The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 6 April 2023 at 09.30 – 12:30
Venue: Kao Park Boardroom

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	17
09.35	**Patient Story: E-Consent – the positive impact of technology on patient experience**				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	19
10.05	2.2	CEO's report including: • COVID-19 update • ICS/ICB update	Inform	Chief executive	24
03 Risk					
10.15	3.1	Significant risk register	Review	Chief nurse	79
10.25	3.2	Board assurance framework 2022-23 *Diligent Resources: PAHT Board Assurance Framework 2022/23*	Review/ Approve	Head of corporate affairs	87
04 Patients					
10.30	4.1	Report from Quality and Safety Committee 31.03.23: • Part I • Part II – Maternity Oversight	Assure	Committee Chairs	91 97
10.40	4.2	Maternity: • Annual Maternity report • SI report	Approve	Chief nurse/ Director of midwifery	99 114
10.50	BREAK 1050-1100				
11.00	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Chief nurse	118
11.10	4.4	Learning from deaths (Mortality)	Assure	Chief Executive	127
05 People					
11.20	5.1	Report from People Committee 27.03.23	Assure	Committee Chair	134
11.25	5.2	Gender Pay Gap	Assure	Director of people	138

11.30	5.3	Staff survey results	Assure	Director of people	143
06 Performance/pounds					
11.40	6.1	Report from Performance and Finance Committee 30.03.23	Assure	Chair of Committee	167
11.45	6.2	Finance update	Assure	Director of finance	173
11.55	6.3	Integrated performance report	Discuss	Chief Information Officer	180
07 Strategy/Governance					
12.05	7.1	Report from Strategic Transformation Committee: 27.03.23	Assure	Chair of Committee	235
12.10	7.2	Report from Senior Management Team Meetings held in March 2023	Assure	Chair of Committee	240
12.15	7.3	Report from Audit Committee: 06.03.23	Assure	Chair of Committee	241
12.20	7.4	Corporate Trustee: • Report from CFC.17.03.23	Assure	Chair of Committee	244
08 Questions from the public					
12.25	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Any unresolved issues	Discuss	Chair/All	Verbal
	9.2	Review of Board Charter	Discuss	Chair/All	Verbal
	9.3	Summary of actions and decisions	-	Chair/All	Verbal
	9.4	New risks and issues Identified	Discuss	All	Verbal
	9.5	Any other business	Review	All	Verbal
	9.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	Verbal
12.30		Close			

Date of next meeting: 8 June 2023

The Princess Alexandra Hospital NHS Trust

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

Board Membership and Attendance 2023/24			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Non-executive director (SID)	George Wood	Chief Nurse	Sharon McNally
Non-executive director	Colin McCready	Chief Operating Officer	Stephanie Lawton
Non-executive director	Helen Howe	Medical Director	Fay Gilder
Non-executive director	Darshana Bawa	Director of Finance	Tom Burton
Associate Non-executive director	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Associate Non-executive director	Anne Wafula-Strike	Director of Strategy	Michael Meredith
Associate Non-executive director	Dr. Rob Gerlis	Director of People	Gech Emeadi
Associate Non-executive director	Elizabeth Baker	Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 2 February 2023 from 09:30 to 13:00

Present:	
Helen Glenister	**Vice Chair (VC)/Non-Executive Director (NED-HG)**
Hattie Llewelyn-Davis	Trust Chair (TC) (for item 2.1 only)
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Chief Nurse (CN)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Giuseppe Labriola	Director of Midwifery (DoM)
Laura Warren	Associate Director – Communications (AD-C)
Staff Story:	
Silpa Dhaneesh	Lead Professional Nurse/Midwifery Advocate (PNA)
Members of the Public	
Ann Nutt (for part)	Chair of Patient Panel
Amy Matheson	Medacs
Apologies:	
Darshana Bawa	Non-Executive Director (NED-DB)
Hattie Llewelyn-Davis	Trust Chair (TC) (for item 2.1 only)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Vice Chair (VC) welcomed all to the meeting, particularly Silpa Dhaneesh, Lead Professional Nurse Advocate (LPNA) who was present for the Staff Story. It was noted that the TC would leave the meeting after item 2.1 to attend an ICB meeting.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 01.12.22 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted.
Staff Story:	
1.6	The Chief Nurse (CN) welcomed the Lead Professional Nurse Advocate (LPNA) to the meeting. She informed members the role was fairly new to the organisation but ensured the

	voice of the organisation's people was heard and enabled them to have clinical supervision. The LNPA introduced herself and went through her presentation.
1.7	The role of the Professional Nurse/Midwifery Advocate was to provide clinical supervision for nurses/midwives and it aimed to facilitate a continuous improvement process which valued nurses/midwifes, built their personal and professional resilience and contributed to the provision of high quality care. Elements of the role included identifying the number of PNAs required to implement A-EQUIP model of supervision, selecting nurses for the PNA course, developing a structured framework for PNAs/Professional Midwifery Advocates (PMAs) and supporting the PNA team to implement the national and organisational objectives.
1.8	At PAHT there were currently 16 PNAs, with 14 nurses enrolled for the PNA course in 2022/23. The PNA course advert was currently live in TRAC to provide a new batch of candidates to enrol for 2023/24.
1.9	The LPNA informed members that she had been appointed as LPNA in November 2022. There were 9 PMAs in the organisation, with 4 midwives enrolled for the PMA course in 2022/23. Current data was recording 19 restorative clinical supervisions (RCS) and two career progression conversations.
1.10	Activities undertaken by the PNA team to date included a Band 6 Away Day where 52 nurses had received RCS, 12 PNAs had facilitated 4 sessions of RCS with very positive feedback via post RCS survey. There had been a 'trolley dash' in October 2022 where the PNA team had visited all inpatient/outpatient departments throughout the month. 121 nurses had participated with wellbeing hampers being provided to clinical staff during the dash.
1.11	The LPNA continued there had also been Wellbeing Weeks in ED and Locke Ward to improve staff engagement and promote morale. The next would take place on Charnley Ward.
1.12	In terms of newly recruited nurses the PNA service was being introduced to all with visible leadership to gain trust and improve engagement. RCS was implemented amongst new nurses and ongoing pastoral support provided for 12 months. Key rings were also provided to colleagues with a QR code which enabled easy access the PNA service. There was a Career Clinic and PNA forum run on the first Wednesday of every month which had started in November 2022.
1.13	Data from August 2022 to January 2023 was showing 121 RCSs, 31 (group) and 90 (1:1). 266 nurses had received RCS and there had been 100 career progression conversations. Feedback to the team was excellent in terms of career progression, personal crisis and pastoral support.
1.14	As a final point the LNPA confirmed there were no current models for AHP colleagues but that was being considered in the hope there would be something in place in the very near future.
1.15	The VC thanked the LPNA for her presentation and handed over to Board members for questions.
1.16	Associate Non-Executive Director Rob Gerlis (ANED-RG) asked whether the remit of the PNA included collaborative team-working between doctors and nurses. In response the LPNA confirmed that was one of her objectives.
1.7	The CEO thanked the LPNA for her presentation and commented that the support services on offer were fabulous. He asked whether all colleagues were aware of the service on offer. In response the LPNA commented she had tried to spread the word amongst nursing colleagues via email and comms. She had also walked the wards and talked to staff but she acknowledged there were still gaps particularly as Band 5 nurses had very little time to read emails/comms. Any Board support with that would be very much appreciated. The CEO responded that the Board would be happy to support that and he would now consider how that could be done.
ACTION **TB1.02.02.23/35**	**Consider what Board support could be provided to the PNA service to spread the word in terms of the service/support available to staff.** **Lead: CEO/Chief Nurse**
1.18	NED Helen Howe (NED-HH) introduced herself as the NED Wellbeing Champion and asked the LPNA about her relationship with the Trust's Staff Health & Wellbeing (SHaW) team. She

	reflected that the role of the PNA was very professional, but often staff had varying concerns including those that were more personal to them for example housing/their finances. In response the LPNA confirmed that she was working well with the SHaW team for the good of all nurses and was herself part of the Steering Committee so she was aware of what was going on in terms of support for colleagues. The SHaW team attended the PNA sessions too to highlight the services on offer to staff.
1.19	The Director of Quality Improvement (DoQI) commented that he very much welcomed the great work that was being undertaken by the team. He asked how specialist nurses were included in the support. In response the LPNA recognised that the work to reach specialist groups was progressing slowly and some felt they were part of a minority. The Palliative Nursing team had however reached out to the service so the word was starting to get out and the focus would continue on that cohort of nursing staff.
1.20	At this point the CN flagged the service on offer was an amazing one but acknowledged it was somewhat of a slow burn in terms of getting the word out to colleagues. All Band 6s had received RCS from the PNAs and all ward manager/ADoNs were aware of the offering. She agreed not all specialist nursing groups had yet been reached but now the organisation had appointed non-medical consultants that should support a greater level of supervision.
1.21	The Chief Operating Officer (COO) then flagged there had been absolute learning for her from the presentation in terms of themes that could be applied to operational teams where there was no such forum for that cohort of staff to come together. For her there was also something about reaching out to the other hospital sites at Epping and Bishop's Stortford. In response the LPNA confirmed the work had not yet reached other sites but a couple of nurses from SMH had enrolled in the programme and she hoped on completion they could start undertaking supervision at SMH.
1.22	At this point the Trust Chair (TC) asked what support the LPNA herself was receiving. In response it was confirmed that the CN and Deputy CN had both been very supportive. There was always more that could be done but currently she felt very supported by senior colleagues. The CN flagged that it would be important that the PNA team did not become overwhelmed once word of the service was fully communicated. .
1.23	The VC asked if there were plans for a similar service in other professions. In response the Director of People (DoP) confirmed that SHaW/LPNA/junior doctors were currently working on that. In terms of the point raised earlier by the COO the organisation was about to launch its Development Programme for Managers which would provide an element of support. She acknowledged that was first steps and there was lots more to do.
1.24	NED George Wood (NED-GW) highlighted that the service should, in his view, support recruitment and retention and he asked if there was any data to support that. In response the LPNA confirmed it was too early to glean any such data – perhaps in another 12 months. She emphasised however there were other current issues such as the cost of living and being near to London which impacted on both.
1.25	NED-GW then asked about staff morale. In response the LPNA confirmed it was a bit low due to staffing gaps but her view was it had improved since the previous year and would hopefully go on improving.
1.26	ANED Liz Baker (ANED-LB) asked what took up most of the role/time. In response the LPNA confirmed that was RCS and conversations with staff. Her preference was to go out to the wards in person to chat with colleagues face-to-face. She could undertake RCS on a group or individual basis and the most satisfaction came from the positive feedback she received afterwards.
1.27	The VC thanked the LPNA for her uplifting and very positive presentation.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC introduced her report and the paper was taken as read. Two key headlines to note were: • The process to recruit a new NED (replacement for NED-HG) had received a promising response.

	• Visits to St. Margaret's Hospital and Herts & Essex Hospital were now being considered as part of the suggested walkabouts to community services and a themed 'dementia' walkabout was also being considered across a couple of wards.
The Trust Chair left the meeting.	
2.2 CEO's Report	
2.2	The CEO presented his update and the paper was taken as read. The three key points to note were: • **Electronic Health Record (EHR):** The organisation's FBC for a new EHR had received formal approval from the frontline digital investment board of NHSE/I with agreement for £24m of investment into a new solution. It was hoped that the contract signing would now follow over the coming week to implement the Cerner solution. This was a key plank of the Digital strategy, one of the five strategic priorities to the delivery of PAHT 2030, and would transform how patient information and data was captured and how it was integrated to enable the organisation to transform many its processes to improve the efficiency and effectiveness of clinical colleagues and speedier decision making for the benefit of patients. • **ICS-wide Pathology Procurement:** Following December Board approval of the Full Business Case for outsourced pathology services across the ICS, the other two acute Trust Boards and the Integrated Care Board had also now approved the FBC. A contract with the third-party supplier would be signed by all contracting authorities in February, enabling the commencement of a nine month mobilisation period. It was expected that services would transfer in late 2023. • **Nitrous Oxide Use in Maternity:** Following atmospheric testing throughout the maternity unit, high levels of residual nitrous oxide (gas and air) were discovered in a number of locations in the unit on 19.01.23. Following discussions with clinical and engineering colleagues the difficult decision had been taken to temporarily suspend the use of nitrous oxide across the unit to protect and midwifery and medical teams from prolonged exposure. This had been discussed with all staff and support from the SHaW team was being provided to colleagues should they want it. The clinical risk to women and their babies was low and a full range of other pain relief options were available. A permanent solution to fix the problem of residual high levels had been determined which would be in place from the end of February and a temporary solution for a number of birthing rooms which would be in place from the week beginning 06.02.23.
2.3	In response to a question from ANED-RG in relation to the use of nitrous oxide it was confirmed other organisations were now experiencing similar issues. The organisation had a Medical Gas Lead and delivered against HTMs (health technical memoranda) which specified how often air changes needed to take place. The standards in relation to nitrous oxide were new and not contained within current HTMs. Long-term exposure (by staff) to nitrous oxide had the potential to reduce vitamin B12 levels.
2.4	ANED-RG then raised a further question in relation to the recent visit by Sir Keir Starmer/Angela Rayner. In response the CEO confirmed it had been an opportunity to talk through the current local, place and system pressures faced by the organisation, the need for a new hospital and how health and care was developing in Harlow and West Essex. Both had walked the urgent and emergency care pathway, spent time talking to colleagues and patients in ED and SDEC, before spending time with EEAST colleagues at Harlow Ambulance Station. Plans for mental health services and Patient @ Home service had also been highlighted.
2.5	ANED-LB then asked about the position, compared to the previous year, in terms of the treatment and management of COVID, and how that had changed. In response the CEO confirmed COVID numbers remained pretty high (54 as of the previous day) and management of the disease had changed in line with the national vaccination programme and in terms of the virulence of the strain. Currently many of the COVID positive patients were being managed for other health conditions, not COVID. Operationally the red ED had just been closed down which was a significant change and teams were working closely with

	ED and IPC colleagues to manage patients safely through the ED to mitigate the risks of cross-infection.
2.6	The CN continued that 12 months previously all patients were swabbed for COVID but now that was only the case for symptomatic patients. She recognised the public was now fatigued in terms of COVID and mask wearing but the hospital was still managing COVID on a daily basis so needed to maintain its protocols around hands/face/space and ventilation. Masks were now only required in certain areas of the building. Patients were now managed on different wards rather than on 'COVID wards' and staff were more comfortable managing them. Currently Norovirus was a bigger issue for the organisation than COVID.
2.7	The COO updated that COVID numbers were up and down and that was mirrored across the region. She agreed Norovirus was a bigger issue currently. The Medical Director (MD) added that being up to date with clinical practice was key and she worked closely with the Trust's Clinical Lead for COVID in terms of delivering the most up to date therapies.
2.8	In response to a question raised by NED-GW in relation to the management of nitrous oxide in another Trust, the CEO was able to provide assurance that staff anxieties had been robustly managed by the service triumvirate and access offered to staff health and wellbeing support including vitamin B12 testing. There was a clear process in place to monitor and manage exposure levels going forward. The Freedom to Speak Up service was in place for staff if concerns needed to be raised. As soon as it was realised the levels were high, immediate actions had been taken. Staff had not knowingly been put at risk.
2.9	In response to a question from ANED Anne Wafula-Strike (ANED-AWS), the CEO confirmed that Labour Party colleagues had appeared to understand the current pressures faced by the hospital and that any opportunities for investment in a new hospital needed to be taken forward at every point. NED-HG there had been much local media coverage of the visit which would raise the hospital's profile and need for investment. ANED-AWS commented the public did not always get to hear the headlines following such visits. NED-HG suggested some thought be given to general communications in terms of what could be shared. In response the CEO stated his view would be the outputs of the visit had been shared widely.
2.10	Going back to the nitrous oxide issue, ANED John Keddie (ANED-JK) asked whether all other potential medical gas risks across the Trust had also been covered off. In response the DoS confirmed this was a very complex environment in which to work. Requirements changed rapidly and the view was the organisation had responded very rapidly in terms of removing nitrous oxide for the environment. The CEO added there was a planned testing programme for all medical gases which would be continuously reviewed.
2.11	The VC summarised by confirming that the update had been noted.
03 RISK/STRATEGY	
3.1 Significant Risk Register (SRR)	
3.1	This paper was introduced by the MD and presented the significant risk register (SRR) for all services. It was a snapshot of risks across the Trust and had been taken from registers on 4.01.23/24.1.23.23. The paper included all items scoring 15 and above. The overall number of significant risks on the register had reduced to 73, a reduction of two from the last paper, with a reduction from 13 to 11 in risks scoring 20.
3.2	The MD drew members' attention to section 3.1 and the increase in the score relating to discharge information sent to GPs in relation to patients' TTAs. COSMIC and the electronic prescribing and medication administration system did not interface with one another so a group was now working to understand a potential solution prior to the new EHR implementation.
3.3	Attention was then drawn to the increase in score for achievement of the ED four hour emergency standard leading to patients waiting longer than they should be with the knock-on effect of overcrowding in the ED.
3.4	The MD also flagged the risks around insufficient medical staffing numbers working in the acute medicine department and high numbers of nursing vacancies resulting in delayed care and treatment in the Adult Assessment Unit.

