication with healthcare teams. • Remote healthcare delivery will be expanded by increasing the number of virtual consultations, as well as remote monitoring pilots for a wide range of patients, to enable proactive care and rapid response inside and outside PAHT.

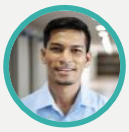
 *Eleanor*	*"As an outpatient, I can access my healthcare records from home, as well as book appointments and renew prescriptions."*
Enhanced staff experience	• Our staff will enjoy a new electronic patient record system with single sign-on and paper-free processes. • Agile working will be enabled by remote access to hospital systems, unified comms and handheld devices. • A digital suite of resources for workforce planning, training and rostering will improve efficiency and reduce costs, as well as ensure high quality services are provided at all times.
 *Mary*	*"As a doctor, I can access run my outpatient virtual clinic from home, allowing me to save time and see more patients."*
Insight-driven care and operations	• PAHT will introduce population health management analytics to gather valuable insights from population data available. This will allow PAHT to plan and adjust service offerings, capacity, staffing and healthcare campaigns in the community, greatly improving health outcomes. • Artificial intelligence and enhanced reporting will gather and analyse valuable data in real time within the hospital.
 *Steve*	*"As an operations manager, I can access population health data, which allows me to plan hospital capacity ahead of time."*
Integrated and inter-operable health care	• PAHT will strive to be a driver of digital integrated care, by piloting, testing and leading initiatives for more efficient and joined-up care. • PAHT will launch My Care Record to allow visibility of patient data to practitioners at different levels of care. Digital transfers of care will improve the co-ordination of care back to the community or to other services. • End of Life planning will be digitally integrated, improving care for our patients in palliative care.
 George	*"Our community GPs can now access PAHT's hospital records, and our patients can now easily digitally transition between care levels."*

8.2 Phase 2

2025-2027: Preparing the digital hospital of the future

Opening in 2027, our new digital hospital will be a tremendous catalyst to achieve our digital aspirations.

Innovative patient care models	• Digital check-in and wayfinding within the hospital will provide a frictionless experience to those visiting the hospital, freeing-up resources to better support patients requiring human support. • Customised, integrated smart rooms will improve comfort and safety to those who need the most support. • Virtual assistants, targeted health promotion and personalised health advice will provide tailored support and proactive chronic condition management.
 *Taylor*	*"I can easily do pre-assessments forms from home, ahead of my appointments. I can also save time by digitally check-in at the clinic."*
Enhanced staff experience	• We will introduce workflow automation technologies that enhance service delivery and patient care, including the automation of repetitive clinical and operational tasks to reduce the margin for error and save valuable time. • A digital workplace and enhanced digital training platform will provide staff with the tools they need to become the workforce of the future.
 *Jessica*	*"The automated pharmacy medication dispensing allows me to quickly discharge patients after their TTA prescription."*
Insight-driven care and operations	• A command control centre and smart building management tools will be introduced to support live decisions on resource management and patient flow to deliver a high-quality care experience and cost efficiencies. • Clinical diagnosis and decision support embedded into the system will nudge clinical staff to adopt best practice • Genomics and precision medicine will enable us to personalise care plans and target treatment to improve patient outcomes.

 *Steve*	*"I can easily visualise live bed utilisation across the hospital to adapt processes and guide my team accordingly."*
Integrated and inter-operable health care	• To improve collaboration, we will introduce advanced solutions for virtual multi-disciplinary team meetings, enabled by real-time patient data sharing. This will be key to achieving holistic care for our patients, as different practitioners will jointly contribute, based on the same available data. • We will achieve interoperability between systems, including a Health Information Exchange, and allow advanced integration with smart devices for enhanced remote care delivery.
 George	*"Our most complex community patients have extensive access to more specialised care without having to go to the hospital."*

8.3 Phase 3

2028-2030: Achieving our digital hospital vision

By 2030, we will become the most digitally-enabled hospital in the UK.

Innovative patient care models	• Immersive technology such as augmented and virtual reality will allow our patients to receive innovative treatments and improve their wellbeing to speed up their recovery. • Advanced smart rooms will bring even more personalisation and comfort to our inpatients, and enhanced virtual assistants will enable preventive care to be at the centre of our work.
 *Harrison*	*"I can use virtual reality in my physiotherapy sessions to exercise my hand after my surgery, making the sessions more engaging."*
Enhanced staff experience	• Further advancements in automation and biometric ID will make systems and processes even more tailored to staff needs, improving patient care, reducing clinical risk and releasing time to care across the organisation.

	• Clinical robotics and access to 3D printing will introduce completely new treatment options for patients being treated at PAHT, increasing our range of services even further.
 *Mark*	*"I can safely login to my open session at any workstation by using my biometric ID. It brings continuity and time saving to my day."*
Insight-driven care and operations	• Advanced artificial intelligence will be embedded into PAHT's processes and will enable supply chain to be automated and clinical decision-making to be supported by AI throughout the trust. • Blockchain will enable secure and efficient data transfer within the organisation and real-time location tracking and smart sensors will improve efficiency in key workflows.
 *Steve*	*"Most of my supply chain processes are now automated. The system automatically reorders from suppliers when stock is low."*
Integrated and inter-operable health care	• PAHT will introduce the integration of non-health system data such as air quality, weather and data from other public entities. This will create new sources of data that can be used by AI to identify healthcare trends, demand and improve the quality of care for our patients. • By 2030, PAHT will have a fully digitally-enabled infrastructure available for our trust and partners to work alongside each other for holistic patient care.
 Mary	*"Based on air pollution levels, the Command Centre team informs us of future increases in respiratory admissions, as well as new guidelines and news on proactive management of patients being undertaken by our community colleagues."*

9. Digital strategy enablers

Achieving our digital aspirations will require a significant organisational cultural shift, substantial improvements to our underpinning infrastructure, working closely with our partners and a brave leadership that leads by example. To achieve buy-in and ownership, we will embed a digital-first culture and deploy a comprehensive and sustained change management programme.

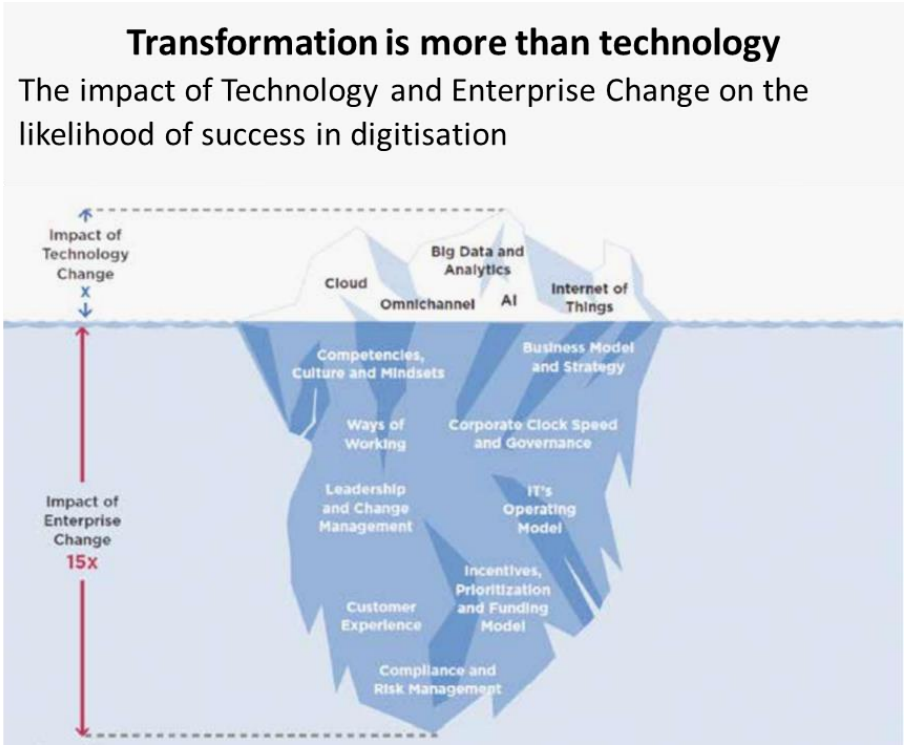


Figure 13 Impact of change iceberg

Source: Gartner, 2019

Four key enablers will underpin the successful delivery of this strategy:

1. **Leadership, Governance and Programme Management**
   Our aligned, 'brave leadership' will set the future direction with a consistent digital narrative. We will also refine our approach to digital programme management and governance.
2. **Change Management and Organisational Design**
   We will focus on developing a digital-first culture at PAHT by building a transformation and culture change capability, that includes all levels of digital literacy across the organisation, with robust training and effective communication.
3. **Partnership Working**

We will build and benefit from partnerships in community care (e.g. GPs, mental health), academia, private sector and other trusts, to accelerate the deployment of digital technologies and augment our impact and capabilities.