3.5	In response to the above, NED-CM asked whether the new EHR solution would solve the issue around discharge information for GPs. In response the MD confirmed it would and in the meantime a huge number of actions were in place to improve the position. The Chief Information Officer (CIO) added that the current EHR provider had been unable to provide a solution (because the organisation was now in the 'maintenance' phase of its contract with them).
3.6	In response to the above ANED-RG asked whether there was GP representation on the group tasked with addressing the issues. In response the MD confirmed there were two different challenges. The first was getting the information to the right person and the second was the explanation. The issues had been raised by the organisation's incident management process.
3.7	ANED-RG then drew members' attention to the risk around obstetric consultant cover achieving 90 hours per week and asked at what point women may be directed away from the hospital. In response the CEO provided assurance that would not happen. A new consultant obstetrician had been appointed and a robust recruitment plan was in place for the service. There were currently four different posts out to advert, the first of which had been appointed to earlier that week. He recognised the role of 'resident on-call' was challenging, but that was currently being addressed.
3.8	In response then to a question from NED-HH it was confirmed there were just under 4k deliveries in the maternity department annually and as a result the Trust was not expected to provide 98 hours of cover. NED-HH then commented that the organisation was therefore compliant in terms of obstetric cover. In response the MD confirmed she had challenged the wording of the risk because she agreed the organisation was currently compliant.
3.9	In response to the above the CEO highlighted that the organisation wanted to provide the best care that it could and was eight hours away from achieving 98 hours cover (for units with annual births between 4k and 5k) with more appointments to be made.
3.10	The CN provided assurance the issue had been discussed at QSC (Part II) with agreement that a deep dive would be undertaken and discussed on medical staffing (alongside midwifery staffing) at its February meeting.
3.11	The VC summarised by stating that the SRR had been presented for information and assurance and no particular actions had emanated from the discussion that day.
3.2 Board Assurance Framework (BAF) 2022/23	
3.12	This paper was presented by the Head of Corporate Affairs (HoCA) who informed members it was proposed to add a new risk to the BAF that month with a score of 20. The risk related to the GMC enhanced monitoring process. The MD was the executive lead for the risk and the People Committee was responsible for its oversight.
3.13	In line with the recommendation the Board was content to approve the wording of the new risk (2.1 GMC Enhanced Monitoring) and it also noted the updates to the remaining risks.
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	<u>Report from QSC.25.11.22</u> This report was presented by the VC as chair of QSC. She informed colleagues the Committee had been unable to review the organisation's mortality indices due to recent coding issues but was reassured the data should be available for its February meeting. The meeting had received the usual escalation reports from its feeder groups with a specific escalation flagged in terms of the Trust's participation in audit, particularly in the core diabetes audit. The Clinical Effectiveness Group had therefore made a request for evidence to be provided that participation was taking place and there was learning. Confirmation had been provided at the meeting that e-consent would now move to amber and that the organisation's Mental Health Strategy would be monitored by the Vulnerable People Group moving forward. A deep dive into ambulance handover had been presented and the annual summary of NHS Blood and Transplant Organ Donation activity was presented which was a good news story with no associated missed opportunities. The MD added that the latter was

	a requirement in terms of Board oversight and was pleased to confirm that a new Clinical Lead for Organ Donation had now been appointed. The Organ Donation Committee would also be stood up again from April.
Giuseppe Labriola – Director of Midwifery invited to the table for maternity items.	
4.2	QSC2.25.11.22 (Maternity Oversight) ANED-RG as chair of the Committee informed members the discussion had included staffing issues, the intermittent closure of the birthing unit, assurance in terms of serious incidents, compliance with the Saving Babies Lives care bundle, and update from the HSIB and a discussion on the recent issues with nitrous oxide. The Committee had also reviewed the evidence of compliance with each of the ten Safety actions of the Maternity Incentive Scheme (MIS) Year 4, including non-compliance with Safety Action 1 and had approved the submission and recommended the Board endorse that decision.
4.2 Maternity Updates	
4.3	Maternity Incentive Scheme (MIS) Year 4 Final Report and Evidence Submission The DoM introduced the paper and informed members that the next four papers had all previously been presented to QSC (Part II). In terms of the MIS paper, this was the fourth year that NHS Resolution were operating the Clinical Negligence Scheme for Trusts (CNST) to support the delivery of safer maternity care and the Trust needed to demonstrate achievement of all the 10 safety actions to recover the element of the CNST maternity incentive fund contribution. The paper outlined the requirements of the scheme, assurance framework and summarised the evidence of achievement against each standard, including, importantly, non-compliance with Safety Action 1.
4.4	In terms of Safety Action 1, the Trust had completed a review and assurance deep dive into its PMRT processes in October 2022 and it was at that point that discrepancies were identified in relation to what had been completed locally and what had been documented on the MBRRACE PMRT reporting page. It had since transpired there had been various issues which had led to the online system not being updated correctly despite the required actions having taken place by the Trust and it being compliant with the process. Other trusts were in a similar position. A panel had then been held with Executive/ICB colleagues on 03.01.23 and following review of evidence the Trust would be declaring non-compliance with Safety Action 1.
4.5	In response to the above the CEO drew members' attention to the fact that declaring non-compliance with one of the actions would mean a reduction in the amount of the money the organisation would receive and this had not been factored into the current financial forecast. The organisation would need to wait until the end of March to receive notification from NHS Resolution on how much it would receive.
4.6	In line with the recommendation the Board approved the report and accompanying evidence that had been submitted to demonstrate compliance with nine of the ten maternity safety actions and agreed to sign-off of the Trust Board Declaration Form.
4.7	SI report (November data) The DoM informed colleagues that the key headline was that one SI had been closed in-month. Points of learning were in relation to cross-border working and he was pleased to inform the Board that a workforce lead for maternity was now in post and was reviewing this. He had met with her earlier that week and the plan was to establish a working group to drive this forward.
4.8	Q2 Perinatal Mortality Review Report (PMRT) (quarterly) The DoM informed members that the format of the report had changed slightly to provide assurance to Quality & Safety Committee (Part II) on timeframes and progress. The report covered the same period as the MIS, so there were some red-rated items.
4.9	Maternity Assurance Report The DoM drew members' attention to the Ockenden aspects of the paper and informed colleagues that a task and finish group had been established to determine for which of the 'essential' actions, the service was already compliant.

4.10	NED-GW raised a concern in relation to the SI report and the lack of resuscitation equipment in main theatres. In response the DoM was able to confirm that the woman in question had arrived via the ED so had gone directly to main theatres (not maternity theatres). Work was underway with the Resuscitation team in terms of the communication with the ED.
4.11	At this point colleagues were commended for the positive progress in terms of the Ockenden recommendations and also for the huge amount of work in terms of compliance with nine of the ten MIS safety actions.
4.12	NED-HH highlighted the positive work of QSC (Part II) and in particular the value added by the presence of external colleagues whose support was invaluable.
4.13	Going back to the conversation around CNST monies, NED-GW asked whether the risks around this should be built into the financial forecast. In response the DoF confirmed the finance team would be reviewing their risk appetite to forecasting going forward.
4.14	In response to a final question from NED-CM in relation to Ockenden 'immediate action' 7, the DoM confirmed some work had been done around the organisation's website and there was a plan in place to achieve a 'green' rating on that action very soon.
Break 1053-1105	
4.3 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.15	This update was presented by the CN and new format of reporting (in line with national guidance) was noted. She informed members that overall fill rates for December had been 89.7% with registered nurse (RN) fill rates decreasing by 5.5% to 85.2% and those for care staff by 5.4% to 89.7%. This was in line with additional escalation areas being opened and increased sickness from COVID/'flu. Nightingale, Henry Moore, Tye Green and Dolphin Wards had all reported average fill rates below 75% for RN against the standard planned template in-month. This was the fourth consecutive month where overall fill rates had been below 75% for Tye Green Ward.
4.16	In response to a question from ANED-RG around the effect of long-COVID on staff, the DoP was able to confirm a programme was in place with ICB colleagues to support that. In terms of the impact of sickness on staff overall, the CN confirmed it was key to ensure health and wellbeing support programmes were in place for staff and links into the People Business Partners.
4.17	At this point the CEO flagged that the organisation's sickness rates were only 0.2% higher than the average for the region (5.5% on average) for all staff.
4.18	The VC summarised by stating the dip in December was noted, there would likely be a dip in January too, but that going forward a strong pipeline of new nurses was in place.
4.4 Nursing Establishment Review	
4.19	This paper was presented by the CN and reported the recommendations following the nursing establishment review (September 2022). The review recommended changes in demand for qualified nurses (reduction of 8.62WTE) and an increase in demand for healthcare support workers (HCSW) (4.8 WTE). In line with changes to the national role profile and banding of HCSWs, the paper recommended the net savings (£244k) be used to part fund the required uplift from Band 2 to Band 3 for HCSWs. A paper detailing the proposed changes and full costings would be presented through the appropriate channels. The recommendations had already been presented to, and endorsed by the Performance & Finance Committee and the People Committee.
4.20	In response to the above NED-HH commented it was important to see the picture in terms of the wider team and her regret was a similar exercise was not undertaken for medical staff. In response the MD was able to confirm that on occasions recommendations were made around medical staffing but there was no agreed template as such. HEE had been tasked to undertake a review of medical workforce. At this point the COO flagged that the work undertaken by the Associate Directors of Nursing on the nursing review should be noted.
4.21	In terms of staffing overall, ANED-RG asked if any progress was being made on housing/accommodation for staff. In response the DoS updated that discussions had begun

	around this and the good news was the town had just received £20m for redevelopment which may provide the opportunity to provide some affordable keyworker housing. The issue was one that was well recognised and was being worked on in conjunction with partners in an endeavour to resolve. The DoP added that the ICB People Strategy had been approved, one element of which was accommodation. Outputs of conversations would be reported via the People Committee. In response then to a point made by NED-HH in terms of the issue having been raised at Staff Induction, the DoP confirmed that the ICB had responsibility with local councils to establish an estate strategy because some existing buildings were not currently being used to maximum benefit.
4.22	In response to the above and to provide some additional assurance the CEO confirmed that discussions were underway around housing but the Trust could not resolve the issues alone and would need the support of partners to find the right solutions. He acknowledged that international colleagues were now staying longer and the environment in Harlow had changed significantly so the picture was complex. In summary work was underway but the solution would not be swift and this was completely outside the remit of NHS capital.
4.23	In response then to a question from ANED-AWS, it was confirmed that international nurses were provided with an initial six months' of housing on joining the organisation but admittedly when that expired there was little affordable housing available to them.
4.24	In line with the recommendation the Board supported the outcome and recommendations of the nursing establishment review.
4.5 New Visiting Arrangements	
4.25	The CN presented this paper and reminded colleagues that post-pandemic the visiting arrangements on adult inpatient areas had been fragmented and subject to local variation which was causing unwarranted communication issues. The senior nursing leadership team had agreed that a return to pre-pandemic visiting hours of 15:00-17:00 and 19:00-20:00 did not meet the aim of putting the patient at heart, improving communication with next of kin/relatives and was too restrictive. An engagement programme had therefore been undertaken to scope new visiting arrangements and the paper presented that day described that and the associated recommendations.
4.26	The CN recognised there had been anxieties expressed in terms of what longer visiting hours would mean for issues such as protected mealtimes and for care and this had led to the Visitor Charter which was part of the paper. Her view was it would be a positive move.
4.27	In response to a question from NED-GW, the CN stated that she believed visiting hours across the NHS as a whole were variable and in response to a question from the VC she informed members that the new arrangements had gone live on Monday that week.
4.28	In line with the recommendation the Board approved the new Visitors' Charter and the new arrangements for visiting between 09:00-20:00 in line with those currently in place on AAU and Charnley Ward.
4.6 Learning from Deaths Update	
4.29	This update was presented by the MD. She informed members that mortality indices were still not available due to the delay in coding patient records but mortality data for the Trust was expected to be available for April Board. However, she had just been informed that fully coded data for September was now available and was placing the organisation at 'as expected'. Some deep dives would now follow into a couple of outliers.
4.30	The VC summarised by stating that the current position in terms of data was noted, and the initial headlines around the September position were good.
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	This update was presented by NED-HH as chair of the PC and key headlines were as follows: • Agreement to cover retention in greater detail at the March meeting. • EDI to move to amber in terms of PAHT2030 targets.

	• PC assured around the processes and actions in place to address the 'over working' issues presented in the Guardian of Safer Working report and noted that Divisional Directors now had oversight of the data and issues being raised. • Progress in terms of the results of the GMC survey would be monitored via the Junior Doctor Committee/Medical Education Committee and GMC Enhanced Monitoring Group. • The Health & Wellbeing Update provided some insight into the current issues relating to nitrous oxide. • In terms of learning and OD, the Trust Chair was considering how to bring 'This Is Me' in NED appraisals. • The Voluntary Services Strategy was due in March.
5.2	In response to a question from ANED-RG, the MD was able to confirm that the GMC enhanced monitoring process was likely to span two years because it would be key for the organisation to provide evidence of sustained improvement.
5.3	In response to the headlines above, the DoQI emphasised that the PAHT2030 culture work-stream was delivering good outcomes albeit EDI had reverted back to amber.
5.4	In response to a question from the VC in terms of how many volunteer slots the organisation currently had, the CN confirmed that would be defined in the Voluntary Services Strategy.
5.2 Freedom to Speak Up (FTSU) Report	
5.5	This report was presented by the DoP and provided analysis on the Trust's FTSU data. It highlighted themes of concerns raised up to Q3, attempted to identify any gaps in groups not speaking up, what actions were being taken to address concerns and triangulated information from other feedback mechanisms.
5.6	The DoP continued that 'behaviours' continued to be the main reason for staff speaking up and patient safety concerns the lowest reason – this was being looked into to determine whether it was due to safety incidents being recorded on Datix. The 11 new FTSU Ambassadors (all from different areas) were highlighted.
5.7	At this point the VC highlighted that she would be handing over the baton of NED FTSU champion to ANED-LB prior to her departure in March. The role was very much about checking-in and providing support.
5.8	In response to the above ANED-AWS asked whether there was a mechanism available to raise concerns anonymously, for example a suggestion box. In response the DoP confirmed this was used in some areas but the key for her was ensuring concerns were addressed quickly and making sure colleagues were aware of all the routes available to them. Other routes included Datix, Guardian of Safer Working and the Professional Nurse Advocates. NED-HH added that FTSU was touched on at induction to provide awareness.
5.9	The DoP flagged that the case raised under item 3.5 had now been resolved and the Managers' Induction Programme would emphasise the organisation's 'no blame' culture.
5.10	As a final point NED-HH commented that future iterations of the report would include benchmarking from and lessons learned from the National Guardian's Office. The DoP noted that at the time the report was prepared, the National Guardians Office had not published any lessons learnt.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	NED-CM introduced the paper as chair of PAF and key headlines from January PAF were as follows: • There had been a detailed conversation around the current financial position but acknowledgement it was not where the organisation wanted to be. • The CIP programme had now been renamed 'Patient Quality and Productivity' (PQP) programme and colleagues had presented their plans for delivery in the coming year. • An update on planning guidance had been provided and how that would play into business planning.

	• PAF had approved the nursing establishment review and discussed the finance modernisation programme and the further work required on the options piece. • PAF had discussed business continuity in terms of the recent burst water pipe on site, d how the organisation had responded well and there had been less impact that had originally been anticipated.
6.2	As a final point the DoF confirmed he would bring a forecast update to the next Board including an update on CNST monies.
6.3	The VC summarised by stating that she very much welcomed the reframing of the cost improvement programme to PQP, the new title for which she felt would be more accepting for clinicians.
6.2 Finance Update	
6.4	The DoF introduced this update and apologised that the wrong appendix had been attached which he would rectify following the meeting. He informed members that the Trust had reported a deficit in M9 of £1.6m and a £14.5m deficit year to date. To land a position in line with the forecast of £14.2m at year end, significant non-recurrent support would be needed in-year.
6.5	The VC thanked the DoF for his update.
6.3 M9 Integrated Performance Report (IPR)	
6.6	This update was presented by the CIO and the three key points to note were: • A continued reduction in complaints (in common cause variation) and evidence of the good work underway despite the pressures on all services. • In terms of sickness the second data point was in special cause variation which triangulated very much with the nursing establishment paper, pressures on services and the gaps in staffing. • Diagnostic services in common cause variation but downward trends seen. Mitigations in place in a couple of specialties but remaining in common cause variation with actions in place.
6.7	For the benefit of members of the public present, the VC highlighted that the report had already been presented to Board Committees and relevant areas discussed in more detail.
6.8	As a final point the CN flagged that she had heard the previous day that the organisation had been awarded gold standard by UNICEF for its work around breast-feeding. She congratulated the breast-feeding and wider teams on their approach. It was agreed a congratulations card would be sent to the team.
ACTION **TB1.02.02.23/36**	**'Thank-you' card to be sent to the Breast-Feeding team.** **Lead: Board & Committee Secretary**
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	This update was presented by ANED-LB as chair of STC and the key headlines from the January meeting were: • STC had discussed its effectiveness review and recommendations. It had been agreed to meet bi-monthly with immediate effect and the next meeting would take place in March 2023. Further discussions would take place regarding the attendance by Place directors and the Committee's terms of reference would be updated on completion of those discussions. • Digital Health and Our Culture strategic priorities were meeting their delivery plan actions and were RAG-rated green. Transforming Our Care and Corporate Transformation strategic priorities were at risk of delivering within the original timescales and rated amber. Our New Hospital strategic priorities carried significant risk of delivery within the original timescales and were rated red. • Going forward the Committee would receive updates on PQP.

7.2 Report from Senior Management Team (SMT)	
7.2	The CEO presented this paper was noted the key items discussed at January meetings. Members had no comments.
7.3 Corporate Trustee: The Princess Alexandra Hospital Charity strategy 2023 - 2028	
7.3	The strategy was presented by the DoP who highlighted it was a five year strategy for the charity. It had been through a full engagement process and had been endorsed by the Charitable Funds Committee (CFC). It was presented that day for Board approval with the caveat it required some fuller debate.
7.4	As chair of CFC, ANED John Keddie (ANED-JK) informed members there was a continuing drive to make the charity a vibrant part of the hospital but there was still work to do. Part of the recommendation was further investment in the structure of the charity and it was important to recognise that those positions supporting the charity would now be substantive and funded by the charity. Revenue streams needed to be increased and the strategy showed commitment to investment and Board approval was sought that day.
7.5	NED-GW raised concerns that the charity had not tapped into NHS charities money, there was no reporting into CN role (linking in to patients) and there was no clarity in the strategy in terms of what the organisation was fundraising for. It was also suggested that the committee consider broadening its membership to include external members.
7.6	In response the CEO commented he agreed in terms of a focus for fundraising and he had discussed this with the Trust Chair outside the meeting – some suggestions included fundraising for dementia friendly areas.
7.7	The CEO continued that the strategy, as stated previously, was a five year one and there would be opportunities over the next six months to work through the detail and agree the right time for further expansion/development.
7.8	NED-HH commented her view was there were positive first steps in terms of substantive posts being funded directly from the charity. It would be useful to consider using volunteers in the work who had experience of applying for grants and maybe other NED colleagues who were involved in local town's groups.
7.9	In line with the recommendation the Board approved the strategy.
7.10	As a final point ANED-JK flagged that some minor governance anomalies had been identified which would be addressed and he requested thanks go to the outgoing Head of Charity for all his hard work on the strategy.
7.4 PAHT Governance Manual	
7.11	The DoF introduced the paper and informed colleagues that the paper set out the changes made to the Governance Manual following review by members of the Finance team and the Head of Corporate Affairs. The Board was asked to note the changes and approve the Manual.
7.12	The DoF flagged that the changes to SFIs were listed in section 3.0. He confirmed approval limits had been simplified to bands in terms of being equitable. In the majority of cases, very little spend would be approved outside the Procurement team. Any agreements outside of budget limits would be overseen by SMT. The intent was not to slow down the process and to be agile so colleagues could get on with their work.
7.13	At this point the DoF raised it had been highlighted by colleagues that the issue of direct engagement for staff had not been identified in the SFIs. NED-HH had suggested it may be worthwhile emphasising the rules around engagement with agencies and to build that in. As part of business planning, one area highlighted in NHS contracting guidance was around use of agencies and additional rules were being built in but that would not fundamentally change the application of the SFIs. If colleagues were in agreement he would build that in.
7.14	At this point the HoCA flagged three areas that had been brought to her attention by NED-GW; a typo in the scheme of delegation, addition of ICB in the glossary and clarification on the role of the NED in relation to security management.

7.15	The DoS requested that clarification in terms of large contract works where procurement had taken place off a framework without full competition and how frameworks could be used in different circumstances. The DoF agreed to include that.
ACTION TB1.02.02.23/37	**Provide some clarification in the Governance Manual on the use of frameworks for large contract works. Lead: Director of Finance**
7.16	In response to a request from NED-CM it was agreed to circulate a copy of the manual to both him/NED-GW which showed the previous narrative prior to amendment.
ACTION TB1.02.02.23/38	**Circulate a copy of the Governance Manual to NEDs GW/CM showing the previous narrative prior to amendment. Lead: Director Finance**
7.17	In line with the recommendation, the Board approved the changes to the Governance Manual with the caveat that some additional changes/inclusions had also been requested that day and would be included.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are noted in the shaded boxes above.
9.2 New Issues/Risks	
9.2	The risk around the uncertainty of CNST monies in relation to the financial outturn was noted as a new risk.
9.3 Any Other Business (AOB)	
9.3	The CN informed colleagues that the Deputy CN would be retiring in April and she was delighted to report that the current Director of Midwifery (DoM) had been appointed to the role. The DoM role would now go out to advert.
9.4 Reflections on Meeting	
9.4	It was agreed that the Trust's values had been kept at the forefront of discussions that day. NED-HH reflected in particular that the Board was operating as a unitary board in that much of the discussion had already taken place at Board Sub-Committee level.