4. **Technical Infrastructure**

We will provide resilient, reliable and high-quality IT hardware and systems required by our staff to carry out their daily tasks in a seamless manner.

Building Commitment to and Capability through Change

Embarking on a digital transformation journey requires a high-level of commitment over time. Implementing digital capabilities to achieve our vision to be the most digitally-enabled hospital in the UK will create a significant amount of change across the organisation for our people and our patients. We will invest in comprehensive and robust change management programmes to enable the adoption of change for all stakeholders across the organisation. The change curve below describes the level of commitment and focus areas required over time to achieve our vision, and demonstrates that **individuals**, rather than organisations, must go through the stages of building commitment to change in order to move the organisation to a new future state.

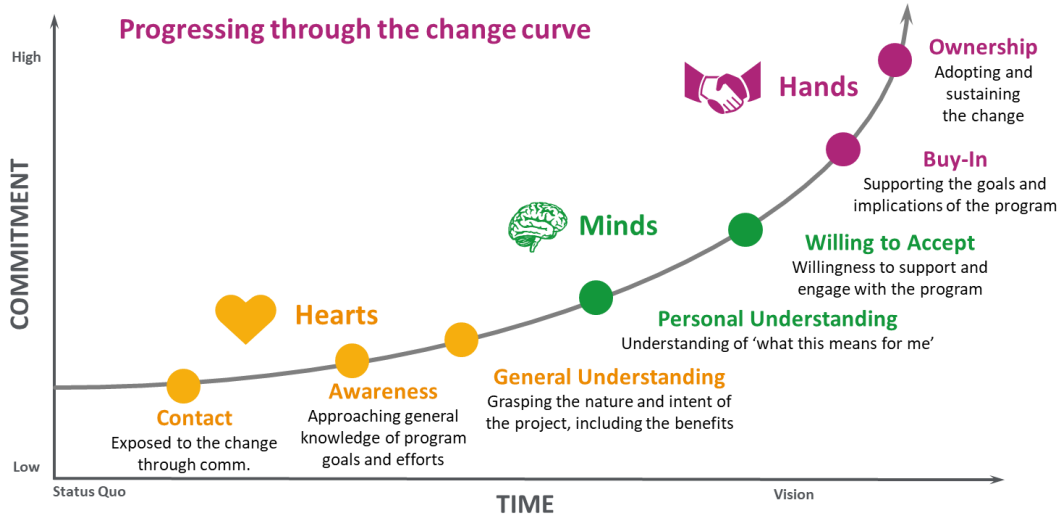


Figure 6 Change curve

9.1 Leadership, Governance and Programme Management

Delivering our digital strategy requires brave leadership with an aligned vision, effective, transparent governance, and robust programme management.

How will we transform over time?

	Establishing the digital foundations 2021-2024	Preparing the digital hospital of the future 2025-2027	Achieving our digital hospital vision 2028-2030
Leadership	• Align internal and external leadership on the digital vision by agreeing common goals and a joint roadmap across the ICS; • Develop and support leaders and staff through digital leadership and development initiatives; and • Agree requirements and business case for an EHR solution.	• Assess achievement of common goals and roadmap progress, adjust as required; and • Continuously develop and support leaders by embedding digital in Executive and SMT performance and development targets and role descriptions.	• Refresh digital vision, reset system goals, develop 5-year roadmap; • Ensure all leaders are consistently involved in horizon-scanning for emerging cutting-edge tech (e.g. Gartner sessions, conference attendance); and • Establish PAHT as a digital trailblazer by sharing good practice insights regionally, nationally, and internationally.
Governance	• Establish e-health governance mechanisms based on good practice; • Assess compliance against national regulations, improving any identified risk areas; and • Establish enterprise wide PMO governance across the New hospital, QI, Transformation and Digital programmes.	• Establish ethics guidelines and policies for newly implemented technologies (e.g. AI); and • Review enterprise wide PMO governance, streamline and improve as required.	• Continuously review and refresh governance policies and ethics guidelines for emerging technologies.
Programme Management	• Mobilise the digital programme and EHR implementation by agreeing leadership and resourcing structure; • Strengthen programme and portfolio management capability by implementing a digital portfolio and	• Expand the digital programme team in preparation for the new hospital; • Strengthen vendor and contract management capabilities, leveraging resources	• Ramp down the digital programme team, transitioning to optimisation and BAU; and • Embed benefits monitoring into BAU performance management activities.

	project management tool to enable seamless management of digital programme; and • Refresh downtime / business continuity policies and procedures.	and insight from the EHR programme; • Establish robust benefits monitoring by setting target metrics and measuring baseline performance; and • Strengthen downtime / business continuity policies and procedures in preparation for the transition to the new hospital.	

9.2 Change Management and Organisational Design

Achieving our digital ambitions requires significant change management, new ways of working, robust training, and sustained engagement with our patients, staff, and partners.

How will we transform over time?

	Establishing the digital foundations 2021-2024	Preparing the digital hospital of the future 2025-2027	Achieving our digital hospital vision 2028-2030
Change Management	• Strengthen change and risk management function for the EHR and digital capabilities implementation by assessing current capabilities against good practice and addressing gaps (e.g. resources, capacity, skills, methodologies); • Conduct change impact assessments to identify specific change interventions ahead of new EHR; • Conduct operational readiness assessments to identify risks prior to the new EHR go-live; and • Deploy digital champions for the new EHR.	• Accelerate change management in preparation for the new digital hospital opening; • Deploy digital champions and change network in new hospital initiatives; • Conduct change impact assessments to identify specific change interventions ahead of new hospital opening; and • Conduct operational readiness assessments to identify risks prior to the new hospital launch.	• Provide ongoing support for digital champions and change network for continuous improvement, ownership and sustained change.
Organisational Design	• Standardise key workflows (e.g. admission, discharge) in preparation for the new EHR; • Develop Target Operating Model (TOM) for new hospital, incorporating digital vision; • Review IT operating model to incorporate the management and optimisation of the	• Redesign priority services, guided by the digital hospital vision; and • Expand secondments and back to floor opportunities.	• Embed patient voices in opportunities to optimise new hospital services and workflows.

	EHR and associated systems; • Redesign roles and responsibilities based on the TOM; and • Recruit and develop key roles required, with a focus on analytics and data science skills.		
Training	• Build the digital workforce by assessing baseline digital skills amongst staff groups using the Health Education England (HEE) digital capability framework; develop an action plan for key gaps; • Accelerate training capability in preparation for new EHR; • Expand digital inclusion / patient education programme with community partners (e.g. local council) based on national guidance and best practice; and • Embed digital and data skills in mandated learning and development for all staff.	• Refresh digital skills and gap analysis; develop and tailor training programmes; and • Accelerate training in preparation for the new digital hospital opening.	• Re-assess digital skills and capabilities against HEE digital capability framework; and • Update digital literacy and training programmes to close gaps.
Engagement & Communication	• Develop staff journeys to illustrate digital hospital vision for various roles; • Launch a multi-channel communications campaign for the digital strategy, incorporating the EHR communications and change management plan; and	• Distribute pulse surveys to maintain broad engagement across staff groups; • Evolve the engagement and change management plan as part of the new hospital activation programme; and • Accelerate communications in	• Evolve staff and patient engagement using modern channels and tools; and • Provide digital champions with the 'spotlight' to showcase new digital hospital success and lessons learnt regionally and nationally.

	• Strengthen patient engagement forums by increasing involvement from patient groups rEHResenting broader demographics.	preparation for the new digital hospital opening.	

9.3 Partnership working

We will develop new relationships and build on existing partnerships to deliver our aligned ambitions, foster adventurous innovation and tackle health inequalities.

How will we transform over time?

	Establishing the digital foundations 2021-2024	**Preparing the digital hospital of the future 2025-2027**	**Achieving our digital hospital vision 2028-2030**
Partnerships	• Embed out of hospital clinical models for COPD, Heart Failure and Falls across health and care system; • Align information governance processes and data-sharing agreements across the ICS; • Establish agile/product-based digital development capability and innovation function; and • Establish/maintain strategic partnerships (including EHR vendor, integration partner, diagnostics partner, infrastructure partner, digital delivery partners, academic partners).	• Deploy integrated and shared people approach with ICS partners; • Explore opportunities for system-wide procurement to create economies of scale; • Strengthen innovation function & partnerships; and • Develop agile/ product-based digital development capability for ongoing innovation.	• Continue to foster relationships with suppliers, tech companies, research institutions, life sciences companies, etc.; • Refresh the ICS digital strategy; • Strengthen and refresh partnerships to collaborate on advanced AI and population health analytics capabilities; and • Embed agile / product-based digital development capability for ongoing innovation.