Signed as a correct record of the meeting:	
Date:	02.03.23
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 06.04.23

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.10.22/20	Staff Story: "Asiya's Story"	Consider sharing the Staff Story with the ICS.	TC	TB1.02.02.23	TC referred to ICB chair as requested.	Proposed for closure
TB1.01.12.22/31	Board Development: Learning from East Kent Hospitals' Report	Draft an agenda for a Board Development session in the new year (date to be determined).	TC CN HoCA	TB2.06.07.23	To run in July in conjunction with the session around Culture. Item not yet due.	Open
TB1.01.12.22/32	Culture	Undertake a Board Development session around culture.	DoP	TB2.06.07.23	Item not yet due.	Open
TB1.02.02.23/35	Professional Nurse Advocate	Consider what Board support could be provided to the PNA service to spread the word in terms of the service/support available to staff.	CEO CN	TB1.06.04.23	Comms strategy to ensure the PN/MA service receives a regular awareness push through our channels.	Proposed for closure
TB1.02.02.23/36	Breast Feeding Award	'Thank-you' card to be sent to the Breast-Feeding team.	B&CS	TB1.06.04.23	Actioned.	Closed
TB1.02.02.23/37	Governance Manual	Provide some clarification in the Governance Manual on the use of frameworks for large contract works.	DoF	TB1.06.04.23	Actioned.	Closed

ACTION LOG: Trust Board (Public) 06.04.23

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.02.02.23/38	Governance Manual	Circulate a copy of the Governance Manual to NEDs GW/CM showing the previous narrative prior to amendment.	DoF	TB1.06.04.23	Actioned.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 6 April 2023

Agenda item:	2.1								
Presented by:	Hattie Llewelyn-Davies								
Prepared by:	Hattie Llewelyn-Davies								
Date prepared:	30th March 2023								
Subject / title:	Chair's Report								
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**		
Key issues:	To inform the Board and other colleagues about my work; to increase knowledge of the role; to evidence accountability for what I do.								
Recommendation:	The Board is asked to note the report.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				

Previously considered by:	Not applicable
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below. The recruitment of the new NED for the board was a full recruitment process following EDI best practice.
Appendices:	None

1.0 Purpose/issue

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

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

2.0 Succession Planning for Non Exec Members and Board Development:

This report begins with the sad acknowledgement that this will be Helen Glenister's last meeting as a NED at PAHT. Helen has been the backbone for the Board for as long as I have been a member of the Board. She has been interim chair of the Trust, my vice chair, chair of our quality and safety committee and has numerous other roles including our maternity and neo-natal safety champion. Helen has brought to her various roles enormous energy, commitment and great knowledge of the NHS. More than all of these things, she has been a wise voice of constructive challenge throughout her time on the board, often reminding us of the human side of things. On a personal note, she also worked with me to get me up to speed when I came in as Chair. A massive thank you to Helen.

Following a competitive recruitment process we have appointed Kim Handel as our new NED. Kim is a nurse by background and will come in to chair the Quality and Safety Committee.

I am pleased to report to the Board that Helen Howe has been re-appointed to the board for a further term of office, which is great news, giving us stability at a time of great change. Liz Baker has also had her tenure as an associate NED extended.

In my last report to the Board I noted that the Board has been working on a Charter to cover the way we worked together, I am pleased to say that this has been agreed and will guide our work going forwards.

3.0 External Work:

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

I continue to play an active role in NHS Providers, where I chair their Finance Committee. My term of office expires in June this year.

On a more local level in addition to the regular meetings of the ICB Chairs, I had a fascinating night shift on an ambulance as part of learning more about the pressure in our system.

4.0 Staff Welfare and Resilience:

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

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

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

Appendix 4: Chair's action matrix

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

Updated: March 23

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

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
27/03/2023	GW, HG	St Margaret's Hospital	OPD and Birchwood House staff met, positive staff engagement. Estates issues noted.	CSS	05/23	Ageing NHS PropCo Estate noted, some escalations to internal teams for review. Open.
08/02/2023	HLD, HG, AN, PP, FtSUG	OPAL Unit	Exemplary system working practice. Staff and patient voices heard and acknowledged.	Medicine	NA	No actions identified other than positive feedback which has been provided to the teams. Closed.
21/11/2022	HLD, GW, HH, AWS	Pathology, Clinical Biochemist	Staff voices heard Highlighted some minor estates issues.	CSS	12/23	Issues reviewed and closed.
27/10/2022	GW, HLD, HH	Lister Ward, Dementia and delirium clinical nurse specialist	Staff and patient voices heard – patient at the heart, some excellent collaborative work observed	Medicine	NA	No actions identified. Positive feedback to the teams. Closed.
05/09/2022	HLD, GW, AWS, AN	Harvey Ward, Medical Matron	Staff and patient voices heard – collaborative engagement. Estate concerns identified and rectified	Medicine	02/23	Estate work on going as part of a longer-term plan. Closed.
28/07/2022	GW, CM, JK	Williams Day, Head of cancer nursing	Staff and patient voices heard – award from RCN recognised with the team.	CSS	NA	No actions required. Closed.

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

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 6 April 2023

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	31 March 2023							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - CQC inspection of UEC - Strategic objectives 2023/24 - Junior doctors' industrial action - NHS Provider Licence / PAHT Establishment Order - National reviews / reports / announcements - Other key headlines / developments for noting							
Recommendation:	The Trust Board is asked to: – note the CEO report and the progress made on key items – approve the maintenance of the strategic objectives for 2023/24							

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

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Legislation, regulatory, equality, diversity and dignity implications:	– Regulatory and legal – impact of the changes of to our provider licence – Regulatory – improvement notice from the CQC in relation to our provision of urgent and emergency care services – EDI – ensuring the 5 strategic objectives do not have any adverse implications on the EDI or our colleagues or our patients – EDI – impact of the next junior doctors strike on our patients and the potential for a disproportionate impact on some of our patients – EDI – positive step taken by national colleagues to develop an EDI improvement plan which we need to articulate fully to all colleagues and ensure planned improvements are reflected in individuals' personal objectives – EDI – the need to continue to work at pace with ICB colleagues to ensure clarity over the expectations of and freedom to act of the HCPs to enable ongoing active addressing of and reduction in health inequalities locally – EDI – ongoing need to ensure that our recovery plans and our PQP plans are quality and equality impact assessed to prevent any unintended consequences or unequal impact on colleagues or patients
Appendices:	– CQC inspection letter, dated 30 March 2023 – PAHT NHS Provider Licence from 1 April 2023 – New PAHT Establishment Order – link to the legislation.gov.uk website - The Princess Alexandra Hospital National Health Service Trust (Establishment) (Amendment) Order 2023 (legislation.gov.uk)

Chief Executive's Report
Trust Board: Part I – 6 April 2023

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

(1) CQC inspection of Urgent and Emergency Care services

The Board will recall that we wrote formally to Care Quality Commission (CQC) colleagues in the autumn, asking them to consider removing our Section 31 improvement notice on our Urgent and Emergency Care services, as a result of the changes and developments we had put in place.

We have been working closely with CQC colleagues since the notice was issued and providing regular information and data to show and track progress against the actions aligned to improvement against the four concerns. CQC colleagues welcomed our request.

On 29 March 2023, 5 inspectors attended our ED as part of a focussed inspection aligned to the Section 31 notice. The inspection team provided verbal feedback in the evening of 29 March outlining that:

- They could feel the positive difference in the department and see the difference
- Great improvements had been made in relation to the management of Mental Health patients
- Having an RMN on shift and mitigating MH risks were gold standard practice
- The Manchester triage tool was in place, well embedded and working well
- There was evidence of good collaborative team working
- Our screening assessments were good,

- Our risk assessments, post screening, were not completed robustly and consistently
- Some of our observations were not undertaken consistently in line with our policy
- Some observations were not acted upon
- Our RAT process was good but was taking too long, causing some delays to patients
- We should look to stream pre-triage to reduce waiting times for initial assessment
- A lack of PGDs in triage was causing some unnecessary delays
- We were 2 nurses down on shift which would have caused some pressures in the department, although recognised that colleagues were moved around the department to address the acuity pressures

- There was nothing that CQC colleagues saw of immediate concern or anything that needed to be addressed immediately

I received an initial post inspection letter from CQC colleagues in the evening of 30 March 2023, which is attached. We are expecting to receive a request for additional information which we will respond to in full as soon as we receive it.

CQC colleagues will confirm next week, the UEC colleagues that they wish to interview as part of their well-led review of UEC services, likely to take place in w/b 17 April 2023.

I will keep the Board updated on progress and ongoing discussions with CQC colleagues.

(2) Strategic Objectives 2023/24 and appraisals

The new appraisal process as part of *This is Me at PAHT* has started with the annual appraisal of the Chair and continues with mine and all Executive Director colleagues' appraisals over the next 3 weeks.

The cascade of all appraisals and personal objective settings across the Trust will be completed by the end of September 2023 for all colleagues.

To enable the effective setting of objectives aligned to the vision of the Trust; to be modern, integrated and outstanding; the Board is asked to reaffirm our 5P strategic objectives for the year ahead 2023/24.

The 5 strategic objectives for approval are outlined below, ensuring continuity and consistency with the 5Ps and alignment with PAHT 2030. Progress will be tracked against the delivery of the specific milestones and key priorities through regular reporting to the Strategic Transformation Committee:

- Our Patients – we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequities in our local population

- Our People – we will support **our people** to deliver high quality care within a culture that supports engagement, recruitment and retention and results in further improvements in our staff survey results as we strive to be a model for equality, diversity and inclusion

- Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership

- Our Performance – we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators

- Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way

(3) Junior Doctors' Industrial Action

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

Locally, the majority of the unions' disaggregated ballots of PAHT colleagues have not met eligibility to proportion threshold. The aggregated ballots from the doctors' unions for junior doctors however met the criteria and we say 72 hours of industrial action from 7.00am on 13 March 2023 until 7.00am on 16 March 2023.

I'd like to formally thank many of my colleagues for their hard work in the planning and preparation for the industrial action, the cancellation and rebooking of many patients (nearly 2,000 appointments from across outpatients, diagnostics and planned care), the undertaking of different roles and different shifts from normal and the multi-disciplinary working across all areas to keep our patients safe. We had no patient safety concerns over this period and slightly better flow of patients in to, through and out of the hospital than normal. A hot debrief took place on 21 March with lots of learning points and opportunities to work differently in the future as a result, and a range of specialty-specific and profession-specific debriefs are in the process of being undertaken currently and learning will be shared.

On 23 March 2023 we received formal notification of further 96 hours of industrial action from junior doctors, in the form of a full stoppage of work, running from 7.00am on 11 April until 7.00am on 15 April. The impact of this, straight after the Easter Bank Holidays is likely to be more disruptive; in terms

of the planning and preparation, the cancellation and postponement of activity and the potential patient safety risk caused.

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

The non-medical staff unions have agreed pay awards in principle with the government for their members for 2023/24 and are currently balloting members on the decision to accept these. Consequently, there are no future planned strikes from these colleagues whilst this process is undertaken.

(4) NHS Provider Licence / PAHT Establishment Order

On Monday, 27 March, NHS England (NHSE) launched the new NHS provider licence, together with their response to the recent provider licence consultation.

The NHS provider licence forms part of the oversight arrangements for NHS providers. It was first introduced in 2013 and has since been held by all NHS foundation trusts, as well as independent sector providers. Changes brought by the Health and Care Act 2022 required the licence to be updated from 1 April 2023.

The new provider licence for PAHT is attached, and aims to:

- support effective system working
- enhance the oversight of key services provided by the independent sector
- address climate change and
- makes a number of necessary technical amendments.

Compliance against the licence conditions will be reported to Audit Committee and Board annually.

On a linked but separate issue, I can confirm that our request for a change to our Establishment Order has been agreed by ministers for health, signed by the SoS for Health and Social Care and published on 23 March 2023. The link to changes on the legislation.gov.uk website is here. The Princess Alexandra Hospital National Health Service Trust (Establishment) (Amendment) Order 2023 (legislation.gov.uk)

(5) National reviews / reports / announcements

Hewitt review

The Hewitt review, set up to consider the oversight and governance of Integrated Care Systems and Boards, has been completed. Commissioned by the Chancellor of the Exchequer, it is expected to make recommendations on:

- How to focus more on clinical outcome improvements for populations
- National targets for which ICBs will be held accountable
- The role of the CQC in enhanced system oversight

It was timetabled to report on 15 March, and is expected imminently, presumably now after the Easter recess of parliament.

Equality, Diversity and Inclusion (EDI) Improvement Plan / NHS Long Term Workforce Plan

The need for an NHS Long Term Workforce Plan has been discussed for many years and was recognised as one of the key elements needed to underpin the NHS Long Term Plan.

The Chancellor of the Exchequer referred to this in his recent budget speech and I understand that it has been completed and is due for publication in May 2023.

The key drivers of demand used within the plan include:
- Drive to deliver more care out of hospital
- Recovery plans within hospitals
- Expect out of hospital workforce to grow quicker than acute workforce, particularly GPs

And the 3 areas of focus within the plan are:
- Productivity - via capacity, flow, innovation and technology
- Retention - expecting improvements in this
- Training - need to train significantly more (up to 50% increase in training places needed in some professions)

I'm expecting to see the plan include a large focus on apprenticeships and international recruitment.

Aligned with the Long-Term NHS Workforce Plan, there is a national EDI Improvement Plan also due to be published shortly.

It will include 6 high impact actions together with strategic EDI workforce outcomes including:
- addressing discrimination
- increasing accountability of all leaders
- supporting the levelling up agenda
- increasing equality of opportunity and potentially
- specific interventions by protected characteristics

The high impact actions are likely to include EDI objectives for all Board members, a focus on fair and equitable recruitment processes, stronger focus on reducing health inequalities, improving onboarding for internationally recruited colleagues and ensuring environments that eliminate bullying, discrimination, harassment and physical violence.

I will ensure all Board colleagues have sight of both plans as soon as they are published.

<u>New Hospital Programme</u>

We have been expecting a national announcement for some time on the timing and funding of the Reinforced Autoclaved Aerated Concrete (RAAC) and Cohort 3 organisations that are part of the New Hospital Programme (NHP).

We are disappointed that this hasn't happened in March, as expected, and it now looks likely that any formal announcement will not be made before early May 2023.

We continue to work hard in the background with NHP and DHSC colleagues to develop our scheme for a new Princess Alexandra Hospital in line with the national guidance, new and revised standards for clinical facilities and enabling schemes to support our Preferred Way Forward.

Since we last met, the Epping Forest District local plan has been approved and formally adopted on 18 March 2023 and includes specific reference to the "opportunity to accommodate the relocation of the Princess Alexandra Hospital".

(6) Other key headlines / developments for noting

Other key items of note for the Trust Board include:

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

- Michael and I attended a Health and Care Partnership workshop on 28 March, working with colleagues across the other place-based and MHLDA HCPs and the ICB to continue to shape how the HCPs interact with the ICB and to agree the key clinical and non-clinical priorities to support the delivery of the ICB's strategic objectives. We will continue to update the Strategic Transformation Committee on progress with integrated care working and delivery of our HCP aims.

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

Author: **Lance McCarthy, Chief Executive**
Date: **31 March 2023**

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

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www.cqc.org.uk

By email

Our reference: INS2-14981160861

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

Date: 30 March 2023

CQC Reference Number: INS2-14981160861

Dear Mr. McCarthy

Re: CQC inspection of The Princess Alexandra Hospital NHS Trust

Following your feedback meeting with Claire Portway, Emma Schofield and Prina Patel on 29 March 2023. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 29 March 2023 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

- We were not assured that risk assessments were completed for patients robustly and consistently in line with trust policy. Risks were identified using the screening tool, however we were not assured that risks such as pressure ulcers and falls were consistently mitigated and evidenced in documentation.

- We were not assured that observations were being carried out in line with policy including those that were triggering on NEWS scoring. Patients consistently did not receive follow up observations within the hour target.
- Patients were not triaged within 15 minutes of arrival, on inspection we observed delays of 45 minutes. This was impacted on further by the lack of streaming at the point of presentation.
- There was lack of timely oversight of staffing and accuity needs across all areas of ED outside of the formalised MDT huddles.
- We observed a lack of PGD's within triage causing delays.
- We were assured patients in the RAT area were reviewed and escalated by the HALO appropriately, but this was compromised by the lack of staffing and space and taking longer than the target.

However:

- We observed staff interacting kindly and compassionately. Patients spoke highly of staff and the care that was received despite the long wait times.
- Staff told us they highly value their team members and feel that there have been significant positive improvements within the department.
- We saw evidence of robust management of mental health patients reflected both in staffing and completion of risk assessments.
- Paediatric staffing was adequate and in line with trust standards and there was evidence of EPALS trained registered nurses on every shift.
- The successful implementation of the Manchester Triage tool was observed. The nurse on duty showed a robust understanding of the tool, identified patients at risk and successfully streamed to services upon completion.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Amba Murdamatoo at NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Antoinette Smith
Head of Hospitals Inspection

c.c. Amba Murdamatoo

John Scott, CQC regional communications manager

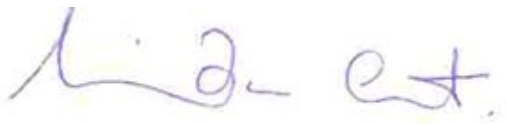
2.2

The Princess Alexandra Hospital NHS Trust

Princess Alexandra Hospital
Hamstel Road
Harlow
CM20 1QX

Licence number: 400056

Date of issue	**Version number**
1 April 2023	1



Miranda Carter
Director of Provider Development, NHS England

Version History

Version number	Date	Comments
1.0	31 March 2023	Licence Created

Contents

Section 1 – Integrated Care

IC1: Provision of Integrated care

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

    where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

IC2: Personalised Care and Patient Choice

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Section 2 – Trusts Working in Systems

WS1: Cooperation

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
     i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
     ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
     iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
     i. as necessary and appropriate for the purposes of delivering NHS services.
     ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:
   a. the Secretary of State for Health and Social Care; or
   b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

WS2: The Triple Aim

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, "the triple aim" refers to the aim of achieving:
    a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
    b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
    c. more sustainable and efficient use of resources by NHS bodies,

and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

WS3: Digital Transformation

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

Section 3 – General Conditions

G1: Provision of information

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

G2: Publication of information

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
   a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
   b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
   c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
   d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
   a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
   b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
      i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
      ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;
      iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;

iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;

v. which passes any resolution for winding up;

vi. which becomes subject to an order of a Court for winding up; or

vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

G5: Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   a. the Conditions of this Licence,
   b. any requirements imposed on it under the NHS Acts, and
   c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   b. regular review of whether those processes and systems have been implemented and of their effectiveness.

G6: Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
    a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
    b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
    a. be made within 7 days of:
        i. the making of an application in the case of paragraph (a), or
        ii. becoming aware of the cancellation in the case of paragraph (b), and
    b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
        i. the making of an application in the case of paragraph (a), or
        ii. the cancellation in the case of paragraph (b).

G7: Patient eligibility and selection criteria

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

G8: Application of section 6 (Continuity of Service)

1. The Conditions in Section 6 shall apply:
    a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
    b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
    c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
    d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
    e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
    a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
    b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
    c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
    d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
    a. in writing,
    b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or
b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or
b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or
d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 4 – Trust Conditions

NHS1: Information to update the register

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee's constitution;
    b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee's most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

NHS2: Governance arrangements

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
    c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 5 – NHS Controlled Providers Conditions

CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within

the rest of the Licensee’s organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 6 – Continuity of Services

CoS 1: Continuing provision of Commissioner Requested services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:
    a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
    b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
    c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.
4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.
5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the

delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

CoS 2: Restriction of the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:
    a. with the consent in writing of NHS England, and
    b. in accordance with the paragraphs 6 to 8 of this Condition.
6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:
    a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
        i. transactions of a specified description; or
        ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
    b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.
9. In this Condition:

"disposal"	means any of the following:

	(a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

CoS 3: Standards of corporate governance, financial management and quality governance

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

CoS 4: Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"):

a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
   a. a health service body, within the meaning of section 9 of the 2006 Act;
   b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
   c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
   d. a trustee of the Licensee and the Licensee is a charity.