9.4 Technical Infrastructure, Data, Hardware

Reliable, robust IT infrastructure is foundational to becoming the most digitally-enabled hospital in the UK, from the data storage to Internet-of-Things to the ability to scale for future leading-edge technology.

How will we transform over time?

	Establishing the digital foundations 2021-2024	Preparing the digital hospital of the future 2025-2027	Achieving our digital hospital vision 2028-2030
Technical Infrastructure	• Continue infrastructure improvement programme to ensure a robust, reliable infrastructure; • Continue to ensure cyber security (e.g. champions, training); • Develop secure network and connectivity; • Launch cloud facilities, using a hybrid cloud approach; • Implement an API and integration layer; and • Deploy a managed network.	• Rollout 5G; • Invest in flexible, scalable tech, e.g. on demand cloud computing; and • Continuous network upgrades and security.	• Continuously invest in and maintain flexible, scalable, future-proof infrastructure to enable adoption of leading-edge technologies, e.g. blockchain to support patient record transactions and information transfer.
Data	• Reconcile data sources; • Refresh data quality and migration strategy; • Adopt SNOMED-CT coding standards; and • Adopt FHIR inter-operability standards.	• Continue to rollout FHIR inter-operability standards.	• Adopt the latest interoperability standards.
Hardware/ devices	• Develop a robust End User Device (EUD) and Operating System strategy; • Refresh device management policies (e.g. BYOD); and • Assess the decommissioning programme for legacy technology (e.g. printer removal to enforce going paper-lite).	• Operationalise EUD strategy for new hospital; and • Accelerate legacy technology decommissioning in preparation for the new hospital launch.	• Refresh EUD strategy and plans to ensure staff are equipped with latest devices; and • Fully decommission legacy technology

9.5 Creating Digital Teams

To ensure successful delivery of the strategy, we need to ensure we have the right resources, and right people making it happen. To do this we will need to build digital teams that are the cornerstone of building a digital organisation. The digital workforce will be supported by effective governance, which enables them to be responsive, open, efficient and work in an agile fashion, and to successfully deliver service transformation. The team will focus on user centred design, agile ways of working, and a knowledge of how to build and operate modern digital technologies.

It is critical that these teams have a balance of skills, and not predominantly made of one particular skill (such as IT). Core skills and roles will include:

Product managers (also known as System Managers): leaders who are focussed on solving problems for users and achieving outcomes for the business. This vision is combined with the right technical and design understanding to be able to determine at a high-level how this can be done.

Delivery manager (also known as Project Managers): a key role to ensure that the team has the right environment to successfully deliver.

Clinical leaders: this is particularly critical when the focus is on the delivery of good clinical outcomes and therefore needs to be clinically led. Clinicians will always be vital champions and stakeholders for the Digital Health element of PAHT 2030.

Designer(s): there are several types of designers that are important to digital teams.

- An interaction designer who focuses on providing clear and consistent user experience.
- A service designer who is responsible for the end-to-end journey of a service
- A content designer who is responsible for creating, reviewing, and iterating the words used across services and digital products.

User researcher (also known as business change managers): responsible for helping the team understand users and their needs. It is important to actually observe users trying and often failing to use a digital product, because what users do can sometimes be different to what they say.

Lead developer: the lead developer writes, adapts, maintains and supports the computer code underpinning the service.

We will ensure we have the tools in place as part of our work plan to enable greater agility and collaboration in the creation of digital teams.

We will develop a cohort of digital champions throughout the Trust in all areas, who will work with teams to help them become more digitally-minded by promoting digital literacy and skills and by encouraging others to embrace new technologies and become more

digital aware and confident. We will also ensure we do not exclude any of our citizens from engaging with our digital vision, and will develop partnerships to ensure inclusivity.

10. Conclusion

We would like to take this opportunity to thank all of our stakeholders, patients, citizens and healthcare partners for providing invaluable input to the development of this document.

10.1 Next Steps

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

We will strive to ensure that, by 2030, the stories of the Willow Road neighbours and office workers of A47 become PAHT's reality. We look forward to your continued collaboration as we deliver our digital strategy.

Appendix

A.1 Digital Capability Glossary

Capability	Description
Innovative patient care models	
Augmented reality / Virtual reality (AR/VR)	Immersive technologies can provide patients and clinicians the experience of being immersed in simulated objects and environments. These technologies are categorised as Augmented reality (AR), Virtual Reality (VR) and a hybrid called Mixed Reality (MR). Main use cases include both surgical procedures (e.g. superimposing computer-generated images on a surgeon's field of vision) as well as for patients, who can visualise potentially different pathways and procedures before making decisions.
Community diagnostic hub platform	A virtual platform where community healthcare practitioners can access all diagnostic data from patients and interact with other professionals involved in the patient care.
Customised smart rooms	Hospital rooms that adapt to patients' conditions and preferences (e.g. ambiance, entertainment), controlled via a digital bedside terminal.
Digital check-in	Check-in is recorded through digital kiosks or smart devices – relevant carers and staff are automatically notified through digital communication channels.
Digital front door	The digital offering of services that usually are offered in the hospital front door (e.g. booking, access to support, answers to frequent questions)
Digital meal ordering	A digital platform to allow inpatients to choose their meals.
Digital wayfinding	Tool to enable patients and visitors to navigate their way through the hospital by providing them the shortest way to their destination via their smart device.
Integrated smart devices	Integration of smart devices that capture and register healthcare data to the patient records.
Patient portal	Central portal for patients to view their electronic care records, manage appointments, communicate with clinical teams and understand care pathways.
Remote monitoring	Platform that remotely captures and transmits patient data to clinical systems; able to detect changes in condition and suggest clinical interventions.
Smart Beds	Beds with sensors that can capture and register information such as patient movement, weight and falls.
Targeted health promotion and personalised information	Centralised repository in the patient portal of content related to patients' personal conditions and profiles, with support provided by AI virtual assistants.

Virtual assistants and chatbots	Smart and intelligent digital agents that support care providers with clinical decision making and administrative tasks to improve accuracy, efficacy and efficiency.
Virtual consultations	Telemedicine/remote consultation solution to provide the ability to perform remote video and/or voice appointments between patients and their careers.
Virtual ward rounds	Ward rounds with the participation of practitioners in a digital way, such as via video. This can be done to support patients at home or to allow practitioners to join ward rounds in the hospital remotely.
Enhanced staff experience	
3D printing	Technology that enables the production of tailored healthcare pieces, such as implants.
Automated dispensing cabinets	Cabinets and/or mechanical robots that can assist with repetitive manual operational tasks, including dispensing of drugs and prescriptions in a pharmacy context – plus delivery of supplies, equipment, and food.
Automated guided vehicles	Vehicles that move independently to do a range of functions in the hospital, such as deliver medication, answer patient's questions and supply chain support.
Barcoding	The use of barcodes in products or assets to track location and stock.
Biometric ID	Use of a unique body part as ID, such as fingerprint or iris.
Clinical robotics	Most immediate use case is being able to assist surgeons to perform micro procedures. Over the longer term, clinical robots are anticipated to become advanced enough to undertake more complex surgical tasks.
Content Management System (CMS)	Software that helps users to create, manage, and modify content online without the need for specialised technical knowledge.
Digital meds management	An optimised system for managing medication, such as stock and prescription.
Digital programme management tools	Digital tools optimised for efficient project management, such as Microsoft Project.
Digital training	A digital platform that provide training for staff.
Digital workforce management	An approach, underpinned by technology, that helps you build a better, more effective working day for your teams in the field. It uses mobile working, schedule optimisation and intelligent analytics. It provides a foundation for driving digital transformation and efficiency.
Digital workplace	An optimised digital platform for staff to access the tools needed for them to work, such as paperless documentation, virtual room booking, and virtual calendars synced between multiple platforms.
Electronic Document and Records Management System (EDRMS)	A system to help manage documents and records virtually.

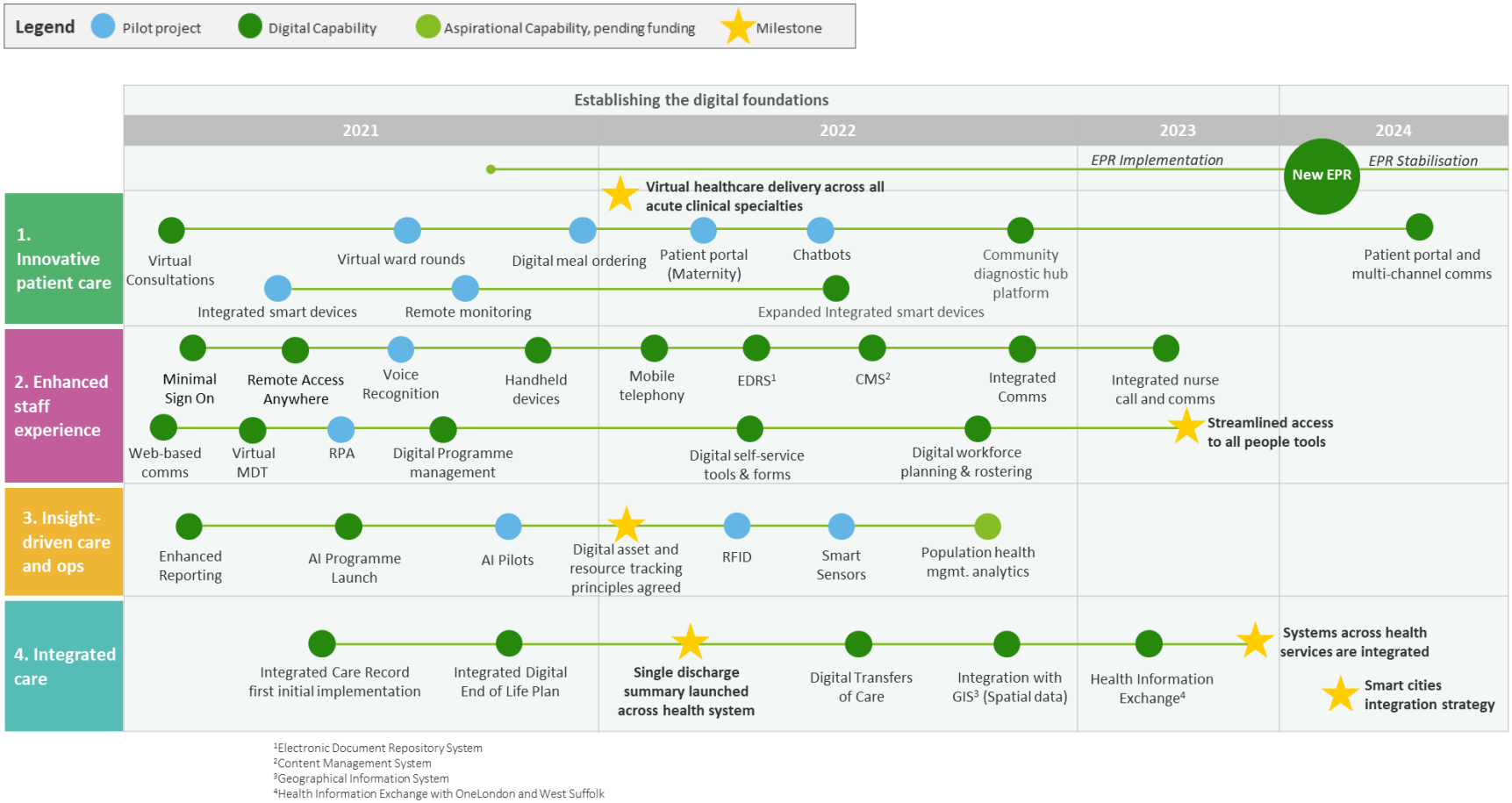
Handheld devices	Devices that are mobile and able to be carried on one's hand, to perform tasks at work and provide mobility.
Integrated nurse call	Systems that enable patients to call nurses remotely from a range of key locations across the hospital, including through bedside terminals, common rooms and bathrooms, supporting two-way communication between nursing and patients.
Pneumatic tubes	A system that enables the delivery of items such as diagnostic samples and letters through pressurized air tubes.
Remote Access Anywhere	A system that allows staff to access their work computer remotely.
Robotic Process Automation (RPA)/Workflow automation/ Digital worker	Algorithms that automate hospital operations and the delivery of some patient experiences and care (including reporting, supply chain automation, remote patient monitoring).
Single Sign On (SSO)	Single Sign On solutions offering the management of credentials authentication and authorisation (username/password).
Unified communication	Platform where doctors, nurses and other agents (e.g. ambulance, social service) can communicate on specific cases, improving ease of communication and accessibility of key patient data.
Voice activated tech and Voice Recognition	Advanced tools to convert speech intelligently to text, supporting efficient production of clinic letters, reports and notes.
Insight-driven care and operations to maximise quality and efficiency	
Advanced bed management	The ability to manage bed usage across the hospital based on real-time capacity and utilisation data.
Advanced scheduling	Digital software that allows intelligent planning and management of staffing.
Artificial Intelligence (AI)	Artificial intelligence (AI) is the use of algorithms and software to emulate human cognition in the analysis, interpretation, and comprehension of complicated medical and healthcare data. Specifically, AI allows to systems to learn from experience, adjust to new inputs, perform human-like tasks, and approximate conclusions without direct human input.
Asset tracking	Monitors valuable medical equipment to understand real–time location, availability and maintenance cycles.
Auto submission to national databases	Automated notification of healthcare data to the NHS, such as incidence of infectious diseases.
Blockchain	Utilising blockchain we can safely store information over the shared system, where everybody can see but can't do any alteration. A blockchain is a growing list of records called blocks which are interconnected by utilizing cryptography. Each block contains a cryptographic hash of the previous block, a time stamp, and exchange information.

Clinical diagnosis and decision support	A range of intelligent applications that act as interactive "knowledge systems". They use patient data to make clinical recommendations on a case-by-case basis.
Digital control centre	A central, data-driven decision making and logistics management capability to aggregate clinical and operational data across care sites, maximising operational flow and enabling remote patient monitoring.
Digital Twin	Digital twin can be used to create a virtual simulation of a real physical environment / scenario to test and understand the impact of events or treatments.
Digital whiteboards	Digital versions of a whiteboard that display information of a ward of information that is specific to a patient in a simple, accessible format.
Drillable reports	Reports that can be expanded to show underlying detailed information, such as individual admissions under the overall admissions report.
Internet of Things (IoT) sensors	Sensors that are connected to the internet and gather data to be used for management (e.g. smoke sensors, humidity sensors)
Population health management analytics	Population Health Management Analytics is an approach for local health and care partnerships to use data analysis to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
Precision medicine and genomics	AI-driven approach that enables clinicians to tailor medical treatment to the individual characteristics of patients.
Predictive and prescriptive analytics	The use of data to predict trends (predictive) and recommend actions (prescriptive), such as inventory planning based on previous usage and capacity planning based on weather season.
Real-time location tracking	Real-time view of where patients and staff are located across the hospital (e.g. wards and common rooms).
RFID	Radio-frequency identification (RFID) uses electromagnetic fields to automatically identify and track tags attached to objects. It consists of a tiny radio transponder, a radio receiver and transmitter.
Smart building management	The use of a range of technology, such as sensors, to gather activity data on various aspects within the building so it can be analysed and utilised to find out which operations can run more efficiently.
Smart lighting and grid	Lighting that offer energy savings, easy maintenance, controllability, visual acuity and integration with building automation systems. In the future, it is also expected to leverage the Internet of Things (IoT) for smart building solutions.
Smart sensors	Sensors that can detect movement and trigger actions (e.g. occupancy sensors to provide insights on utilisation of an area, triggering enhanced hygiene protocols)
Smart staff management	Optimises staff scheduling to patient needs through AI-driven analysis – for example, dynamically adjust nurse staffing ratios according to predicted activity, patient acuity, seasonal conditions, etc.
Smart triage	Patient-facing tool that uses technology to aid diagnosis of risk and illness by analysis of patient data and symptoms, triaging patients to appropriate care route.