CoS 5: Risk pool levy

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

CoS 6: Cooperation in the event of financial or quality stress

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
   a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
   b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
   c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
   a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
   b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
   c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.

CoS 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
    a. “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
    b. “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”.
    c. “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.
6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have

the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts;

"Required Resources" means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

Section 7 – Costing Conditions

C1: Submission of costing information

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:
    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:
    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on

	the breaking down and allocation of costs published annually by NHS England.
“other relevant information”	means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.

C2: Provision of costing and costing related information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
    a. in the case of information (data) or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

C3: Assuring the accuracy of pricing and costing information

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
    a. Regular assessments by the providers internal and/or external auditor
    b. specific work by NHS England or NHS England nominated representative on costing related issues and
    c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
    d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

Section 8 – Pricing Conditions

P1: Compliance with the NHS payment scheme

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

Section 9 – Interpretation and Definitions

Condition D1: Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

“the 2006 Act”	the National Health Service Act 2006 c.41;
“the 2008 Act”	the Health and Social Care Act 2008 c.14;
“the 2009 Act”	the Health Act 2009 c.21;
“the 2012 Act”	the Health and Social Care Act 2012 c.7;
“the 2022 Act”	The Health and Care Act 2022;
“the Care Quality Commission”	the Care Quality Commission established under section 1 of the 2008 Act;
“Commissioner Requested Service”	a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;
“Commissioners”	NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;
“Director”	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a company constituted under the Companies Act 2006;
“Governor”	a Governor of an NHS foundation trust;

“Hard to replace provider”	has the meaning given in condition G8 of the licence;
“Integrated Care Board”	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
“the NHS Acts”	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of IFRS 10;
“NHS England”	the body named as NHS England in section 1 of the 2022 Act;
“NHS foundation trust”	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
“NHS Trust”	an NHS trust established under section 25 of the 2006 Act;
“Relevant bodies”	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
“Trusts”	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.
3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.
4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

The Princess Alexandra Hospital NHS Trust

3.1

TRUST BOARD
6 APRIL 2023

Agenda item:	3.1							
Presented by:	Sharon McNally							
Prepared by:	Sheila O'Sullivan – Associate Director of Quality Governance							
Date prepared:	28 March 2023							
Subject / title:	Significant Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents the significant risk register (SRR) for all our services. The significant risk register (SRR) is a snapshot of risks across the Trust and was taken from registers on 1 March 2023 and updated during March. This paper includes all items scoring 15 and above. The overall number of significant risks on the register has reduced from 73 to 68 (table 1 and section 2). The main themes for the 10 risks scoring 20 on the SRR are: • Seven risks are for our performance - five risks covering Emergency department (ED), one for cancer access standard, and one for or referrals to treatment standard. This is unchanged since the last paper. • One for our people, a new risk – pharmacy staffing to cover the wards • One new risk for our patients: regarding sufficiency of operating slots for breast care surgeons, resulting in delays to procedures • One risk for our places, a new risk regarding electrical infrastructure. Actions and mitigations for each risk are detailed in section three. Two new risks scoring 16 raised since 4.1.2023: • One for our people: Neurology medical workforce, • One for performance: Neurology appointments Three new risks with a score of 15 raised since 4.1.23. • Three new for our people, (two for maternity and one for junior doctors in training in medicine division)							
Recommendation:	Trust Board are asked to review the contents of the significant risk register.							

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

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

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

The Princess Alexandra Hospital NHS Trust

3.1

Boo1.0 Introduction

This paper details the significant risk register (SRR) across the Trust; the registers were taken from the web-based Risk Assure and Datix systems on 1.3.2023 and updated during March as assessment of risk is a dynamic process. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including all significant risks.

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

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 67 significant risks on the risk register, a reduction of four from the paper discussed at Trust Board in February 2023.

The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	0 (2) *	0 (0)	0 (0)	(0)	**0 (2)**
Cancer & Clinical Support	2 (5)	9 (8)	2 (2)	(0)	**13 (15)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	3 (3)	5 (5)	1 (0)	0 (0)	**9 (8)**
Finance	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Health Safety and Resilience	(0)	0 (0)	0 (0)	0 (0)	**(0)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Governance	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
IM&T	1 (1)	0 (1)	0 (0)	0 (0)	**1 (2)**
Integrated Hospital Discharge Team	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Learning from deaths	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Nursing	0 (0)	1 (1)	0 (0)	0(0)	**1 (1)**
Operational	4 * (2)	2 (1)	4 (4)	0 (0)	**10 (7)**
Workforce - training	2 (2)	0 (0)	0 (0)	0 (0)	**2 (2)**
FAWs Child Health	1 (2)	4 (4)	0 (0)	0 (0)	**5 (5)**
FAWs Women's Health	5 (5)	4 (5)	0 (2)	0 (0)	**9 (12)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	1 (0)	0 (1)	0 (0)	0 (0)	**1 (1)**
Surgery	3 (2)	2 (2)	0 (0)	0 (0)	**5 (4)**
Urgent & Emergency Care	2 (3)	2 (3)	3 (3)	0 (0)	**7 (9)**
Totals	**25 (28)**	**32 (34)**	**10 (10)**	**0 (0)**	**67 (73)**

(The scores from paper presented at RMG/ SMT in January and Trust Board in February 202 are detailed in brackets)
*Risks moved from Covid risk register

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

It should be noted that the Trust is in the process of transferring risks from the risk module on the Allocate system over onto the Datix system.

3.0 Summary of risks scoring 20

There are 10 risks with a score of 20, three of which are new/increased. A summary of these risks and mitigations is below, information taken from divisional risk registers:

3.1 Our Patients

3.1.1 NEW: Insufficient Substantive Breast Operating Capacity

- Currently there are insufficient allocated theatre operating slots for breast surgery, with two lists for three breast surgeons. This is resulting in some operating delays which are negatively impacting upon patient experience and the national 62 day Cancer standard (Risk reference: Breast/2022/02 on CSS register, agreed by CSS Board in February 2023)

  Action: Weekly requests for extra lists are mostly granted, but not guaranteed. Extra lists have also been allocated at weekends, but at an increased additional cost.

  Mitigation: Enhanced monitoring of the waiting list regarding patient delays. 62-day compliance monitored via the breast operational team and fed into appropriate compliance governance meetings.

3.2 Our People

3.2.1 NEW: Pharmacy staffing

- There is a risk that pharmacy will be unable to provide a robust service to all wards due to staffing vacancies and a lower budget against the national average, this is impacting staff retention (Risk reference: Allocate Pharm/2014/03 and Datix 130, raised March 2014 and score increased due to a reduction to 7.4WTE pharmacists covering 15 wards, and a total of 13.5 vacancies, this has increased as a result of staff leaving in the last two months, coupled with a national skills shortage).
  Action: Temporary workers in place within the cap rate. Recruitment ongoing and looking at alternative roles and professionals considered. Overtime is authorised by Chief Pharmacist. Considering how to reduce service provision safety. Developing a bid to take on additional pre-registration pharmacists and monitoring the recruitment pipeline.
  Mitigation: Vacancy rate discussed and monitored by division.

3.3 Our Performance

Five risks for the urgent and emergency care department

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

- Compliance with the statutory 4-hour standard on the operational risk register for the Emergency department (ED) (Risk reference: Allocate 001/2017 raised April 2014, Datix 85 on operational register).
- Achieving the standard of patients being in ED for less than 12 hours (Risk reference: Allocate: 002/2016 raised July 2016 on operational register).
- Deliver safe high-quality care when not meeting the national four-hour access standard on the urgent & emergency care risk register (Risk reference: Allocate ED012, Datix 310 raised in July 2016 with score amended in December 2022).
  Actions: Complete the accountability and responsibility grid for roles to provide clarity on roles for staff in charge. Expand the skill base of nursing staff through our training programme, expand consultant presence until 22.00 hours, with use of rapid assessment, triage and adult assessment unit. Continuous review of escalation areas.
  Mitigations: Daily monitoring of previous days breaches, numbers & patterns of attendance to facilitate changes to ED pathway and improve performance. ED board rounds daily and daily huddle to review treatment plans and pathways (7 days per week). Internal professional performance standards agreed and implemented. Monitoring of performance against internal professional standards and deviations escalated. East of England escalation process in place to reduce ambulance offload delays.

3.3.2 Length of wait for patients in ED

- Patients are waiting for longer than 60 minutes (our internal professional standard) to be seen by a doctor in the emergency department. (Risk reference: Allocate ED-LongWaits-01, Datix 302 raised December 2022 on urgent and emergency register).
  Action: Appropriate use of the Manchester Triage tool to stream patients to the right place. Review and revision of safety huddles, review of medical staffing allocation to particular areas in ED and rota template.
  Mitigation: Direct speciality referrals, movement of medical staff around the department to address patient with longest waits, use of agency and NHS Professional staff to cover gaps in rota.

3.3.3 Risk of overcrowding in the ED

- Risk of overcrowding during busy periods that is caused by lack of capacity within the department. This could result in delays to patient pathways through the ED and onto wards, experiencing longer time in ED, resulting in poor patient experience. A risk the ED is non-compliant with national operating performance standards (Risk reference: Allocate ED009, Datix 298 raised in June 2026 and score increased December 2022 as a result of new care standards received from NHSE for ambulance off-load to take place within 60 minutes).
  Action: ED overcrowding electronic action cards for staff to use for guidance, full capacity protocol / business continuity plan amended, looking to develop self-assessment kiosks (planned implementation January 2023), recruitment of additional consultant cover.
  Mitigation: Bronze role as point of escalation for speciality delays and overcrowding issues covering seven days per week.

3.3.4 Cancer access standard

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

Actions: Tumour site recovery action plans are monitored and tracked. Speciality level recovery plan in place monitored daily, and reviewed at tumour site weekly meeting.
Mitigations: Revised patient treatment list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway. Revision of the recovery trajectory set for 22/23.

3.3.5 Referral to treatment constitutional standards

- Risk of 52-week breaches because of the pandemic, pauses to Out Patients Department clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored and tracked by operational teams (Risk reference: Allocate 006/2017 raised February 2017).
  Action: Refreshed PTL meetings with outpatient bookers attending to escalate relevant cases to divisional teams. Patients booked in order of clinical priority, monitoring of PTL continues weekly, with cancer PTL reviewed daily. Working with Integrated Care System partners to manage paediatric urology and plan to address longer term service provision underway with Addenbrooke's and East & North Herts.
  Mitigation: Weekly recovery performance meeting with executive directors monitors activity levels to improve utilisation and trajectories planned. Detailed monthly dashboards shared.

3.4 Our Places

3.4.1 Score Increased: Electrical infrastructure

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

3.5 Our Pounds: Nil

4.0 Two risks with a score of 16 have been raised since 4/1/2023

4.1 New: Neurology medical staffing

- There are insufficient neurology consultants in post and limited junior staff to sustain the service. This is as a result of a growing demand and service expansion with difficulty in recruiting staff and unplanned leave. There are insufficient clinicians to support the outpatient clinic capacity, not able to recruit into out to advert posts. (Risk reference: Neuro005, raised in December 2022 and accepted by CSS board in late January 2023)
  Action: Locum and agency cover sourced, out to advert to recruit to substantive roles, clinics reduced to enable clinicians to review both inpatients and manage clinics. Forensic analysis of the service is in progress and due to be completed by end of March 2023. It is anticipated that additional capacities will be released as a result and so the risk score expected to be reduced in April 2023.

Mitigations: Operational teams monitoring performance against constitutional standards.

4.2 Our Performance

4.2.1 Score Increased: Insufficient staff in neurology to meet timeframe for appointments

There is a risk that patients are not been seen within the desired timeframes requested for neurology appointments (Risk reference: Neuro002, risk raised November 2021 and score increased due to worsening staffing position as a result of long-term sick, maternity and sabbatical leave).
Action: Locum doctors sourced and advert out for further interim support. Forensic analysis of the service is in progress and due to be completed by end of March 2023. It is anticipated that both additional capacities will be released as a result and so the risk score can be reduced. Job plans under review
Mitigation: Constitutional targets monitored through operational teams

5.0 Four new risks with a score of 15 raised since 4/1/2023

5.1 Our People

5.1.1 NEW: Culture and professional relationships in maternity service

- To improve the culture and professional relationships within the Maternity Service. (Risk reference: Datix 96, raised February 2023). **Action:** Safety huddles, Nursing & Midwifery Council (NMC) & General Medical Council (GMC) workshop for an open forum to discuss culture, behaviours and boundaries.
  Mitigation: Daily Datix review completed. Sage and Thyme Mandatory training and birth rights training to be undertaken by all clinical staff.

5.1.2 NEW: Staff compliance with basic life support training

- There is a risk to safety due to poor compliance rates for basic life support (BLS) training in the Maternity service. This is caused by midwifery and medical staff not being able to complete their training within a timely manner due to clinical commitments and staffing gaps. (Risk reference: Datix 64, raised February 2023).
  Action: Advertising BLS training, with 10 training slots allocated just to Maternity for specific training dates to be undertaken. Regular review of compliance by Practice Development Midwifery team. New education week in place incorporating BLS
  Mitigation: Review of training programme and BLS now included within mandatory maternity speciality training that is provided in house. Trajectory in place for full compliance within all staff groups. In site live drills programme available throughout the maternity service focusing on obstetric and neonatal emergencies.

5.1.3 NEW: Staffing for Junior Doctors in training

- There is a risk that Medicine will lose GMC/HEE recognition for training of doctors. This is caused by insufficient junior doctors to meet the needs of patients in our ward and assessment areas. Our junior doctors are not able to maximise the benefits of their training programme whilst at PAHT

with daily gaps in junior doctor workforce in the Medicine division, over and above gaps uncovered from sick leave and annual leave. (Risk reference: Datix: 278 raised January 2023).
Action: Temporary staffing used to cover gaps and redeployment of existing workforce to cover shortfalls. Business case for sustainable numbers of junior doctors to be completed. Non-medical workforce strategy to be developed.
Assurance: Rotas monitored, incidents are reported and reviewed. Evidence of medical staffing recruitment

6.0 Recommendation

Trust Board is asked to review the contents of the significant risk register and approve new and risks with an increase score.

Author: Sheila O'Sullivan – Associate director of quality governance

The Princess Alexandra Hospital NHS Trust

Trust Board – 6 April 2023

3.2

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

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

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during March 2023. It is proposed to reduce the risk score for BAF risk 1.0 Covid from 12 to 8. The risk will be removed from the BAF as it has achieved its target risk score. The Chief Nurse is the executive lead for the risk. Quality and Safety Committee reviewed the risk and supported the reduction in risk score. The risk is attached as Appendix C. The remaining risk scores have not changed this month and are summarised in Appendix B. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Approve the reduction in risk score for BAF risk 1.0 Covid. - Note the updates to the remaining risks.

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

Previously considered by:	STC, QSC, PC and PAF in March 2023.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF risk 1.0 Covid

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2022-23**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic 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) National incident level reduced to level 3 - May 22) ii) PAHT incident co-ordination centre and incident management team established for surge periods 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 for surge periods vii) Staff 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~~ Covid patients now in cohort bays and siderooms ~~xii) Use of independant sector for elective patients~~ xiii) Staff vaccination programme xiv) Engagement with critical care network as necessary ~~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	i) Incident management action and decision logs ii) QSC updates monthly from March 2020 to date and annual report iii) Trust Board updates (March 20 to date) iv) Recovery Plans and submissions to PAF and QSC v) Covid risk register	**~~4x3=12~~ 4x2=8**	i) Adaptability and configuration opportunity of clinical areas (managed by changing configuration of wards)	None.	Mar-23	**Proposed to reduce risk score to 4x2=8**	**4x2 =8 February 2023**
			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				

Board Assurance Framework Summary 2022.23

Risk Ref. Committee	Risk description	Year- end score (Apr 22)	June 22	August 22	Oct 22	Dec 22	Feb 23	Year-end score (Apr 23)	Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequity in our local population										
1.0 QSC	COVID-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	12	12	12	12	12	8	↓	8	CEO/ DoN&M
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16	16	16	16	16	↔	12	DoN&M/ MD
1.2 STC	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16	16	16	16	↔	12	DoIMT/ CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15* New risk	15	15	15	15	15	15	↔	10	COO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.1 PC	GMC enhanced monitoring: There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services.						20 New risk	20	↔	10	MD
2.3 PC	Workforce: Inability to recruit, retain and engage our people	16	16	16	16	16	16	16	↔	8	DoP
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20	20	20	20	↔	8	DoS
3.2 STC	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16	16	16	16	16	↔	12	DoS
3.5 STC	New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16	16	16	16	16	↔	9	DoS
	Strategic Objective 4: Our Performance - we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators										
4.1 PAF	Winter resilience: Risk that the Trust will be unable to sustain and deliver safe, high quality care during the Winter period due to the increased demand on its services.					12 New risk	12	12	↔	12	COO
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16	16	16	16	16	↔	12	COO
	Strategic Objective 5: Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way.										

Board Assurance Framework Summary 2022.23

5.1 PAF	Finance – revenue: Risk that the Trust will fail to meet the financial plan due to the following factors: An indicative annual budget for 22/23 has been established. A deficit plan has been submitted but national, allocations are not yet known and are linked to system envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement, with additional deficit expenditure to reflect the current and forecast additional rising Inflation costs in 22/23.	12	12	12	12	12	12	12	↔	8	DoF

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 April 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Infection Prevention & Control Update	Y	Y	N	It was noted there was some work to be done around the data pertaining to the organisation's use of antibiotics which did not align with its (relatively low) performance in terms of cases of clostridium difficile. The results of the work would be reported to a future QSC meeting. In terms of COVID it was noted that the wearing of masks was no longer a requirement in non-clinical areas. In clinical areas staff and patients had the option, as they did also in immuno-compromised settings. The revised testing guidance is expected to confirm that unless a patient was severely immuno-compromised even symptomatic staff did not now need to test for COVID before returning to work. It was agreed there needed to be a renewed focus on the communications to both staff and patients in terms of mask-wearing, particularly in the William's Day Unit noting that the term 'immuno-compromised' was hard to define in this area.
2.1 BAF Risk 1.0 (COVID)	Y	Y	N	In line with the recommendation it was agreed that the risk score be reduced to 8. As the target score for the risk is 8 the risk will be removed from the BAF but will continue to be monitored through the IPC Committee.
2.2 Report from Strategic Learning from Deaths Group	Y	Y	Y	Members' attention was drawn to the fact that the HSMR for May, June, July and August had risen to 'above expected', had reduced in September and was back to 'as expected' for

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 April 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Learning from Deaths Update				October 2022. It was believed this was due to some challenges with the data submission in terms of incomplete patient spells which were not coded. Some additional coders had been recruited to address the backlog and all data was now fully coded. This was unfortunately too late to be reflected in the Trust's position which would not now happen until July after the refresh in May.
2.3 6 Monthly Research & Development Update	Y	Y	N	The report showed the activity for the last financial year including: - • Growth of both commercial and academic studies • The position of the Divisions/Directorates and their activity. The recruitment of patients into studies so far this year was nearly 800 however there had been no target set by NTCRN as the National Institute for Health Research (NIHR) structure is currently being reconfigured – PAHT would become part of Eastern Academic Health Science Network (AHSN) in April, 2024.
2.4 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	In line with the recommendation it was agreed that the risk score should remain at 16.