Supply chain automation	Automating the monitoring, procurement and fulfilment of equipment and supplies that are critical to run the hospital.
Surveillance/thermal cameras	Cameras that can detect heat and improve security. They don't need visible light and use sensors to detect invisible heat radiations.
Integrated and interoperable health care	
Advanced non-health system data integration	Ability of devices (e.g. ECG, glucose, blood pressure monitors), medical and personal wearable devices to integrate with clinical systems, including the hospitals smart building infrastructure (e.g. sensors).
Digital directory of services	A digital Directory of Services (DoS) is a central directory that is integrated with NHS Pathways and is automatically accessed if the patient does not require an ambulance or by any attending clinician in the urgent and emergency care services.
Digital transfers of care	Allows the flow of key patient data between primary, secondary, community and social care on different levels (from Device Data, to Personal Care Record, EHR, LHCRE, Regional and National levels).
Integrated digital 'End of Life' plans	Seamless integration between all levels of End of Life care, allowing efficient planning and quick start of palliative care.
Integration with Geographic Information Systems (GIS)	Use of location data to understand population demographics and obtain insights of healthcare trends and needs
Interoperable information systems	Enables sharing of sharing of patient data and records between disciplines, agencies, organisations, other Trusts, and national systems. This is done by adopting common open standards for internal and external integration (e.g. HL7 FHIR or SNOMED CT).
Shared care record	Patient records that can be accessed by different levels of care.
Vendor neutral archive	Technology in which images and documents (and any file of clinical relevance) are stored (archived) in a standard format with a standard interface, such that they can be accessed in a vendor-neutral manner by other systems
Virtual multi-disciplinary team (MDT) solution	Platform for MDTs to operate efficiently virtually, and therefore improving the ability to communicate and coordinate care.

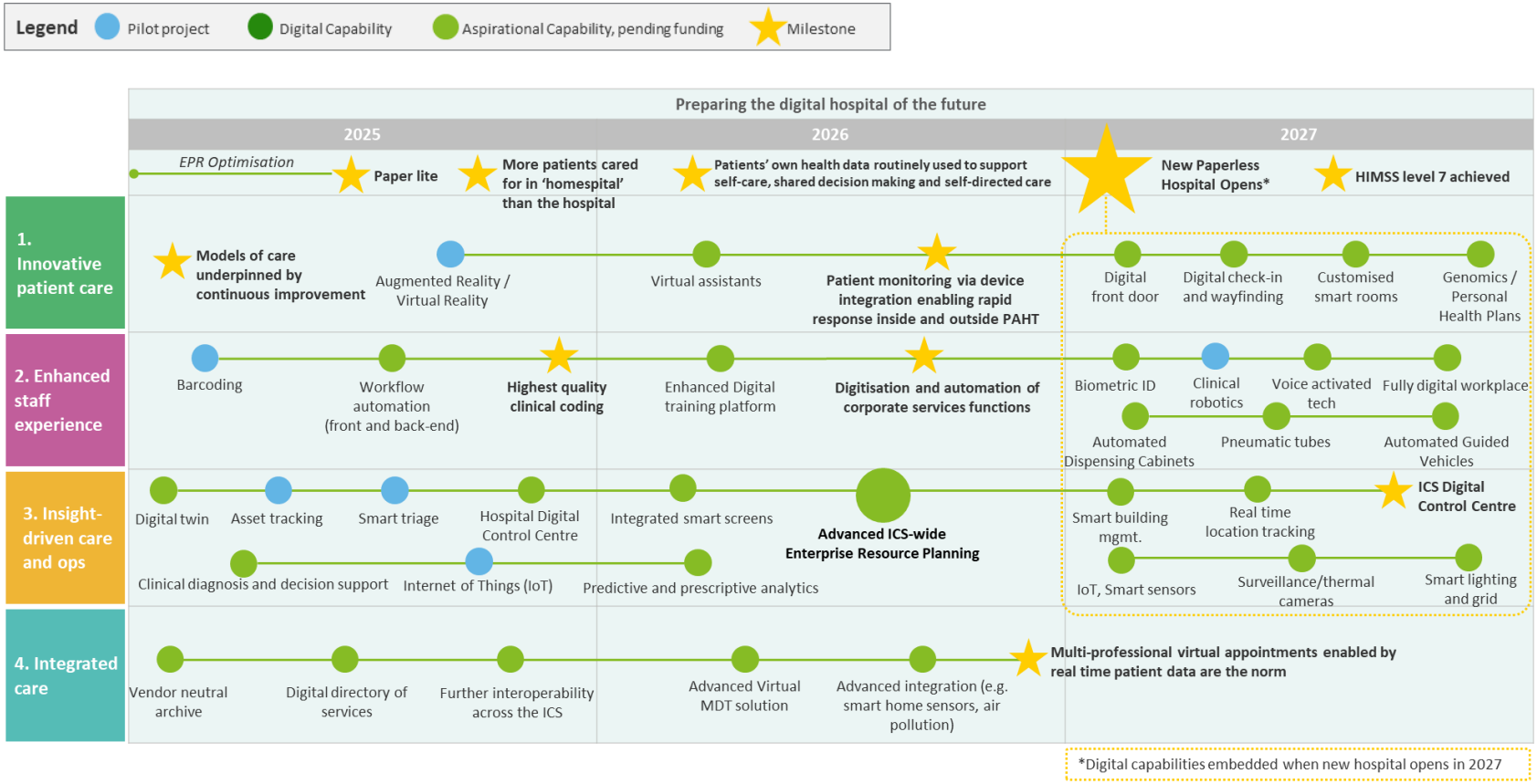
A.2 Roadmap

Phase 1: Establishing the digital foundations (2021 – 2024)

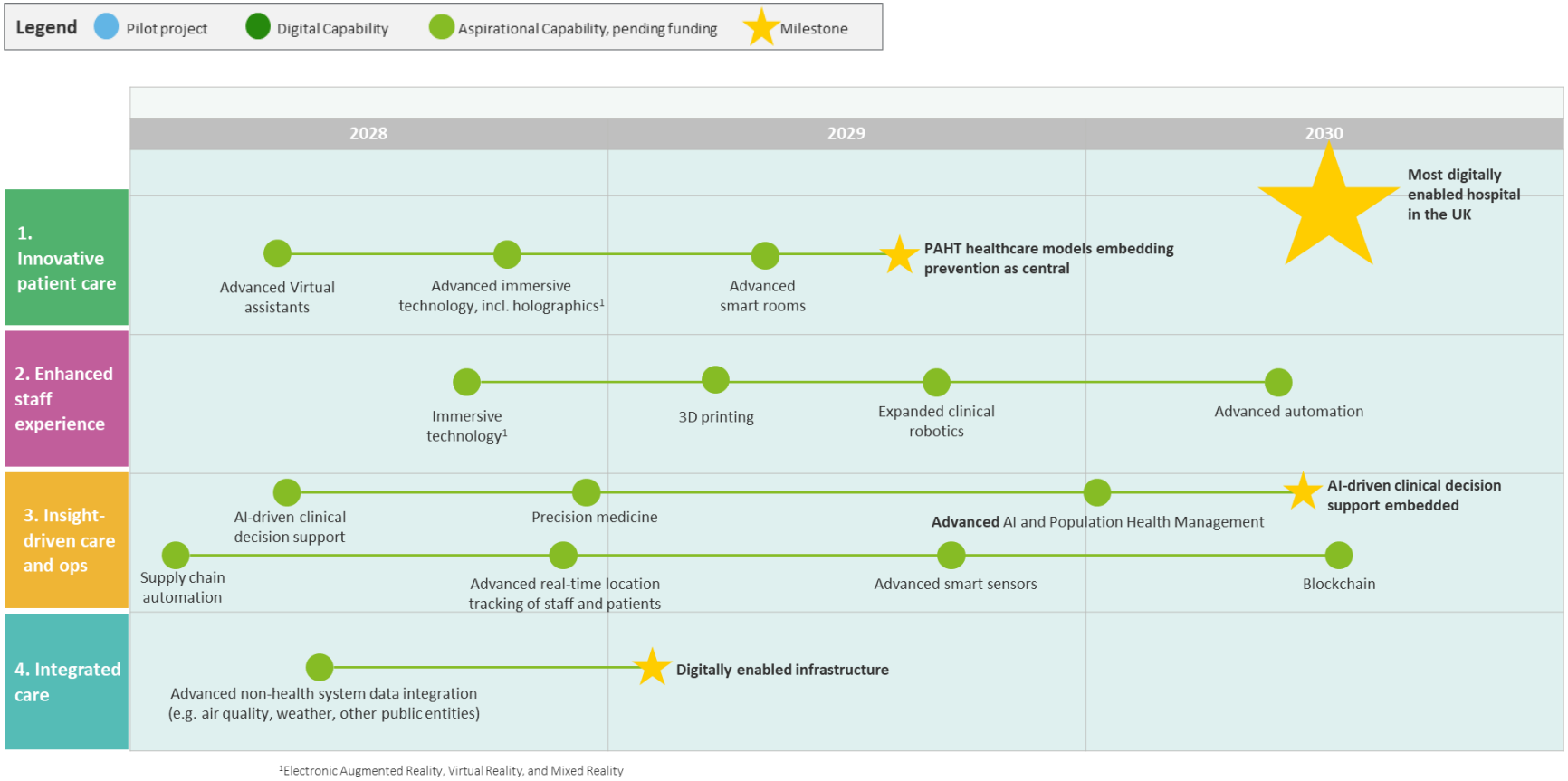


[1]Electronic Document Repository System
[2]Content Management System
[3]Geographical Information System
[4]Health Information Exchange with OneLondon and West Suffolk

Phase 2: Preparing the digital hospital of the future (2025 - 2027)



Phase 3: Achieving our digital hospital vision (2028 - 2030)



[1]Electronic Augmented Reality, Virtual Reality, and Mixed Reality

A.3 Interviewees

Thank you to our stakeholders for taking the time to provide their input to the development of the digital strategy.

Name	Role
Jenny Abel	Head of nursing for urgent care and transfer of care
Hannah Anderson	EHR business change manager
Darrel Arjoon	Non-exec Director
Ganesh Arunachalam	Senior Registrar – Elderly Care
Chloe Atkinson	New Hospital Transformation
Robbie Ayers	Deputy Director of Quality Improvement
John Biddulph	Chief Pharmacist
Monica Bose	AMD-Cancer, Cardiology & Clinical Support (CCCS)
Ayse Casey	General Manager – Planned Care
Toni Coles	Director of ICP Development & Transformation
Diane Dane Bowers	Patient Panel
Helen Davis	Deputy Programme Director (new hospital)
Finola Devaney	Director – Clinical Quality Governance
James Diss	Radiologist
Manal El-Maraghy	Consultant Adult Liaison and Perinatal Psychiatrist
Ogechi Emeadi	Workforce Lead
Jacqui Featherstone	Associate Director of Nursing & Midwifery
Lynne Fenwick	Director of IM&T
Alex Field	Obstetrics and Gynaecology consultant
Rob Gerlis	GP WECCG
Bob Ghosh	AMD Medicine
Fay Gilder	Chief Medical Officer
Ian Hanmore	Clinical Safety Officer
Lindsay Hanmore	Associate Director of Nursing of Quality Improvement
Rachel Hazeldene	GP & Chief Clinical Information Officer, WECCG /CCIO My Care Record, Herts & West Essex STP

Fiona Hikmet	Associate Medical Director – Paediatrician
Darren Hobbs	Director of Operations – CCCS
Pam Humphrey	Associate Director of Nursing
Jon Keene	Deputy Medical Director for Strategy
Steph Lawton	Operations Lead – Director of Ops or COO
Tylan Lucas	Junior doctor
Julie Matthews	Associate Director of Operations
Lance McCarthy	CEO
Jim McLeish	Director of Quality Improvement
Sharon McNally	Director of Nursing & Midwifery
Michael Meredith	Director of Strategy and Estates
Mandi Osoba	Training lead
Helen Pardoe	Chief Clinical Information Officer
Andrea Philip	Associate Director of Operations – FAWS (Family & Women's)
Elizabeth Podd	Head of Performance and planning
Polly Read	ADoN - UEC
Jonathan Refson	AMD-Surgery, Consultant General & Vascular Surgery, Director of Medical Education
Saba Sadiq	Director of Finance
Rajamani Sethuraman	Critical Care Lead
Katie Silk	Head of Therapies
Ajay Sooknah	Head of Operations
Blessing Tasara	Clinical manager - Urgent care management
Natalie Vidler	EHR business change manager
Mark Vincent	New Hospital Digital Lead
Beverley Watkins	Deputy Director of People
Sarah Webb	Deputy Director of Nursing & Midwifery
Helena Wilson	EHR business change manager
Jeff Wood	Deputy Director of ICT

A.4 Digital Strategy Working Group

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

Name	Role
Darrel Arjoon	Non-Executive Director
Chloe Atkinson	New Hospitals Transformation
Robbie Ayers	Deputy Director of Quality Improvement
Monica Bose	AMD CCCS
Toni Coles	Director of ICP Development & Transformation
Finola Devaney	Director of Clinical Quality Governance
Louise Edwards	Nurse Lead Cancer
Joanna Eley	EPUT
Ogechi Emeadi	Director of People OD and Comms
Gopesh Farman	GP West Essex CCG
Dr Fay Gilder	Chief Medical Officer
Jacqui Featherstone	ADoN Midwifery
Lynne Fenwick	Director of IM&T
Rob Gerlis	GP West Essex CCG
Bob Ghosh	AMD Medicine
Ian Hanmore	Nurse Lead Technology
Lindsay Hanmore	ADoN Quality
Rachel Hazeldene	CCG CCIO
Fiona Hikmet	FAWS
Phil Holland	CIO
Pam Humphrey	ADoN Surgery and Critical Care
Nuala Jennings	Head of site management
Jon Keene	Deputy Medical Director for Strategy
Steph Lawton	COO
Sharon McNally	Director of Nursing & Midwifery
Michael Meredith	Director of Strategy and Estates
Jane Osgathorp	Head of Nursing (Medicine)
Helen Pardoe	CCIO

Polly Read	ADoN UEC
Jonathan Refson	AMD Surgery
Ahmed Soliman	AMD Urgent Care
Mark Vincent	IT Director (new hospital)
Sarah Webb	Deputy Chief Nurse
Jeff Wood	Deputy Director of ICT
Toni Wright	ADoN CCCS

A.5 Willow Road Neighbours Journeys

PAH Digital Strategy_Willow Roac

A.6 Office A47: Office of the Future

PAH_Digital Strategy_Office A47.p

A.7 What Good Looks Like Assessment

What does good look like for your organisation?	PAH Response
Success Measure 1 - Well Led	
Boards are equipped to lead digital transformation and collaboration. They own and drive the digitally enabled transformation journey, placing citizens and frontline perspectives at the	
build digital and data leadership expertise and strong board-level accountability for digital transformation - this would include having a CIO or CCIO (or role within this function) as a member or attendee of the board	We have appointed a board level CIO with accountability for digital transformation. However, we need to continue to promote the digital agenda across the Board to ensure understanding of the opportunities as well as the complexities
establish board governance that regularly reviews digital and data strategy, cyber security, services, delivery and risks, underpinned by meaningful metrics and targets	Digital Health is one of the core workstreams of PAHT 2030, we have established a routine for quarterly boards updates on our digital health development and strategy. Detailed assurance is provided and sought at a more detailed level on cyber, service delivery and risk through the Peformance and Finance Board Sub Committee. We currently don't have a key set of metrics to measure performance against, and these require development
ensure that your digital and data strategy has had wide input from clinical representatives from across the organisation	Our digital health strategy has been developed in coordination with a wide group of clinical stakeholders both within the organisation and the Integrated Care Partnership (One Health and Care Partnership).
ensure board ownership of a digital and data strategy that is linked to the Integrated Care System (ICS) strategy and underpinned by a sustainable financial plan	The ICS digital strategy is still in development, therefore the links between our digital health strategy, and the ICP and ICS strategies still need to be established. This in turn will need to be supported by an ICS wide financial plan
identify digital and data solutions to improve care by regularly engaging with frontline users and citizens	We have a Clinical Digital Senate in place which has representation from XX specialties and XX professions. We attend the patient panel meetings regularly
invest in regular board development sessions to develop digital confidence, manage cyber security risk and achieve the sustainability agenda	With digital health being a key part of PAHT 2030, we have regular board development sessions covering a range of topics including cyber, electronic health records, business intelligence, digital strategy etc
invest in a multidisciplinary CCIO and CNIO function	We have a CCIO, and funding and plans for a CNIO