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 April 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Quality Programme Management Office (QPMO) Update	Y	Y	N	An additional item had moved to blue in-month (M34/N - Paediatric ED Mental Health Room). Focus remained on addressing red and progressing ambers. Red-rated items remained: • S2 (ED 4 Hr standard) sustained lower quartile performance • S3/N (Safeguarding Training) where it is considered there is currently insufficient assurance and grip, remain a cause of concern. S5, previously red had been moved to amber following a 30% improvement in compliance from February (currently at 70%). A review of all amber actions had taken place. There were three red milestones which was a reduction of 11, indicating progress and those three related to compliance trajectories not being met or required evidence of sustainable improvement rather than actions undelivered.
2.6 Report from Patient Safety Group	Y	Y	N	The March meeting was cancelled due the Junior Doctors' strike. A small pack of papers was circulated to members by email for review/comment. Those papers not included within that pack have been deferred to the Group's April meeting.
2.7 Patient Safety & Quality Report	Y	Y	N	QSC was assured in terms of the in-month analysis provided. It was agreed however that the focus going forward should be

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 April 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				on closing those incidents which had been open from 2021 and 2022.
2.8 4 Monthly Patient Experience Update	Y	Y	N	Key headlines for Q3/Q4 were: **Complaints** • 110 received, 125 closed, 137 open (vs. 145 remain open at Q2) • Surgery and medicine, 37 and 38 (vs.45 and 43 cases at Q2) • **Focus: 41 of 137 older than 6 months (Medicine 17, Urgent care 17, Surgery 16, Child and women 6)** • Oldest case. UEC Oct 2021 • 9 (prev. 10) open PHSO cases. **PALS** • 2108 received, 2179 closed, 497 remain open. 907 compliments received since April 2022 led by Surgery (425). It was noted that the largest proportion of complaints sat with Orthopaedics/Rheumatology and some focussed work would now be undertaken in that area, acknowledging this was the service with the biggest backlog of procedures and where patients were most likely to be in pain as a result of that.

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 April 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.9 Update from Patient Panel				Key headlines included: • **Membership**: 4 new members so far this year, plus two working on specific projects. • **Patient Panel 2030:** Work now underway around succession planning and the form that should take.
3.1 M11 Integrated Performance Report	Y	Y	N	QSC noted that the rate of pressure ulcers per 1000 bed days was reducing and the concerns around first level cleaning scores were also noted – this was being overseen at the Infection Prevention & Control Committee.
3.2 Deep Dive: Update on Section 31 Notice including Paediatric ED Pathway	Y	Y	N	Some very high level feedback was provided on the CQC unannounced visit to ED which had taken place on 29.03.23 and the written report was now awaited.
4.1 Horizon Scanning Update	Y	Y	N	Key points to note were: • **Junior Doctors Industrial action:** During March junior doctors undertook 72hr industrial action. The Trust's industrial action governance structure had been instigated to support the teams and minimise disruption to services as far as possible during the period. From feedback to date there had been no safety concerns during the strike

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 April 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				days and some learning which could be taken forward for any future strikes. • **CQUINS 2023/24:** Five CQUINs had now been agreed for 2023/24. Two would be rolled over from the current year and the three new ones were 'Switching from IV to oral antibiotics', 'Identification and response to frailty in the ED' and 'Assessment and documentation of pressure ulcers'.
4.2 Quality Account Timeline	Y	Y	N	QSC noted the proposed timetable for the 2022/23 Quality Account. It was recommended that QSC receive the final version for approval and Audit Committee would receive an update. The Board is asked to note this.

BOARD OF DIRECTORS: Trust Board (Public) **AGENDA ITEM: 4.1**

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

REPORT FROM: Rob Gerlis - Committee Chair

DATE OF COMMITTEE MEETING: 31 March 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Maternity Report (dashboard)	Y	Y	N	The red rated KPI's were discussed and it was agreed that the recovery trajectory for continuity of carer would be presented to the next meeting. Labour ward staffing is improving and the recruitment pipeline for midwives was commended.
2.2 Maternity Annual Report	Y	N	N	The annual report was noted and will be discussed at the Trust Board meeting on 06.04.23.
2.3 Medical Staffing/Use of Locums	Y	N	N	QSC II received a presentation on the engagement of short-term locums in maternity care and was assured around the processes as well as compliance with safeguarding training requirements.
2.4 Maternity Serious Incident Report	Y	N	N	One new maternity incident has been declared in month and currently 8 SI's are under investigation (0 HSIB). The report will be discussed at the Trust Board meeting on 06.04.23

BOARD OF DIRECTORS:	**Trust Board (Public)**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Maternity and Neonatal Safety Champions' Report	Y	N	N	The report was received and members noted that some junior doctors were working a 1 in 7 rotation but the rota has been revised to a 1 in 10 rotation with recruitment underway. The actions taken in response to the issues surrounding Entonox were noted; Entonox is now available in 2 rooms in the birth centre and provision in the labour ward has improved. The permanent solution is also in progress.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 April 2023

4.2

Agenda item:	4.2
Presented by:	Giuseppe Labriola, Director of Midwifery
Prepared by:	Giuseppe Labriola, Director of Midwifery, Jo Keable, Deputy Director of Midwifery & Erin Walters, Head of Maternity Governance and Assurance
Date prepared:	3rd March 2023
Subject / title:	Maternity Services Annual Report 1st February 2022 – 28th February 2023

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

Key issues:	The purpose of this paper is to provide a review between 1st February 2022 – 28th February 2023 (13 months), since the inception of the Quality and Safety Committee (Part II Maternity Oversight). This paper will provide an overview of some elements of the workplan that have been discussed at this committee, highlight areas of celebration and areas of challenge for maternity services. The paper will also identify key milestones for the upcoming year and discuss any support required to achieve these.
Recommendation:	It is recommended that the Board reviews the information provided within this report and is assured by the reporting processes the service has in place. It is recommended that a deep dive for legal claims is added to the work plan for the forthcoming year. The service would like to recommend that this committee continues, to enable a supportive environment in which maternity services can demonstrate evidence of ongoing work and provide critical oversight.

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

Previously considered by:	To be considered at Divisional Board 29.03.23 QSC (Part II).31.03.23.
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	NHS Resolution - Maternity Incentive Scheme Year 4 (2022-23) Saving Babies Lives Care Bundle v2 Maternity Self-Assessment Tool Ockenden Report 2022 East Kent Report 2022 There are no ED&I implications identified in this report
Appendices:	None

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

The purpose of this paper is to provide a review between 1st February 2022 – 28th February 2023 (13 months), since the inception of the Quality and Safety Committee (Part II Maternity Oversight). This paper will provide an overview of some elements of the workplan that have been discussed at this committee, highlight areas of celebration and areas of challenge for maternity services. The paper will also identify key milestones for the upcoming year and discuss any support required to achieve these.

2.0 Background

At The Princess Alexandra Hospital NHS Trust (PAHT), the Child Health and Women's Division provide both routine and emergency obstetric care. There is a Consultant led high risk labour ward with nine birth rooms. There are two maternity theatres with a three bedded recovery room. Antenatal inpatient services include a thirteen bedded ward with one bereavement suite. The postnatal inpatient ward has twenty-two beds. Elective caesarean sections are carried out within the footprint, in maternity theatres. There is a co-located birth centre for low risk women to access midwifery led care. The birth centre has three birth rooms all with the provision for water births, there are six post-natal beds. Infant feeding specialists and a maternity helpline are both located on the birth centre. There is a Maternity Day Assessment Unit open 6 days a week for planned appointments (Mon-Sat) and a Maternity Triage that is open 7 days a week as a 24-hour service to assess, treat and signpost women and birthing people to the most appropriate location dependant on their needs. The Maternity Service runs antenatal clinics across all three sites linked with PAHT.

From 01st February 2022 – 28th February 2023 the service undertook 4622 maternity booking appointments and saw the birth of 3892 babies.

PAHT forms part of the Herts and West Essex Local Maternity and Neonatal System (LMNS) with our partners across the system being East and North Hertfordshire NHS Trust and West Hertfordshire Teaching Hospitals NHS Trust.

There have been challenges within maternity services nationally during this time frame following the publication of two national reports; and the challenges experienced by women, people and families due to COVID-19 pandemic which impacted on their experiences.

The final Ockenden Report was published in March 2022 detailing the concerns raised by families of the failings of care at The Shrewsbury and Telford NHS Trust. This independent report examined the maternity care and treatment provided to 1,486 families over two decades at the Trust. The report identified 15 immediate and essential safety actions for all NHS Trusts in England that provide maternity services. This report was followed by the independent investigation led by Dr Bill Kirkup on maternity and neonatal services in East Kent.

The divisional team are passionate about continuously improving the maternity service we provide for women, birthing people and their families.

3.0 Quality and safety accounts

Incidents

During the reporting timeframe there were a total of 1326 incidents reported for Maternity Services. The detail is provided in Table 1

Table 1 – Harm grading

No Harm	862
Minor Harm	406
Moderate Harm	55
Severe Harm	3

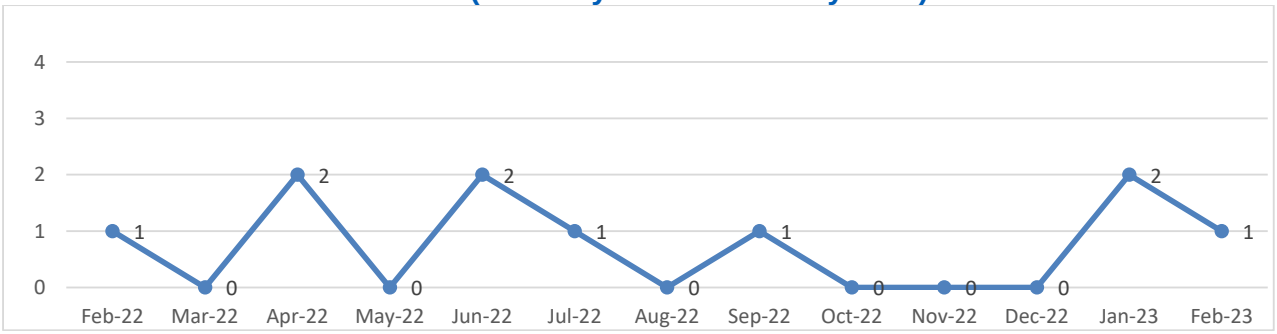
Of the moderate and severe harms:
49 were Massive Obstetric Haemorrhages requiring transfusion
2 were ureteric injuries following caesarean section
1 was a bladder injury at caesarean section
1 was a patient fall
1 was a neonatal anaemia due to snapped cord at birth
1 was a post mortem examination that was consented for but not undertaken.

The 3 severe harm incidents all related to the same incident with a haemorrhage, hysterectomy and admission to intensive care.

A review is currently underway with assistance from the LMNS with regards to Harm grading. This was raised by the Quality and Safety Committee (Part II Maternity Oversight) by our regional partners that the gradings for moderate harm incidents may not be reflective of the national picture. A bench marking exercise is underway with the LMNS and region, with a recommendation to be discussed at this committee once finalised.

Serious Incidents

Table 2. Serious Incidents (February 2022 – February 2023)



Throughout the reporting period there were 10 serious incidents declared:

Table 3. Description of Serious Incidents

New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Paweb107031 **STEIS 2022/2608** **04.02.2022** **Closed**	35 weeks with history of reduced fetal movements and Covid. On arrival intrauterine death diagnosed and disseminated intravascular coagulation. Post-mortem consistent with covid placentitis. Complex case which required a multi-agency approach including PAHT, ENHT, GP and EoE ambulance service.	• Cross border working with reviewing results – discussions ongoing with ENHT • Communication barriers due to language barrier
Paweb 108641 **STEIS 2022/8021** **22/04/2022** **Closed**	Patient at 32+4 weeks pregnant was admitted for management of vomiting. Fetal heart rate concerns were noted on the monitor and therefore a decision for an emergency (category 1) caesarean section was made for "chronic hypoxia of fetus". The baby was born in poor condition with low APGAR scores and abnormal cord gases (Arterial PH: 6.928, BE -24.3, venous PH: 6.944, BE -23.9). The baby was intubated and admitted to Neonatal Unit.	• Escalation was a concern from all parties involved. • Lack of appropriate documentation including use of CTG stickers
Paweb 113165 **STEIS 2022/8111** **25/04/2022** **With ICB**	Woman attended another Trust with history of bleeding and infertility. Hysteroscopy undertaken which identified a man-made foreign object in the cervix and uterus. Unable to remove so booked for laparoscopy/laparotomy for removal.	• Round table held with Trust and notes/images received.
PAweb111144 **STEIS 2022/11147** **01/06/2022** **With ICB**	Woman attended at 26+2 gestation with abdominal pain and amniotic fluid leaking. The birth was imminent and the baby required extensive resuscitation at birth. After 52 minutes a decision was made to stop of resuscitation.	• Room layout in rooms 7,8 & 9. In cases of preterm birth resuscitaire needs to be used via piped gases. • Neonatal Consultant to be called at earliest opportunity
PAweb115539 **STEIS 2022/11968** **13/06/2022** **With ICB**	A woman in her fourth pregnancy attended the emergency department at 22+1 weeks gestation with a history of abdominal pain, dizziness and feeling unwell for 3 days. The mother collapsed whilst in the emergency department and was clinically unstable with a Hb of 30g/L. The baby was born with signs of life and passed to the midwife and neonatal consultant who was present for the birth. Neonatal resuscitation was not commenced for approximately 10 minutes. A 2222 neonatal emergency call was placed and resuscitation equipment was brought up to main theatre including a resuscitaire. The baby responded well to resuscitation, was intubated and transferred to the neonatal intensive care unit (NICU).	• Case used for Perinatal Mortality and Morbidity Meeting • Review of gestation and pathways between ED and Maternity • Communication between ED and Labour Ward

	The Paediatric and Neonatal Decision Support and Retrieval Service (PANDR) declined transfer as the baby had not had any resuscitation for >10 minutes (transfer criteria not met). The baby died approximately 4 hours later.	
Paweb 117972 **STEIS 2022/16043** **27/07/2022** **With ICB**	Baby boy born via vaginal birth following induction of labour due to irregular maternal antibodies (Anti-C and Anti-E). Baby was diagnosed as DAT positive (risk that he/she could develop anaemia due to maternal antibodies) and was discharged home on day 1 with a prescription for folic acid. The mother called the community team on day 12 to report concerns regarding abnormal skin colour, behaviour and feeding. She was advised baby is well and discharged from community care. The mother attended a clinic on day 17 to report her concerns and was immediately advised to attend the emergency department. Baby was diagnosed with haemolytic disease of the newborn and required urgent admission, a total of 5 blood transfusions and treatment for low saturations and tachycardia.	• Communication surrounding paediatric plan • Communication between the midwifery team and the family • Case booked for perinatal mortality and morbidity review
Paweb 119843 **STEIS 2022/20047** **16/09/2022** **Awaiting ICB**	Mixing wireless telemetry CTG and wired CTG recording. Patient was on CTG and then discontinued to go to toilet but the CTG was still recording from fetal monitoring in adjacent room.	• Escalated to MHRA and Manufacturer to review • Quick escalation at time of incident by midwife • Wireless telemetry recording suspended • Escalated to national maternity team
Paweb 126142 **STEIS 2023/2179** **30/01/2023** **Open**	Client was seen in Fetal Medicine Unit after a growth scan at 36+3 pregnant on 18/1/23 showed possible polyhydramnios and that fetal heart was shifted away from the normal position of centre-left. On being scanned by the fetal medicine consultant- a diaphragmatic hernia was noted along with a mediastinal shift to the right of the fetal heart. The patient was referred to a tertiary Unit- Royal London Hospital immediately, where the findings were confirmed and a transfer of care has been arranged by them. The fetal medicine consultant has since reviewed the Anomaly scans (x 2) as not completed initially and notes that the heart looks in the wrong position then, and not commented on.	• A screening incident assessment form (SIAF) has been completed in line with national reporting processes • Care has been transferred to tertiary centre.
Paweb 98450 **STEIS 2023/1053** **16/01/2023** **Open**	A baby was born at 28+1/40 via emergency caesarean section and required extensive resuscitation. The decision to cease resuscitation was made and the baby died at 68 minutes of life. A rapid review was completed by The Princess Alexandra Hospital and the incident was classified as no harm. The trust commissioned an external review by another trust in 2021 and due to clinical pressures, the review was not completed until December 2022.	• PMRT report not to be closed until case has gone through Divisional Mortality and Morbidity Meeting • Nominated governance representative is required to attend obstetric and perinatal M&M meeting to ensure all discussions from M&M are

	The external review identifies numerous clinical concerns regarding the neonatal resuscitation and has classified the incident as a 'death'	included as part of the PMRT review process • Learning with neonatal teams regarding the neonatal algorithm and maintaining situational awareness
Paweb 127181 **STEIS 2023/3821** **21/02/2023** **Open**	The patient had a forceps birth with an episiotomy in maternity theatres. She was discharged home the following day with no postnatal concerns. She was seen by the community midwifery team at home and perineal inspections were not completed. The patient reported an abnormal smell from her perineum and was advised to attend Maternity Triage for assessment. At this stage she was 9 days postnatal. A large swab was found inside the vagina – a retained item from birth or suturing.	• Ensure the WHO checklist is completed for every patient undergoing a surgical procedure in theatre • LOCSSIPS forms are in place for procedures outside of theatre • "Pause for Gauze" - when counts are taking place noise and distractions must be kept to a minimum to enable the scrub and circulating practitioner to complete the surgical counts. • All swabs should be recorded in multiples of five on the count board. Additional swabs require an individual count and are added to the count board in five's e.g. 5+5+5 • Perineal checks should be offered at every postnatal opportunity. If declines this should be documented.

Risk Register

The Maternity services risk register is reviewed on a weekly basis at the Weekly assurance meeting led by the Director of Midwifery. All risks that are new or to be closed will be authorised at the monthly divisional governance meeting, with final approval at divisional board. Currently the service has 23 open risks, 12 of which were added over the reporting period.

Table 4 details that there are 9 risks on the register with a rating of over 15. Two risks will be reviewed during March 2023 with their overall risk score substantially reduced, due to the work undertaken. It is anticipated that In April-May 2023 two further risks will be reduced from a 16.

Table 4. Risks over 15

Location	Description	Actions:	Score (CxL)
Women's Health	To ensure the appropriate systems are in place to maintain safety to staff in relation to Entonox exposure.	Risk to be reduced due to ongoing works. Systems have been implemented and further testing will ensure that the new equipment is sufficient at reducing the risk. Works have been completed on Labour ward with work still to be undertaken on birth centre. For risk reduction March 2023	04x04=16

Operational	To ensure there are working IT systems (including printers) in community	IT is using multiple avenues to get connectivity for the Community midwives. There're some new laptops that will be coming in. Exploring a multi SIM to provide efficient connectivity. It will help with regards to the Community midwives being able to undertake their work in a live element and hopefully aid with the new EPR system.	04x04=16
Operational	Phase 1 - The implementation of Centralised Cardiotocograph Monitoring in MDAU Phase 2 - To review the feasibility centralised CTG monitoring for Antenatal and Intrapartum areas.	Centralised CTG monitoring in MDAU was completed – to confirm it is up and working Centralised CTG for antenatal is not being considered presently Centralised CTG is being operationalised presently with a go live date of May 2023. For risk reduction May 2023	04x04=16
Antenatal	To reduce delays in admissions to the antenatal ward and subsequent transfers to delivery suite (IOL delays)	Forms part of IOL work stream. IOL electronic booking system being developed. Draft guideline complete and out for peer review. For risk reduction April 2023	04x04=16
Women's Health	Ensure staff compliance with basic life support training meets the trust's compliance target of 90%.	New training week commenced in March 2023. This incorporates BLS as a standard on Day 4 and is MDT with both midwifery and obstetric staffing in attendance. Whilst compliance is currently below the expected standard the implementation of the training week will see consistent figures of over 90% once all staff have been through the new programme.	03x05=15
Community	All midwifery community teams to have a suitable location to work from	Currently in the process of mapping all community spaces.	03x05=15
Labour Ward	To implement a low-level ventilation 'Scavenger' system in all birthing rooms including the bereavement suite.	Risk to be reduced due to ongoing works. Systems have been implemented and further testing will ensure that the new equipment is sufficient at reducing the risk. Works have been completed on Labour ward with work still to be undertaken on birth centre. For risk reduction in March 2023	03x05=15
Women's Health	To improve the culture and professional relationships within the Maternity Service.	GMC/NMC workshops undertaken. Datix have reduced. Service to work through staff survey results and will be undertaking a nationally renowned culture survey in spring this year (SCORE survey). Risk will be reviewed once this has taken place	03x05=15
ANC	To review the pathway for reviewing scans due to the lack of consultant and registrar presence for all clinical areas.	Part of the fetal growth workstream. Meeting has been arranged with CCCSS to review current process and scope for further capacity.	03x05=15

Patient Experience

Throughout the reporting period there were 26 complaints raised and 101 PALs. Of these 31% of complaints are open with 15% of PALs pending further investigation.

Table 5. Breakdown of monthly Complaints and PALS received

Month	Complaints	PALs
Feb 2022	0	10
Mar 2022	2	7
Apr 2022	2	3
May 2022	4	11
Jun 2022	3	6
Jul 2022	1	7
Aug 2022	3	3 (1 open)
Sep 2022	0	9 (4 open)
Oct 2022	4 (4 open)	9 (1 open)
Nov 2022	3 (1 open)	7 (1 open)
Dec 2022	0	11 (3 open)
Jan 2023	2 (1 open)	10 (2 open)
Feb 2023	2 (2 open)	8 (3 open)
Total	**27 (8 open)**	**101 (15 open)**

Themes from complaints relate to direct care provided and communication. With PALS, the themes centre around communication and delay. A new streamlined, strengthened and family centred complaints process will be operational from April 2023.

Procedural Documents

There has been a good level of improvement in the amount of outstanding guidelines for maternity services with 6% (9) outstanding. All guidance has been allocated to the relevant clinician, progress is reviewed at the divisional governance meeting where escalation occurs for non-compliance. The service has recently introduced a procedural document forum to improve this process and to ensure all relevant stakeholders are involved in the review and implementation of new and updated guidance.

Table 6. Procedural documents and NICE guidelines update

Local Document Tracker	New Draft	Due Review	Under Review	Expired	Approved and Published	Total
Women's Health	1	3	11	9	120	144

NICE Tracker	Not Assessed	Under Review	Mostly Implemented	Review outstanding	Fully Implemented	Total
Women's Health	**2**	**18**	**9**	**3**	**42**	**74**

Legal

There were 3 new claims relating to maternity services received between February 2022- February 2023. All cases received referred to post birth complications with blood loss and retained products of conception. It is recommended that a deep dive is undertaken to highlight themes from claims and to report on lessons learned. It is recommended that this is added to the workplan for 2023-2024.

One case was closed during the time period reported which related to poor care during and post birth. The claim was settled.

4.0 Review of Committee Work Plan

All papers that were scheduled for the committee were presented by the service in accordance with the pre-determined work plan.
A number of deep dives were presented to the committee for assurance and to show progress:

- Pre-term birth
- Post-partum haemorrhage
- Instrumental birth and Caesarean at full Dilatation
- Serious Incidents Thematic Analysis
- Maternity Digital Strategy
- Perinatal Mortality Review Tool
- Review of NHSE Maternity Self-Assessment Tool

5.0 Regional Feedback

An insight visit to PAHT was completed on the 8 April 2022 by the regional team. The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the first Ockenden report. The insight visit team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice. Conversations were held with members of the senior leadership team and front-line staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions headings

Key headlines from the visit:

- Investment in the senior leadership team had enabled positive progress
- Joining the governance team and PDM and preceptor midwives together had developed working relationships and strengthened risk, governance and training
- The education bus was welcomed by staff
- PMA Padlett was described as a very useful resource
- Weekly ‘Ask Giuseppe’ meeting
- Suggestion box was appreciated by staff and they could see the suggestions being acknowledged and changes made.
- Maternity Voices Partnership (MVP) webinars were appreciated
- Staff were more confident and understood their roles and responsibilities
- Training compliance was very good

Recommendations from the visit and points for consideration were:

- A review of the director of midwifery's portfolio which was vast, detailing that it may not be achievable to give the assurance required to improve all of the services within the current portfolio and demands
- Triage processes were not being followed. The RAG rating telephone sheet not completed or audited. A review of process whilst awaiting the new geographical footprint was recommended
- Midwifery staff were reviewing high risk women having repeated scans, a review of Maternity Day Assessment Unit (MDAU) flow, antenatal clinic appointments and scans needing a high-risk review
- Anaesthetists were not always at handover and ward rounds
- The triumvirate need to exception report directly to Board
- Signage around the hospital needs improving
- Transitional care pathway needs reviewing
- The IT system needs to have good functionality specific to maternity service needs
- Midwives must have correct training and competency checks to scrub and recover in line with national guidance
- Maternal medicine pathways require further work

6.0 National workstreams

- CQC – the service is currently rated as requires improvement and has been working closely with our Maternity Service Support Programme Lead. It is expected that the service will have a full inspection undertaken by May 2023 as per national trajectories.
- Ockenden – out of 103 actions for Trusts, PAHT have completed 84. 15 are in progress and 4 are outstanding. The 4 outstanding actions refer to antenatal care pathways and preconception care which is currently unfunded.
- Maternity Incentive Scheme – the maternity service declared compliance with 9/10 safety actions as reviewed by this committee. No update has been received from NHS Resolution relating to the submission of the declaration form.
- East Kent – the service has a local action plan that was implemented following the publication of the report. This has been paused pending the forthcoming single delivery plan anticipated in March 2023.
- Saving Babies Lives Care Bundle v2 (SBLCBv2) – Compliance was declared for all 5 elements of SBLCBv2. Although compliant, improvement work continues as part of the Maternity Improvement Board.

7.0 Maternity workforce overview

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

In 2021, a full workforce review was completed by the director of midwifery. The methodology of this review involved reviewing each cost centre to determine funded posts, alongside establishing what was recommended by BR+ for midwifery staffing, and using professional judgement to determine the staffing levels needed for all midwifery areas. The BR+ report and the workforce review identified

that 22.74 WTE posts (midwives, support workers, specialist and managerial posts) were needed for the maternity service. This was approved and funded by the Trust board in February 2022

Further managerial and specialist roles were needed as detailed in the BR+ report. A gap analysis was completed with the Royal College of Midwives strengthening midwifery leadership manifesto which enabled a review of services to include more specialist roles necessary for a modern maternity service.

Table 7 provides an overview with the specialist and managerial posts that have been recruited to, following the uplift in establishment

Table 7. Specialist and Manager recruitment

Post	Recruited	Started
Band 8c Consultant Midwife		
Band 8a Matron: Labour Ward		
Band 7 Diabetic Midwife		
Band 7 Perinatal Mental Health Midwife		
Band 7 Preceptor Support Midwife		
Band 7 Fetal Medicine Midwife		

Midwifery vacancies

There is a continued challenge extrapolating the midwifery establishment, with differing data available on e-roster, the provider workforce return and the budget statements. A thorough review of the workforce has been undertaken utilising the funded establishment as approved by board against staff in post on e-roster, due to this data being more accurate.

The current vacancies are detailed in Table 8 and are correct as from January 2023.

Table 8. Midwifery vacancies

Staff group	Budget	Actual	Variance
Registered Midwives	157.93 WTE	144.87 WTE	-13.06 WTE (8.2%)
Registered Nurses	6.19 WTE	7.44 WTE	+1.25 WTE
Unregistered Staff (Bands 2-4)	62.89 WTE	45.41 WTE	-17.48 WTE (27%)

Following a successful recruitment event, 16.18 WTE newly qualified Band 5 midwives joined the maternity service between September to December 2022. During the same time period 10.24 WTE midwives were promoted. 8.24 WTE midwives were internally promoted to Band 7 and Band 8 roles. With 2 WTE midwives leaving the organisation for promotion to Band 7 and Band 8 roles.

A further 9 WTE Band 5 midwives are joining the service between January to March 2023.

10 WTE maternity support workers were recruited and commenced in November and December 2022. 3 WTE maternity support workers are joining the service in February 2023.

A recruitment event was held in March 2023 with 23 WTE Midwives offered Band 5 roles and 10 WTE Maternity Care Assistants offered roles

The service continues to monitor its sickness rates as this continues to be high. Table 9 demonstrates that sickness rates remain to be high amongst unregistered staff, where there is the highest vacancy. A practice development midwife for unregistered staff is in post to support in career development and aligning the workforce to national competency frameworks. The new recruitment, retention and wellbeing lead midwife continues to provide pastoral support. This post is also the lead Professional Midwifery Advocate for the organisation.

Table 9. Workforce metrics (December 2022 data)

Staff group	Maternity Leave	Sickness %	Total unavailability and vacancy
Registered Midwives	6.44 WTE (4.1%)	5.90 WTE (3.7%)	25.40 WTE (16%)
Registered Nurses	1 WTE (16.2%)	N/A	0.25 WTE
Unregistered Staff (Bands 2-4)		10.64 WTE (17%)	28.12 WTE (44%)

Obstetric workforce

Recruitment continues for key obstetric posts. The post of divisional director has been recruited to. Currently 1 WTE Consultant Obstetrician and Gynaecologist post is out to advert on NHS Jobs. 1 WTE Consultant Obstetrician and Gynaecologist will be joining the service in spring 2023

8.0 The NHS England Maternity Safety Support Programme (MSSP)

PAHT entered the NHS England Maternity Safety Support programme (MSSP) following the CQC's inspection of PAHT maternity services between March and April 2019. Following a further CQC unannounced inspection between July and September 2021 and subsequent submission of evidence, the CQC did not revise the ratings for PAHT

Table 10. Previous and current CQC inspection ratings

Year	Safe	Effective	Caring	Responsive	Well-led	Overall
2015	RI	G	O	G	G	G
2016	G	G	O	G	O	O
2019	RI	RI	G	G	RI	RI
2021	RI	RI	G	G	RI	RI

Although the Trust has not met the full requirement criteria to exit the MSSP, significant improvement has been made and sustained over a period of time.

The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England. The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

Criteria for entry to the MSSP are maternity services which have:

- An overall rating of inadequate
- An overall rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain
- Been issued with a CQC warning notice
- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains
- DHSC or NHS England request for a review of services or inquiry
- Been identified to CQC with concerns by HSIB

A Maternity Improvement Advisor (MIA) was allocated to PAHT to work with the executive and divisional leaders to support the delivery outcomes identified in the CQC Report.

Criteria for leaving the programme is a CQC improved rating by at least one in the safe and well led domains. This has not been achieved but with external recognition of the significant improvement progression made, the Trust seeks to exit the programme with support of a formal paper being presented to the Quality and Safety Committee, regional and national teams for consideration. This is currently being drafted by the Director of Midwifery

9.0 Key Achievements

2022 saw some key achievements for the maternity service at PAHT:

- Baby Friendly Initiative (BFI) gold accreditation. PAHT is the first Trust in the East of England to be accredited with such an award.
- Launch of the new 24/7 PAHT Maternity Triage service. The service is now in line with national best practice standards

- Introduction of monthly multidisciplinary diabetes meetings, to ensure a consistent and coordinated process for identifying, planning and delivering personalised care plan to pregnant women and people with diabetes.
- Introduction of electronic digital booking for Caesarean Sections and theatre procedures.
- Review of the Maternity Improvement Board structure with the development of 10 transformation workstreams to strengthen, transform and develop the maternity services.
- Launch of the Maternity Education and Training forum, to bring together members of the maternity and neonatal teams to support the timely identification, planning and implementation of education and training initiatives whilst monitoring training compliance and targets for all staff groups.
- Healthy Lifestyle post in place offering in house smoking cessation and post-natal contraceptive implants
- Pelvic health service running and fully recruited to (Midwife, Physiotherapist, Maternity Support Worker)
- Joint Nursing and Midwifery Council and General Medical Council culture workshops to strengthen multidisciplinary working
- Quadrumvirate Culture Training Course provided by NHS England
- Direct reporting to board – director of midwifery represents maternity at Trust board and portfolio reviewed with sole focus on women's services.
- Increased and improved collaboration between the maternity service and the MVP. We have worked collaboratively on improving women's experiences by working together during the pandemic, on messaging and recruitment

Challenges

- Current infrastructure and estate not fit for purpose. This will be addressed with the planned refurbishment and new hospital build.
- Recruitment and Retention for Midwifery/Obstetric/Maternity Support Worker posts. Recruitment action plan in place with trajectories. Successful recruitment events throughout reporting period
- COVID-19 recovery plans – Statutory and Mandatory training below expected targets, new training week developed which will improve compliance
- Digital maturity – new Trust wide electronic patient recorded to be implemented in 2024
- Cross boundary working – Reviews underway with counterparts at Lister Hospital to review workforce and boundaries.
- Lack of provision of community midwifery bases remains a risk. The service is looking at community hubs

Next Steps for 2023

Maternity enhanced care – A competency framework is to be developed for all staff working within the recovery area of Maternity. The site does not have a maternity high dependency unit but it is expected that midwives and nurses working within the unit have the appropriate knowledge and skill set to recognise deterioration. There is now a rolling continuous professional development (CPD) course for care of the critically ill woman with the aim of at least 1 trained member of staff to be available on every shift.

Transitional care unit – whilst the service offers transitional care further work is required to develop this service and ensure that both the workforce models and facilities are in place to support this service. This will require a staffing review and will require financial backing to be successful and meaningful.

Culture work (Score Survey) – commencing in late spring 2023 the service will undertake a culture survey with all staff working within maternity and neonatal services. It is recommended that the findings of this survey be shared with the committee.

Continuity of Carer – paused due to COVID-19 and following the Ockenden Report. The service will have an improved position with staffing and therefore able to look at reintroducing further Continuity of care models across Essex, with the aim of a further team being launched in late 2023.

Relaunch of strategies following single delivery plan – The single delivery plan is a national plan for all maternity and neonatal services following review of all of the national reports and scrutiny into services provided. This is expected to be published in March 2023. The service will review the planned actions for implementation and will report through this committee the initial findings of the report and expectations. A review of the local strategies in place will be undertaken following this to ensure they are in line with the national trajectory.

Recommendation

It is recommended that a deep dive for legal claims is added to the work plan for the forthcoming year. The service would like to recommend that this committee continues, to enable a supportive environment in which maternity services can demonstrate evidence of ongoing work and provide critical oversight.

Author: Giuseppe Labriola, Director of Midwifery, Jo Keable, Deputy Director of Midwifery & Erin Walters, Head of Maternity Governance and Assurance

Date: 03.03.2023

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 April 2023

4.2

Agenda item:	4.2							
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance							
Date prepared:	3rd March 2023							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There was 1 new maternity incident declared since the last report There were 0 maternity incident closed since the last report Maternity services currently have 8 SI's under investigation (0 HSIB).							
Recommendation:	To provide assurance to the Board that the maternity service are continually monitoring compliance and learning from Serious Incidents.							

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

Previously considered by:	Patient Safety Group – 14.03.2023 To be considered at Divisional Board 29.03.2023 To be considered by QSC 31/3/03
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	1. Open Serious Incidents under investigation

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

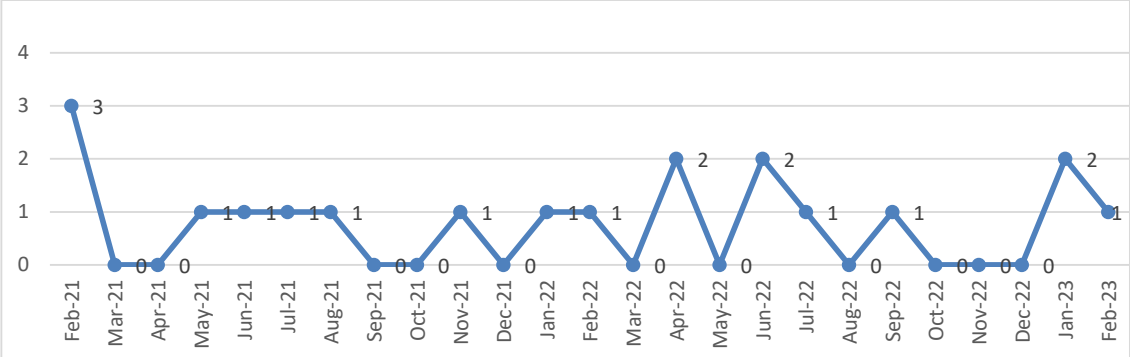
2.0 Background

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

3.0 Analysis

Maternity currently have 8 SI's under investigation, 0 of which are being investigated by Healthcare Safety Investigation Branch (HSIB). Table 1 details the trend of declared SI's within the last 24 months to February 2023.

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



There was 1 new serious incident declared in February 2023.