Success Measurre 2 - Ensure Smart Foundations	
Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Organisations have well-resourced teams who are competent to deliver modern digital and data services.	We have invested significatly in upgrading our core infrastructure and have a refresh policy of 5 years for PCs and 3 years for iOS devices ensuring we utilise supported OS and applications where possible. We have recently undergone a restructure to ensure we have the right team with the correct competencies and invest in our training. Our Security team undertake cpd to retain their security qualifications.
invest in and build multidisciplinary teams with clinical, operational, informatics, design and technical expertise to deliver your digital and data ambitions	Our team are recruited from various NHS and Private Sector to ensure a broad spectrum of experience and knowledge, we have opportunities forsecondment from other areas throughout the Trust and provide training to assist them. All projects include Clinical leadership where possible as well as a broad end user base to ensure we get the right requirments and outcomes.
ensure progress towards net zero carbon, sustainability and resilience ambitions by meeting the Sustainable ICT and Digital Services Strategy (2020 to 2025) objectives	Utilising Hotdesk booking systems and cloud telephony we are able to reduce our carbon emmissions or staff travelling on the roads. We have also invested heavily in remote virtual consultations reducing patient travel. We are cloud first by design to ensure we capitalise on green sustainable data centres
make sure that all projects and programmes meet the Technology Code of Practice and are cyber secure by design	Our Strategy includes our design principles which include Security by design and pick up elements from the Technology code of Practice.
have a plan and move to cloud data hosting and management	This is within our Design principles and strategic roadmap. We utilise SaaS where we can and are currently running POCs on AVD. We are part of the NHS Shared Tenancy
maintain a robust and secure network	Secure network with boundary firewalls in place and are Part of the Essex CoI for HSCN. We undertake regualr pen tests ad securty reviews. We are currently in progress for CE+ Certification.
ensure hardware, software and end user devices are all within the suggested supplier life cycle and fully supported	We follow guidelines provided by Suppliers in terms of supported Os and applications ensuring these are upgraded to remain in support or for critical fixes and security. We have a refresh policy as above.
remove fax machines and non-emergency pagers, and maximise use of modern telephony and communication methods, for example, communications software	We have removed all fax machines from the Trust and are currently rolling out Alertive as a Clinical Communication Tool. This is envisaged to replace first our non-emergency bleeps then our emergency bleeps and finally our Pagers as part of various phases.
ensure staff have access to the technology and devices that best support their roles	Desktops, laptops, 2in 1 devices, ipads, ipods and iPhones are supplied as requiired for roles throughout the Trust. Further work is being undertaken for DaaS on a CYOD basis. Webcams, headsets, etc are supplied for communication purposes as well as more generic ward based static phones.
maintain a central, organisation-wide, real-time electronic care record system	We currently have a PAS in place but sre in the process of procuring a new EPR/EHR
extend the use and scope of your electronic care record systems to all services, ensuring greater clinical functionality and links to diagnostic systems and electronic prescribing and medicines administration (EPMA)	We currently utilise a TIE for integration but are looking to extend the scope of our PAS as we procure the new EPR/EHR
contribute data to the ICS-wide shared care record in line with the Professional Records Standard Body's (PRSB) Core Information Standard	The Trust contributes data into the ICS HIE Shared care record in accordance with the standards required. The first phase went live 13/10/21 with second on track December 2021.

Success Measure 3 - Safe Pactice	
Organisations maintain standards for safe care. They routinely review digital and data systems to ensure they are safe, robust, secure, sustainable and resilient. Digitally-enabled	
comply with the requirements in the Data Security and Protection Toolkit which incorporates the Cyber Essentials Framework	We are compliant with the DSPT and Cyber essentials, and have positive internal audit opinions and are currently applying for CE+ certification
fully use national cyber services provided by NHS Digital	We fully utilise the cyber service (ATP, Secure Boundary, Vulnerability Monitoring Service (VMS), BitSight and on-site assessments (AD, backups)), and ensure prompt response and action to the alerts
have a secure and well-tested back-up, a plan to get off and stay off unsupported systems, and a rapid turn-around of High Severity Alerts	We have resilience and DR Plans in place and these are tested frequently.
establish a process for managing cyber risk with a cyber improvement strategy, investment and progress regularly reviewed at board level	We have a Cyber Security Strategy in place with roadmaps for our improvement. Weekly Security meetings take place between the DPO and Security Teams to assess risks.
have an adequately resourced cyber security function, including a senior information risk owner and data protection officer (DPO)	We have a virtual Cyber Security Team in place. Our SIRO sits on the Exec Board. A DPO is in place and sits separate to the ICT team to ensure independence.
have an adequately resourced clinical safety function, including a named CSO, to oversee digital and data development and deployment across all care services	CSO is in place utilising an IT Lead Nurse and a Team of officers
establish a clear process for reviewing and responding to relevant safety recommendations and alerts, including those from NHS Digital (cyber), NHS England and NHS Improvement, the Medicines and Healthcare Products Regulatory Agency (MHRA) and the Healthcare Service Investigation Branch (HSIB)	Weekly security meetings undertaken with DPO to assess risks. Urgent / Immediate risks are actioned by priority as soon as viable.
ensure clinical systems and tools meet clinical safety standards as set out by the Digital Technology and Assessment Criteria (DTAC) and DCB0129 and DCB0160	WE utilise DTA approved suppliers where possible
ensure you are compliant with NHS national contract provisions related to technology-enabled delivery (for example, clinical correspondence and electronic discharge summaries)	Where our system allow us, we ensure compliance with contractual provision. Where they don't, we have plans to replace to ensure compliance

Success Measure 4 - Support People	
Your workforce is digitally literate and are able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.	
create and encourage a digital first approach and share innovative improvement ideas from frontline health and care staff	Our governance structure places patient facing clinicians at every decision making point, with our redefined ICT Programme Board chaired by our CCIO. Each significant digital change has clinical safety as a core part of its sign off process
support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development	Training and education is provided for all digital solutions as well as annual cyber and information governance training. Ongoing support and advice is provided by drop in sessions and our Tech Bar
ensure that the systems that your staff use are intuitive and easy to use	All significant changes have decision making groups with multi disciplinary membership, ensuring no implementation is completed without full end user sign off
support your staff to work flexibly, remotely, and across multiple wards or sites	Full remote access is available to everyone who requires it, either within out sites or remotely
provide front-line staff with the information they need to do their job safely and efficiently at the point of care, for example ICS shared care record	Our digital strategy sets out our plan to provide fit for purpose applications, such as a new electronic health record in 2024
provide access to digital support services 24 hours per day, resulting in high first-time fixes	We have 24/7 support in place for all critical infrastructure to aim to provide high level of availability

Success Measure 5 - Empower Citizens	
Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their	
develop a single, coherent strategy, in conjunction with your ICS, for citizen engagement and citizen-facing digital services that is led by and has been co-designed with citizens	We have significant patient panel involvement in defining patient portal requirements and evaluation process as part of EHR procurement
make use of national tools and services (the NHS website, NHS login and the NHS App), supplemented by complementary local digital services that provide a consistent and coherent user experience	We use national tools, such as NHS mail effectively and widely, and ensure that our local applications are able to integrate effectively
use digital communication tools to enable self-service pathways such as self triage, referral, condition management, advice and guidance	PIFU and digital fracture clinic pathways in place with clinical advice & guidance solution being rolled out. PKB self management portal pilot being explored across the ICS
ensure that people can access and contribute to their health and care data	We have included these options within the Trust EHR Output Based Specification
ensure that citizens have access to care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools	Our Digital Strategy sets out our plans to provide citizens with access to their integrated record across multiple providers in a simple and intuitive manner
have a clear digital inclusion strategy, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities	We have a close working relationship with our patient panel to ensure inclusivity

Success Measure 6 - Improve Care	
Health and care practitioners embed digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing.	
use data and digital solutions to redesign care pathways across organisational boundaries to give patients the right care in the most appropriate setting	Building of dashboards using qlik sense to allow real time data and dashboard access to perfect ward audits and Nerve Centre assessments to align quality improvement and celebration and sharing of good practice. This will also support the challenge from external moderators and inspectors such as CQC.
promote the use of digital tools and technologies that support safer care, such as EPMA and bar coding	Phlebotomy ICE- a single point of access for requesting Phlebotomy tests to reduce waste paper, duplication of tests and maintain patient safety alongside a clear electronic audit trail. JAC used for prescribing
provide decision support and other tools to help clinicians follow best practice and eliminate unwarranted variation across the entire care pathway	Implementation of the ward accreditation programme designs standards to eliminate variation across care pathways. The use of the Perfect warcd to support the ward audit programme and the ward accreditation programme on a digital platform supports compliance and transparency alongside the reductin of unwated varriation. Introduction of Alertive to support the standardisation of communication messaging and the removal of the bleep system. Perfect Ward being a digital platform suports easy access to audits and transparency to expectations. Policies and guidelines avalaible on the Intranet, with links to other systems such as Royal Marsden Manual of clinical Nursing, Antimicrobial Guide, Thrombosis and Anticoagulations guides and BNF.
provide remote consultations, monitoring and care services, promoting patient choice and sustainability	The use of remote consultations within outpatient clinics supported through patient choice, supporting patient flow within the trust- virtual fracture clinic, virtual wating room ED
enhance your collaborative and multidisciplinary care planning using an array of digital tools and services alongside PRSB standards	Introduction of standards for records keeping for both digital and paper platforms has reduced duplication of record keeping and supported good documentation and care planning on a range of digital platforms, supporting appropriate access to records to the right professional at the right point in time.