Serious Investigations	
Number Declared for February 2023	1
Number Submitted for February 2023	0
Number Past CCG Deadline as of February 2023 (Not including HSIB/Approved Extensions)	0

New Serious Investigations declared			
Ref	**Ethnicity**	**Summary**	**Learning Points**
Paweb 127181 **Steis 2023/3821** **21.02.2023**	White British	Forceps birth with an episiotomy in maternity theatres. Discharged home the following day with no postnatal concerns. Following concerns at she was 9 days postnatal, a retained swab was found– a retained item from birth or suturing.	• Ensure the WHO checklist is completed for every patient undergoing a surgical procedure in theatre • LOCSSIPS forms are in place for procedures outside of theatre • "Pause for Gauze" - when counts are taking place noise and distractions must be kept to a minimum to enable the scrub and circulating practitioner to complete the surgical counts. • All swabs should be recorded in multiples of five on the count board. Additional swabs require an individual count and are added to the count board in five's e.g. 5+5+5

			• Perineal checks should be offered at every postnatal opportunity. If declines this should be documented.
Closed Serious Investigations			

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

4.0 Themes

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

Table 3. Top Themes

Total Number of SI's	Theme	Number
19	Cardiotocograph (CTG) interpretation	7
	Obstetric Haemorrhage	6
	Neonatal death	5
	Delay in care	4
	Compliance with guidance	3
	Hypertension	3
	Intrauterine death	3
	Escalation	3
	Hypoxic ischaemic encephalopathy	3
	Laceration at caesarean	1
	Fetal growth	1
	Cross Border Working	1
	Medical Equipment	1
	Screening Incident	1

5.0 Oversight

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

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

Current work streams include:

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

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

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

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

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

6.0 Recommendation

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

Author: Erin Walters – Head of Maternity Governance and Assurance
Date: 3rd March 2023

Trust Board (Public) – 6 April 2023

Agenda item:	4.3
Presented by:	Sharon McNally – Chief Nurse and Deputy CE
Prepared by:	Sarah Webb – Deputy Chief Nurse
Date prepared:	16.2.2023
Subject / title:	Report on Nursing and Care Staff Levels for February 2023– 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	The overall fill rate for February was 92.5%. RN fill rate increasing by 1.8% to 87.6% and care staff fill rates decreased by 0.1% to 107.2%. The report includes the fill rate for Critical Care for the first time. This will be a regular inclusion to meet NQB requirements to report on Trustwide nurse staffing fill rates.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	People Committee: 27th March 2023
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2a:** Ward staffing exception reports. **Appendix 3**: ITU / HDU compliance with Guidelines for the provision of Intensive Care Services

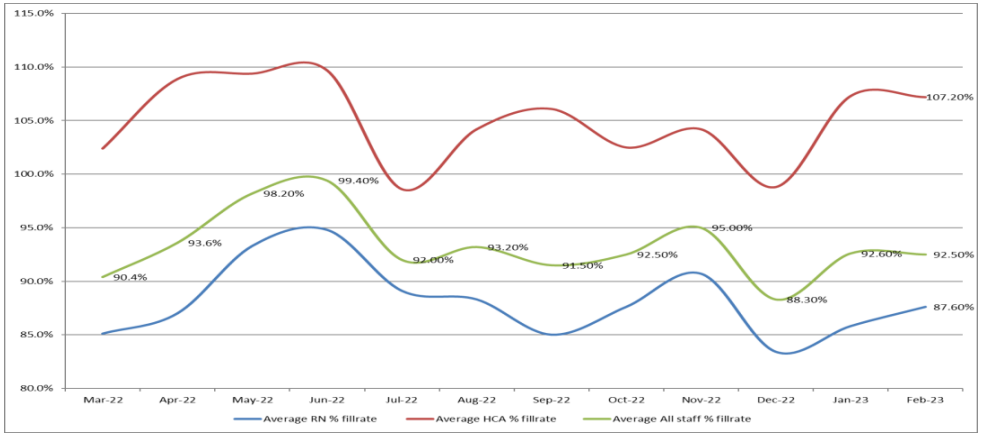
There was an upward trend in average fill rates in February; with the overall fill rates for February being 92.5%. RN fill rate increasing by 1.8% to 87.6% and care staff fill rates decreasing by 0.1% to 107.2%. Nightingale ward continues to be open as part of winter escalation plans.

AAU continues to be an area of concern with a 39% Band 5 vacancy rate. The ward is being supported and prioritised for new starters from the International pipeline and as well a number of other measures to ensure fill rates and skill mix meet demand and acuity.

ED fill increased in February although day fill remained low at 76.5%. Overall vacancy in ED continues to reduce and care staff fill rates have increased. The Respiratory ED (RED) area closed in February and this has supported safer staffing.

Critical care fill rates are reported in this paper for the first time in this format. See Appendix 3 for background on how safe staffing is calculated for critical care areas. In February the unit had more than the required numbers of staff for acuity of patients on 13 occasions (green bars). The numbers on the left of the graph and length of the bars denotes by how many staff. There were 12 occasions in the month when staffing fell below the required staffing levels. On three occasions this was by 2 staff. Regular reporting and comparison month on month will help to provide a benchmark for this variation.

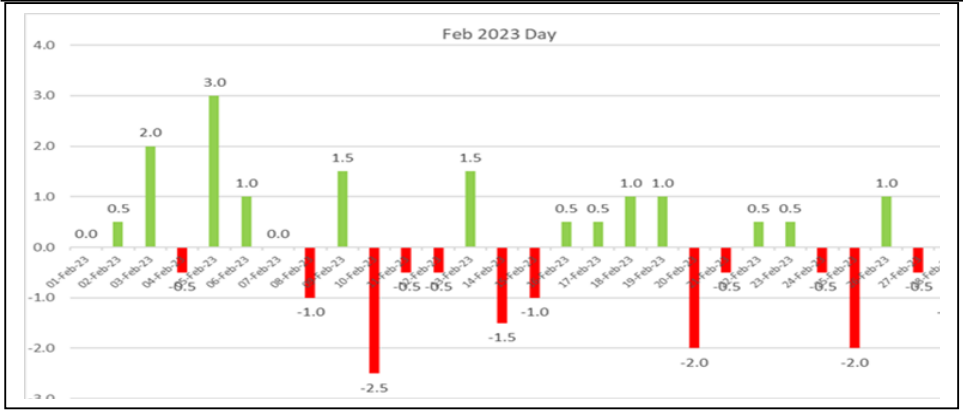
Inpatient Fill rate



ED Fill rate

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
December 22	77.2%	79.3%	84.3%	73.9%
January 23	74.5%	86.8%	86.4%	84.6%
February 2023	76.5%	93.4%	91.4%	95.3%

Critical Care Fill rate



The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) decreased to 239 (↓40) against January, (December had 383 occasions). If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

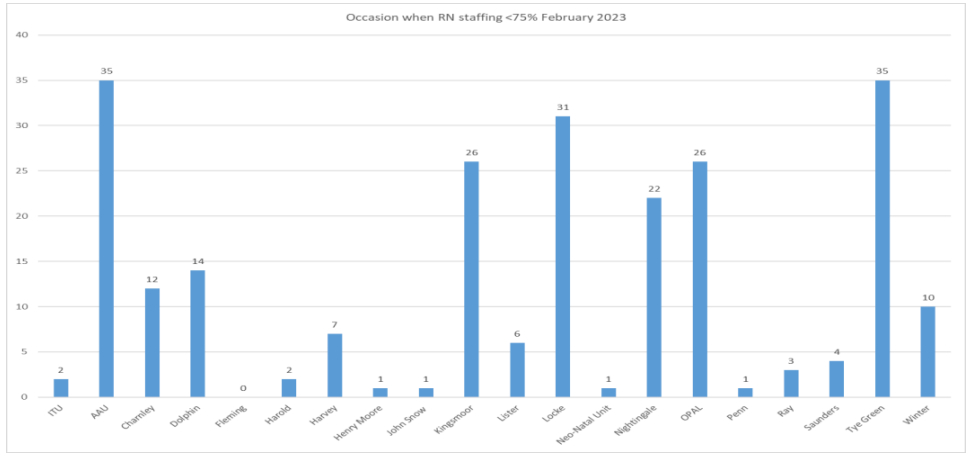
Datix reports in relation to staffing levels decreased to 38 (↓24) against January and 82 in December. Tye Green raised 6, AAU 7, with Kingsmoor and Ray raising 4 each. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

Nightingale, Locke and Tye Green reported average fill rates below 75% for RN against the standard planned template during February. This is the sixth consecutive month overall fill rates have been below 75% for Tye Green. Details on the impact on care can be found below.

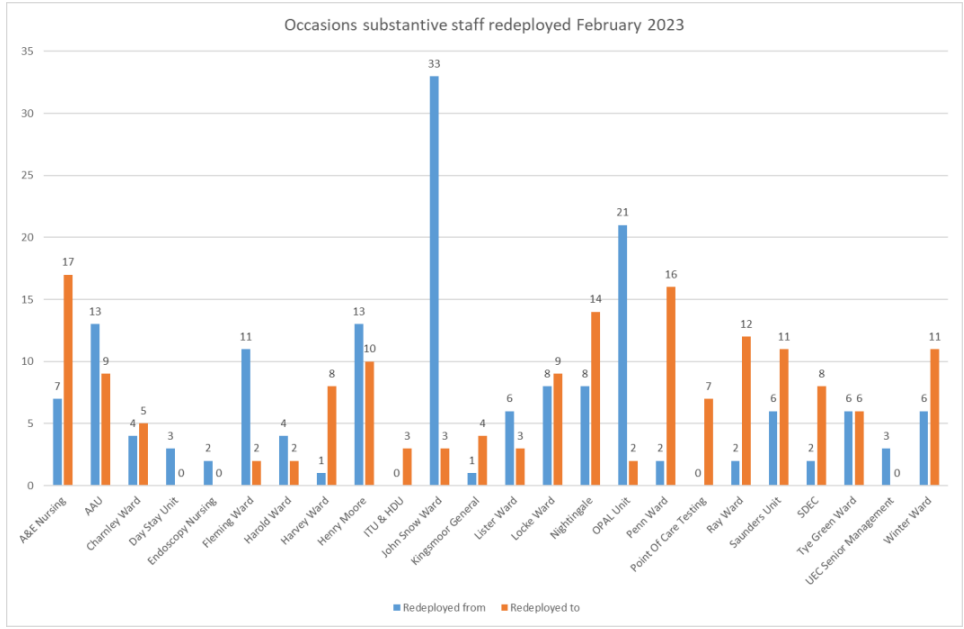
Redeployment of staff continues to be undertaken to support SafeCare as part of the daily huddles. In February staff were moved from elective surgical wards (JSU and HMU) followed by Opal and Fleming both wards that have very low vacancies or are over establishment as well as fluctuating acuity of patients based on bookings. Highest net receivers of staff were Nightingale (winter escalation), Penn and A&E.

Following the ward managers awayday a small working group are developing the redeployment SOP

Occasion when RN staffing <75%

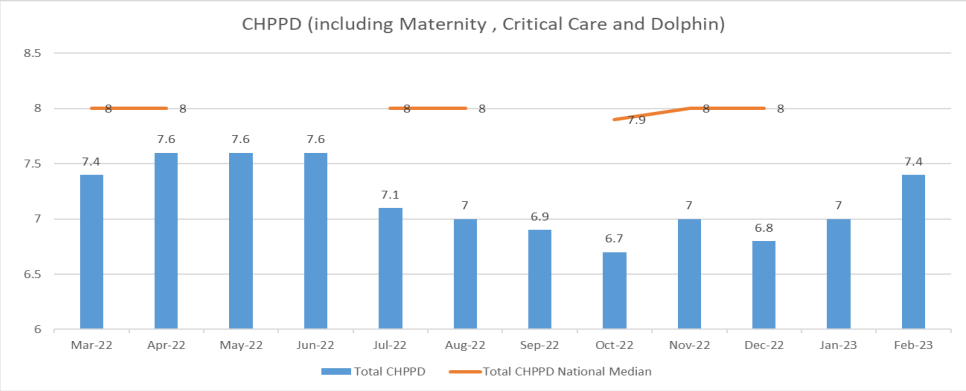


Redeployment



Overall Care Hours Per Patient Day (CHPPD) was 7.4 for February 2023. The Model Hospital data for December 2022 shows the Trust with a CHPPD of 6.8 against the national median of 8.

CHPPD



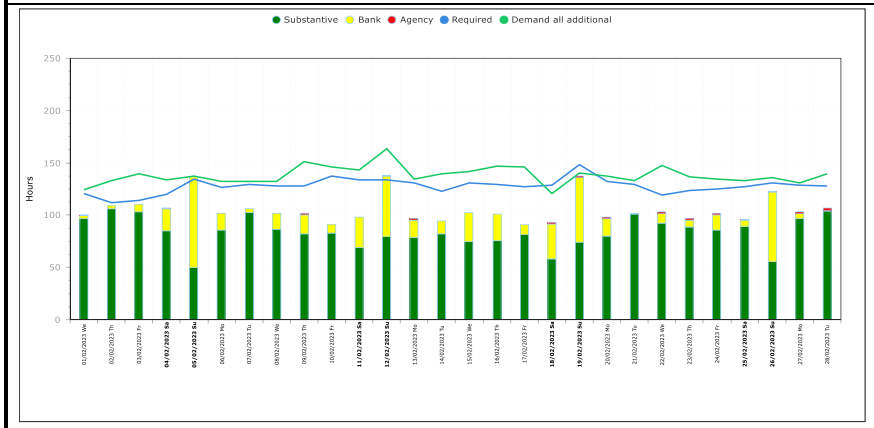
Appendix.1. Ward level data: fill rates February 2023. *(Adjusted Standard Planned Ward Demand)*

	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	93.0%	109.5%	97.0%	131.5%	95.0%	120.5%	97.3%
Saunders Unit	83.5%	107.6%	93.8%	112.4%	87.8%	109.4%	95.6%
Nightingale	72.2%	66.6%	69.0%	76.7%	70.7%	71.4%	71.0%
Penn Ward	89.3%	121.4%	96.3%	150.2%	92.3%	132.4%	106.6%
Henry Moore Ward	100.1%	148.6%	103.9%	117.9%	101.9%	134.5%	113.0%
Harvey Ward	87.7%	124.1%	123.9%	120.1%	102.4%	122.2%	109.6%
John Snow Ward	103.8%	50.3%	96.7%	32.1%	100.4%	44.6%	76.3%
Charnley Ward	81.5%	104.8%	77.8%	119.1%	79.7%	111.6%	88.9%
AAU	97.9%	148.5%	94.9%	183.8%	96.4%	165.4%	114.2%
Harold Ward	91.9%	92.3%	93.9%	136.3%	92.9%	113.3%	99.7%
Kingsmoor General	62.6%	119.2%	99.5%	123.9%	76.6%	121.4%	93.3%
Lister Ward	79.6%	123.0%	91.9%	122.2%	84.8%	122.6%	99.9%
Locke Ward	70.2%	96.3%	68.3%	120.0%	69.3%	107.6%	83.7%
Ray Ward	98.2%	102.0%	121.1%	178.2%	107.9%	130.9%	116.2%
Tye Green Ward	67.8%	97.0%	70.4%	125.6%	68.9%	108.6%	84.4%
OPAL	91.7%	179.5%	114.7%	96.3%	100.4%	125.7%	109.8%
Winter Ward	79.4%	112.0%	90.3%	130.5%	84.0%	120.9%	98.7%
Fleming Ward	96.3%	103.1%	103.2%	103.4%	99.3%	103.3%	100.6%
Neo-Natal Unit	106.4%	74.6%	100.8%	92.9%	103.6%	83.7%	100.3%
Dolphin Ward	84.2%	86.0%	84.0%	94.6%	84.1%	88.9%	85.3%
Total	87.6%	107.2%	92.5%	120.1%	89.9%	113.0%	97.2%

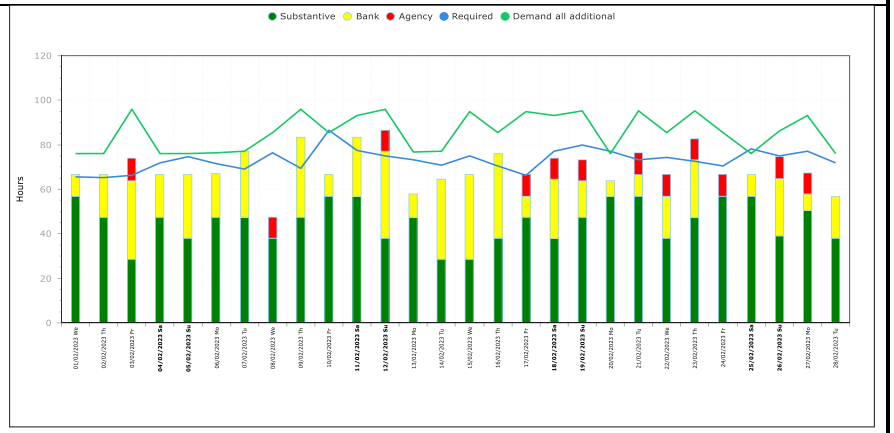
Appendix.2. Ward staffing exception reports for 3 areas where fill was below 75% NB In graphs below bars = staff on shift; blue line = staffing required based on acuity and dependency recorded twice a day and the green line = demand template based on establishment review.

Report from the Associate Director of Nursing for the Division							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
This is the 6th consecutive month that Tye Green overall RN fill rate has been below 75%	RN overall Fill: 68.9% HCSW Overall Fill: 108.6% Overall Fill: 84.4%			Increase in falls and pressure injuries but low or no harm as a result			• WM worked clinically in the numbers • OPD support • PDN Support • Additional support from HCSW • Support from Matron
Quality Metric	PU	Falls	Staffing Datix	Sis	Drug Errors	Complaints	PALS
Number in month	9	8	6	0	0	0	0

Required vs Actual Day

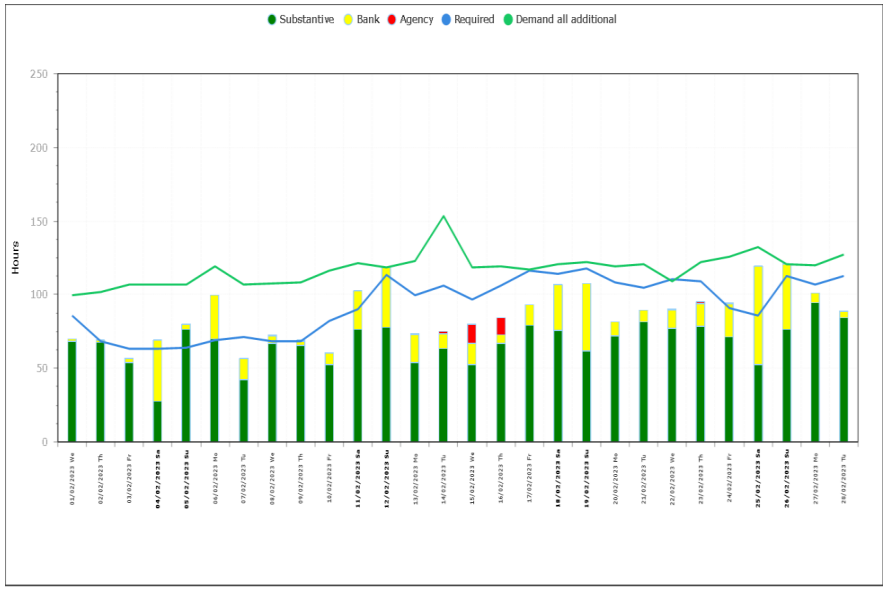


Required vs Actual Day

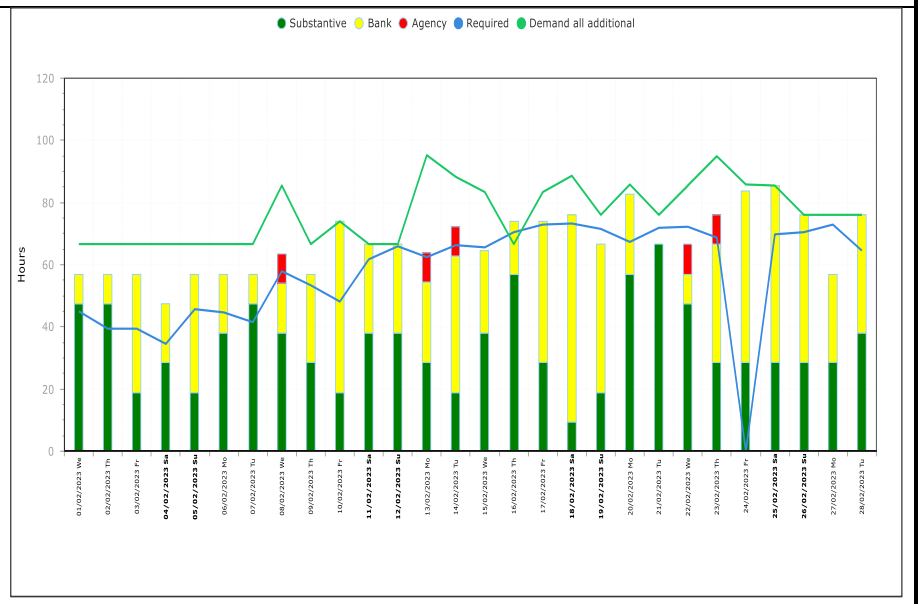


Report from the Associate Director of Nursing for the Division							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
Locke	RN overall Fill: 69.3% HCSW Overall Fill: 107.6% Overall Fill: 83.7%			Nil			• Locke had an outbreak of Norovirus in Feb which accounts for the low fill rate as beds closed and empty and staff re-deployed to other areas.
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	5	8	0	0	1		1