Success Measure 7 - Healthy Populations	
Organisations use data to inform their own care planning and support the development and adoption of innovative ICS-led, population-based, digitally-driven models of care.	
use data to inform care planning and decision making in your organisation	Qliksense and BI tools being developed to support use e.g e-Obs, Meds Management in ED Qliksense app
contribute data and resources to the ICS-wide population health management platform and use this intelligence to inform local care planning	ICS population health programme established and learning sets delivered during 2021. Plan being developed
support the implementation of new ICS-led pathways and personalised care models that use digital platforms to coordinate care seamlessly across settings	We are currently working on an ICS implementation for econsent, and reviewing options for a patient portal.
make data from your organisation available to support clinical trials, real-world evidencing and the development of AI tools	AI assurance board established 24 months ago.AGFA Lung cancer AI tool deployed 5 months ago. Project scoping underway with Uni of Herts around potential joint development opportunities
drive digital and data innovation through collaborations with academia, industry and other partners	UCLP, AHSN, ARU and Uni of Herts engaged in discussion around innovations and their adoption

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BOARD OF DIRECTORS:	**Trust Board (Public) 2022**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Audit Committee**			
REPORT FROM:	**George Wood –Committee Chair**			
DATE OF COMMITTEE MEETING:	**07 March 2022**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 Summary Internal Controls Assurance (SICA) Report	Yes	Yes	Follow up of recommendations underway.	The report detailed three audit reports finalised since the last meeting, one of which provided a 'Limited' level of assurance while two provided a 'Reasonable' level of assurance. Limited assurance was received for the audit of pre-operation assessment, reasonable assurance was received for Cancer and MDT and BAF and Risk Management. Follow up of recommendations is underway.
2.2 Draft Internal Audit Annual Report and Head of Internal Audit Opinion	Information item.	Yes	No	The Committee noted the opinion would be available for the Audit Committee in May. A number of audits are to be completed by 31 March 2022.
2.4 2022/23 Internal Audit and LCFS Plan	Yes	No	No	The Committee approved the 2022/23 Internal Audit Plan and the 2022/23 Counter Fraud Plan.
3.1 External Audit Progress Report and Planning Report	Information item.	Yes	Year end audit underway.	The external auditors provided an overview of expected risks identified based on initial planning procedures. A referral to the Secretary of State/NHS England/NHS Improvement under Section 30 and Schedule 13 of the Local Audit and Accountability Act 2014 will be made – this relates to the Trust meeting its statutory duty to break even.
4.1 Caldicott Guardian Annual Report	Yes	No	No	The report summarised the activities of the Caldicott Guardian in the last year. It was noted the audit of the DSPT received substantial assurance and the information governance training was at 95% prior to the 20/21 DSPT submission.
4.2 Draft Annual Governance Statement	Yes	No	No	The Committee reviewed the draft Annual Governance

BOARD OF DIRECTORS:	**Trust Board (Public) 2022**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Audit Committee**			
REPORT FROM:	**George Wood –Committee Chair**			
DATE OF COMMITTEE MEETING:	**07 March 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				Statement. The areas where year-end information was awaited were noted and would be included in the final version.
4.4 Waivers, Losses, Special Payments and Debt Write Offs	Yes	No	No	The Committee approved and recommended to the Board an amendment to the Standing Financial Instructions: - The current SFI's require a waiver form to be completed for each item of spend to the value of £500 if 3 quotes are not obtained. - The proposed amendment increases this limit from £500 to £10,000 which makes PAH consistent with the other ICS providers. Three quotes are still required. The Committee noted: - Losses in the reporting period, 1st November 2021 to 31st January 2022, totalled £196k. - 710 debts totalling £406k were put forward for write off - From 1st November 2021 to 31st January 2022 the Trust had raised 46 waivers worth £701,744.
4.5 Register Gifts and Hospitality	Yes	No	No	The Committee approved the updated Register of Gifts and Hospitality.

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Trust Board – 7th April 2022 **Item No: 7.4**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy – Chairman
DATE OF MEETINGS: **01.03.22 and 15.03.22**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in March

1 March 2022:

- Chaplaincy Development & Workforce Review
- ICE Phlebotomy deployment for phase 2
- National Support for Discharge Update
- Ward Accreditation Programme – PACE
- Pharmacy response to 'To Take Away' (TTA) medication turnaround requirements
- VCOD Update
- Selling Annual Leave
- Freedom to Speak up Report
- Patient initiated follow up (PIFU) update
- Recovery Dashboard
- Operational Planning
- Car Parking
- Gen Med Managed Service Contract – Sebia
- M10 financial performance

15 March 2022:

Due to operational pressures this meeting was reduced and reports were noted. Discussion occurred on the management of the business continuity incident.

- Quality Briefing
- Quality PMO report
- Briefing Paper: Commissioning for Quality and Innovation 2022/23
- Executive Children and Young People Board Report
- Staff Survey Results
- Significant Risk Register
- Recovery Dashboard
- Digital Strategy

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- SIRO Report
- Draft Internal Audit Plan 22/23

BOARD OF DIRECTORS:	**Trust Board (Public) 7th April 2022**			**AGENDA ITEM: 7.5**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**John Keddie – Committee Chair**			
DATE OF COMMITTEE MEETING:	**11 March 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Breast Fund Update	Yes	No	No	The Committee approved the following events; • Royal Parks Half Marathon • Bollywood Evening
2.2 Charity Update	Yes	No	No	The Committee approved the following proposals; • Tap to Donate Machines • Door Drop Appeal • Donor Appreciation Guidance • Spending of Restricted charitable funds discussed with a further paper outlining the approach to be presented to the next meeting of the committee. It was agreed the timeline targets for the spending of restricted funds would be removed from the proposal.
2.6 Charity Action Plan	Item for information	Yes	No	The report detailed the action plan for remainder of the financial year and 2022/23. It was noted the Charitable Funds Strategy was a work in progress and the action plan would bridge the gap until a working strategy was in place.
2.7 Charity Risk Register Update	Yes	No	No	The Committee noted the risk (relating to the butterfly hub) had been updated (scored at 8) and it would be closed by the end of March; with the completion of The Butterfly Hub. An additional reputational risk was noted around events taking place without fundraising team/committee being informed.
2.9 Annual Report and Accounts Timetable 21/22	Yes	No	No	The Committee approved the Annual Report and Accounts Timetable 2021/22.

BOARD OF DIRECTORS:	**Trust Board (Public) 7th April 2022**			**AGENDA ITEM: 7.5**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**John Keddie – Committee Chair**			
DATE OF COMMITTEE MEETING:	**11 March 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.10 Ernest & Young Resignation and Appointment of External Auditors KMPG	Item for information	No	No	The Committee noted the formal resignation of External Auditors Ernest and Young and the appointment of KMPG.

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Trust Board – 7 April 2022

Agenda item:	7.6
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Report on Use of Trust Seal 2021/22

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	This report sets out the use of the Trust Seal from 01.04.21 to 31.03.22. The Seal is used in order to execute a deed or agreement when required to do so by law, for example, the conveyance of land.								
Recommendation:	The Board is asked to note the report.								

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

Previously considered by:	N/A
Risk / links with the BAF:	BAF risk 5.1
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with Trust's Standing Orders. No impact on EDI.
Appendices:	N/A

7.6

The Princess Alexandra Hospital NHS Trust

1.0 Purpose

1.1 This report sets out the use of the Trust Seal from 01.04.21 to 31.03.22.

2.0 Background

i. The Common Seal of the Trust is held in a secure place by the Head of Corporate Affairs on behalf of the Chief Executive.

ii. The Seal is used in order to execute a deed or agreement when required to do so by law, for example, the conveyance of land.

iii. The use of the Seal is approved and signed by two Executive Directors who shall not be the originating officer.

iv. An entry of every sealing is numbered consecutively and entered into a register, which is available for scrutiny.

3.0 Use of Trust Seal

3.1 The following table sets out the use of the Trust seal during 2021/22.

Number	Date	Description	Signatories
01	6.12.21	Lease for first and second floor Galen House	CEO and DoF
02	27.01.22	Lease for first floor suite, Keats House	CEO and DoF

4.0 Recommendation

4.1 The Trust Board is asked to note the use of the Trust seal during 2021/22. .

Author: **Heather Schultz Head of Corporate Affairs**

Date: **31.03.22**