Required vs Actual Day

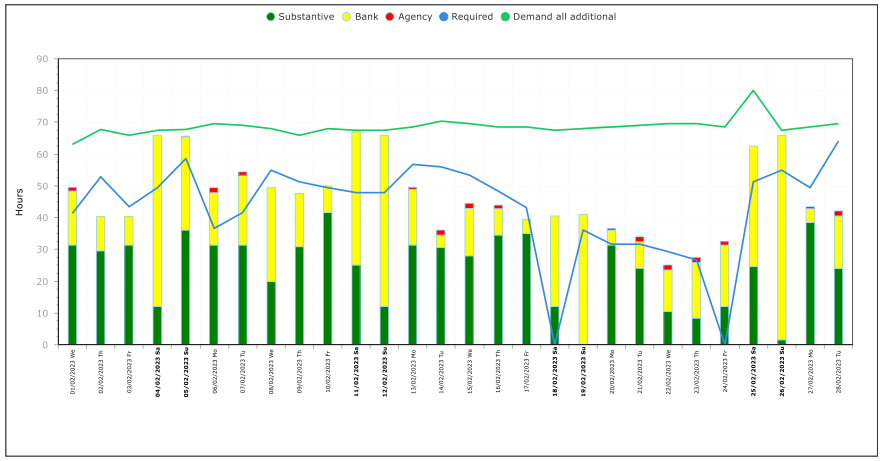


Required vs Actual Day

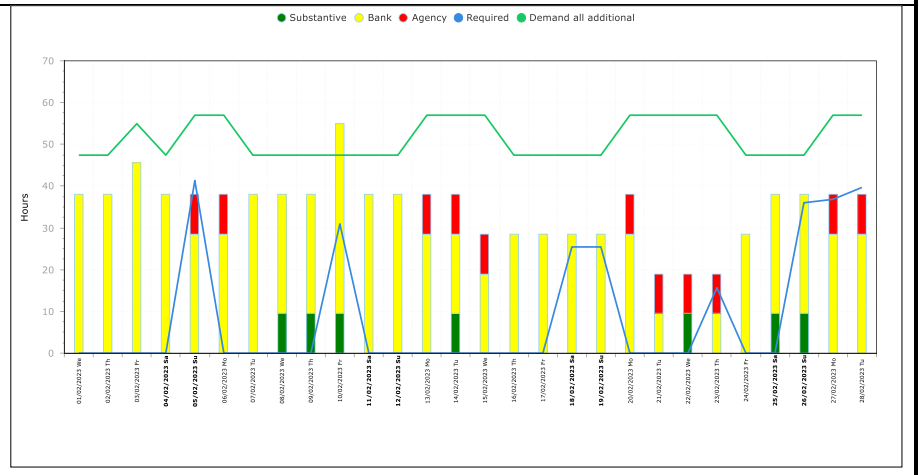


Report from the Associate Director of Nursing for the Division							
Ward	**Analysis of gaps**			**Impact on Quality / outcomes**			**Actions in place**
Nightingale	RN overall Fill: 70.7% HCSW Overall Fill: 71.4% Overall Fill: 71.0%			Staffing levels were maintained above the reported level as the ward manager worked to support in the nursing numbers, Safecare should be updated to reflect this. As there are only a small number of substantive staff and reduced bed numbers this is appropriate.			• WM worked in numbers to ensure minimum staffing levels achieved
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	3	4	0	0	1	0	2

Required vs Actual Day



Required vs Actual Day



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

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

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

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

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

All shifts include a supervisory nurse.

The Princess Alexandra Hospital NHS Trust

Learning from Death and Mortality Paper for Trust Board April 2023

4.4

Agenda item:	4.4
Presented by:	Lance McCarthy | Chief Executive
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team Fay Gilder | Medical Director
Date prepared:	30 March 2023
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
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.*
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.4

1.0 Purpose/issue

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

2.0 Background

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

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

3.1 Background

Due to staff shortages in the clinical coding team, the complete coding of the PAHT superspell data has not been completed by the Hospital Episode Statistics (HES) monthly freeze date for the months of May-August 2022. Between 15-23% of spells were uncoded (identified by the term 'residual code') over this period – see figure 3 below. Completed data has been submitted by the HES freeze date for September and October 2022. This section discusses the current mortality position for PAHT and the impact of the uncoded superspells on the mortality indices.

3.2 Analysis

REPORT HEADLINES

Data Period: Nov 2021 - Oct 2022

Metric	Result
HSMR	113.23 (higher-than-expected) (105.74 – 121.10)
HSMR position vs. peers	Regional peer group = 14 acute trusts: • 8 higher-than-expected • 4 within expected • 2 lower-than-expected Region as a whole = 105.3 (higher-than-expected) (103.8 – 106.8) **Trust are not statistically significantly different than current peer group*
All Diagnosis SMR	109.2 (higher-than-expected)
***Proportion of activity uncoded (most recent month) vs. national**	*7.8% (vs. 2.3% nationally) (n=454 superspells)*
***Proportion of activity uncoded (last 12 months) vs. national**	*8.3% (vs. 2.1% nationally) (n=5767 superspells)*
Significant Diagnosis Groups	• **Acute and unspecified renal failure (355 superspells; 60 deaths)** • Diabetes mellitus with complications (164 superspells; 11 deaths) • **Genitourinary symptoms and ill-defined conditions (392 superspells 5 deaths)**
CUSUM breaches	• **Acute and unspecified renal failure (Oct-22)** • Gastrointestinal haemorrhage (Sep-22) • Septicemia (except in labour) (Aug-22) • Lung disease due to external agents (Dec-21) • Lymphadenitis (Nov-21) • Viral infection (Nov-21)
SHMI position	(Oct-21 to Sep-22) 105.61 (as expected)

The Princess Alexandra Hospital NHS Trust

Figure 1. HSMR and SMR figures are 12 month rolling averages and have been affected by the coding position explained below

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

Key points

HSMR for the period Nov-21 to Oct-22 is 113.23 and "higher-than-expected", based on 21,001 superspells and 850 deaths.

HSMR for Oct-22 is 118.96 and "within expected", based on 1770 superspells and 70 deaths.

The proportion of uncoded SUS data appears to have increased again for October, with 7.8% of all discharges in October reporting with a primary diagnosis of 'residuals code, unclassified'. This compares to a rate of 2.3% nationally. However, as presented previously, the number of deaths from this diagnosis group remains low and resultantly, there is still merit in analysing the data for mortality insights. It must be caveated though that it is likely that there are missing survivals yet to be coded for the HSMR basket.

As a consequence, the crude rate for HSMR at PAH continues to rise and move away from the expected rate, driving HSMR further upwards despite the improved single-month HSMR values being reported.

Figure 1 – HSMR Monthly Trend

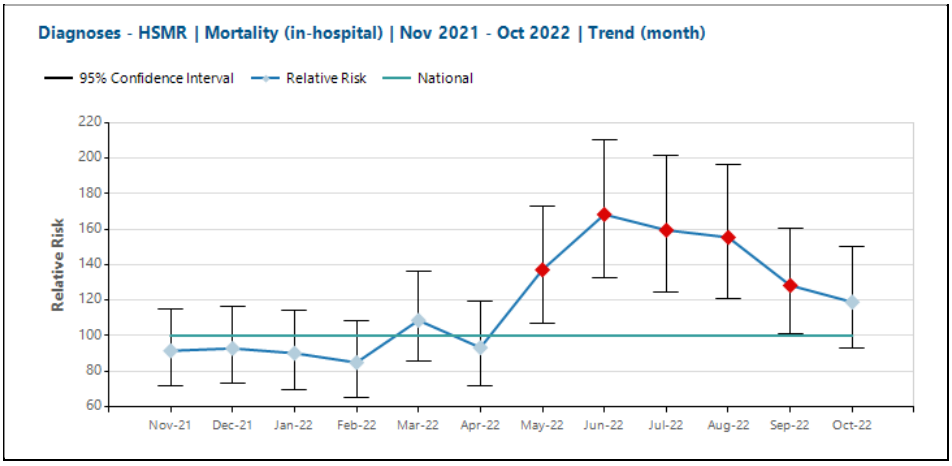


Figure 2. Monthly HSMR trend

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO
All	5,386	100.0%	5,402	29	0.5%	63.2	1.2%	-34.2	45.9	30.7
Oct-21	81	1.5%	81	0	0.0%	0.9	1.1%	-0.9	0.0	0.0
Nov-21	49	0.9%	49	0	0.0%	0.2	0.5%	-0.2	0.0	0.0
Dec-21	72	1.3%	72	0	0.0%	0.4	0.6%	-0.4	0.0	0.0
Jan-22	71	1.3%	71	0	0.0%	0.7	1.0%	-0.7	0.0	0.0
Feb-22	55	1.0%	55	0	0.0%	0.3	0.6%	-0.3	0.0	0.0
Mar-22	529	9.8%	529	9	1.7%	12.4	2.3%	-3.4	72.4	33.0
Apr-22	229	4.2%	229	3	1.3%	3.7	1.6%	-0.7	81.5	16.4
May-22	857	15.9%	858	6	0.7%	9.6	1.1%	-3.6	62.5	22.8
Jun-22	1,260	23.4%	1,261	2	0.2%	13.0	1.0%	-11.0	15.4	1.7
Jul-22	911	16.9%	912	6	0.7%	8.8	1.0%	-2.8	68.4	25.0
Aug-22	1,102	20.4%	1,105	2	0.2%	11.1	1.0%	-9.1	18.1	2.9
Sep-22	180	3.3%	180	1	0.6%	2.1	1.2%	-1.1	48.3	8.6

Figure 3. Residual codes as activity – single month position for the last 12 months

The table above describes the percentage of superspells uncoded for the months of May to August. The total number of superspells is therefore artificially small as those with residual codes are not taken into account in the calculations underpinning the mortality indices. We know, from the Telstra analysis that there are very few deaths in the uncoded superspells as coding of deaths was prioritised. The impact is that the denominator (superspells) is up to 25% less than it should be which has the effect of artificially exaggerating the impact of the number of deaths (numerator) on the HSMR figure.

The Princess Alexandra Hospital NHS Trust

STANDARDISED MORTALITY RATIO OVERVIEW

Key points

SMR for Oct-22 is 122.4 and "within expected", based on 5948 superspells and 98 deaths.

SMR for the period Nov-21 to Oct-22 is 109.2 and "higher-than-expected", based on 69,386 superspells and 1106 deaths.

There are three outlying groups – those in bold are new:

(i) Acute and unspecified renal failure (355 superspells; 60 deaths)
(ii) Diabetes mellitus with complications (164 superspells; 11 deaths)
(iii) Genitourinary symptoms and ill-defined conditions (392 superspells 5 deaths)

Acute and unspecified renal failure
Analysis finds that this diagnosis group is likely reporting as an outlier in a reflection of the known Trust-wide position of survivals yet to be fully coded. However, there may be some merit in performing an early review of the group by looking at the five deaths of those admitted as low-risk (modelled risk of mortality between 0-10%) and have no comorbidities.

Genitourinary symptoms and ill-defined conditions
This diagnosis group is low-risk/low-volume and sensitive to alerting if any deaths are reported. There may be some use in taking a look at the five deaths to understand diagnosis, care and pathway in greater detail.

Figure 4 – SMR Monthly Trend

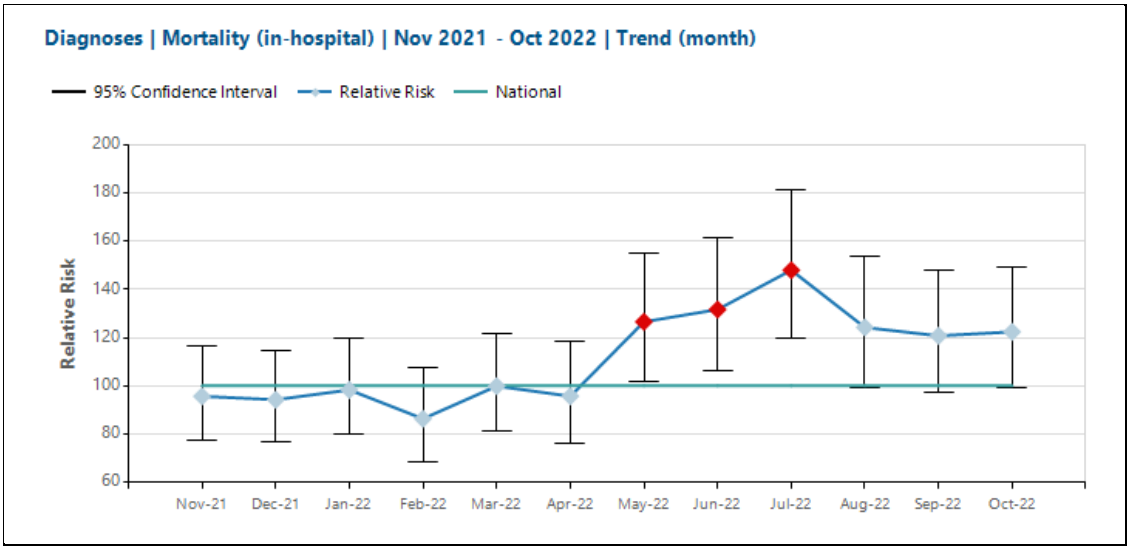


Figure 3

SMR overview with the figure showing monthly data

The SMR monthly trend is impacted in a similar way by the number of superspells coded with a residual code.

SMR Statistically Significant Diagnosis Groups November 21-October 22

Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		908	100.0 %	911	76	8.4 %	49.4	5.4 %	26.6	153.8	121.1	192.5
Genitourinary symptoms and ill-defined conditions	163	391	43.1 %	392	5	1.3 %	1.6	0.4 %	3.4	320.6	103.3	748.1

Acute and unspecified renal failure	157	354	39.0 %	355	60	16.9 %	43.2	12.2 %	16.8	138.9	106.0	178.8
Diabetes mellitus with complications	50	163	18.0 %	164	11	6.7 %	4.7	2.9 %	6.3	235.4	117.3	421.1

SMR Statistically Significant Diagnosis Groups October 21-September 22

Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		797	100.0 %	801	144	18.1 %	115.3	14.5 %	28.7	124.9	105.3	147.1
Septicemia (except in labour)	2	538	67.5 %	541	133	24.7 %	110.6	20.6 %	22.4	120.3	100.7	142.5
Diabetes mellitus with complications	50	170	21.3 %	171	10	5.9 %	4.7	2.7 %	5.3	213.9	102.4	393.5
Lymphadenitis	247	89	11.2 %	89	1	1.1 %	.0	0.0 %	1.0	10,131.6	132.4	56,371.0

Figure 4 Statistically significant diagnosis groups for the report periods October 2021-September 2022 and November 2021-October 2022

After discussion with Telstra – it has been agreed to review the notes of all diagnostic outliers referred to here (lymphadenitis has been investigated and recoded -there was a clinical documentation error). An approach to investigating the sepsis position has been agreed and commenced in March.

MONTHLY SHMI

Key points

SHMI for the period Oct-21 to Sep-22 is 105.61 and 'as expected' (representing a small increase on last month). Once more, there are no diagnosis groups appearing as an outlier in either control limit or confidence interval methodology.

3.3 Summary

Analysis of the impact of uncoded spells (as denoted by a residual code) shows the monthly HSMR from April-September as 'above expected. Fully coded data was submitted for September and October 2022. In month HSRM and SMR for October is 'as expected'.
SMR diagnostic outliers are summarised above and all will be investigated.
12 monthly rolling SHMI is as expected.

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

4.0 Mortality Programme Updates

There were no programme updates scheduled in February 2023

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 104 deaths in February 2023.

41 cases referred for SJR's.

There are 91 outstanding SJRs (over 6 weeks of the patients' death.) A trajectory and plan needs to be set by the divisional directors and will be overseen by the newly appointed associate medical director for mortality (commences in post April 17th 2023).

There were 13 Covid related deaths. 5 of which were nosocomial case (3 x on part 1a of death certificate and 2 x on part 2 of the death certificate). These will be reviewed by Respiratory Lead.

There were no cases presented to the second review panel.

5.2 Key Learning from Structured Judgement Reviews

All key learnings have been raised with treating teams and in local speciality M&M meetings to share the learning.
Themes include lack of DNACPR, opportunity to improve end of life care by early involvement of the specialist palliative care team and repeated admissions for alcohol related issues (raised with the gastroenterology team and a detailed review requested).

6.0 Medical Examiner (ME) Headlines

100% of deaths scrutinised between 10 Medical Examiners.

25 cases referred to the Coroner, with 6 post mortems requested and 3 inquests logged.

93.7% of MCCDs were completed within 72 hours due to delays in doctors' availability to complete the Medical Certificate of Causes of Death (MCCD). (National Target 95%).

Ongoing Developments:

GP death scrutiny is in the process of being expanded with meetings completed or pending with a large number of GP practices. Several have now been on board and made a commitment to participate in the process ahead of the April deadline.

Quality First improvement project in process to improve the timely completion of MCCD's.
Electronic ME system SMART continues to be used daily for Trust deaths.
Community deaths are done on the National ME system.

New Developments:

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

A new SOP is being finalised which will facilitate the release of Drs from ward duties to complete paperwork for the ME Service in a timely manner.

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

The ME service will be clarifying the process of SJR submission for ALL cases readmitted within 30 days of discharge.

7.0 Risks

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

8.0 Recommendation

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

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 27 March 2023

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Horizon Scanning	Yes	N	N	PC noted the emerging people issues including; • Spring budget to encourage increased employment including pension taxation changes, childcare support and support for disabled people to enter employment. • Pay offer 'in principle' to Agenda for Change trade unions to put to their members • Development of the first NHS Equality Diversity and Inclusion (EDI) Improvement Plan to be a 'compendium of actions' for NHS organisations to address existing inequalities across the workforce
2.2 PAHT2030 Culture Milestones & Deloitte Well Led Review Update	Yes	N	N	The Committee noted the positive position in regards to the 5-culture related KLOEs and the Deloitte Well Led review actions.
2.3 People Report	Yes	Y	N	The following was highlighted; Trust wide vacancy rate 10%, increase in bank/agency spend, the change to direct engagement booking process (non-direct engagement booking no longer permitted) which has been a driver for increased temporary staffing; but overall, a cost improvement, sickness/absence rate 4.3% and rolling turnover was slowly decreasing. The current retention programmes of work were noted. It was agreed a deep dive into flexible working would be presented at the next meeting

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 27 March 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 Learning and OD Update	Yes	N	N	PC were assured in regards to the measures being taken to address statutory and mandatory training compliance. An update on This is Me @ PAHT was received.
2.5 Staff Survey	Yes	N	N	The Committee noted the Staff Survey 2022 results, the approach to sharing the results across PAHT, and planned/underway actions to implement changes in response to the findings. Actions included the specific Staff Survey Feedback to Action Programme, in addition to the wider programmes of existing initiatives connected to our staff survey improvement priorities. This report would be discussed at Trust Board.
2.6 GMC Enhanced Monitoring Process	Yes	Y	N	The Committee were assured on progress being made in relation to the GMC enhanced monitoring process. The HEE Engagement for Surgery Visit in January 2023 was postponed due to the junior doctor strike. The Medical Workforce Review and Multi-professional Educational review had been commissioned.
2.7 BAF risk: GMC enhanced monitoring	Yes	N	N	The Committee noted the score remained unchanged at 20 with a target score of 10 to be achieved by December 2024.
2.8 Safer Nurse Staffing Report	Yes	N	N	The Committee were assured in regards to the provision of safer nurse and midwifery staffing and that processes are in place for managing and monitoring staffing levels. The paper would be discussed at Board.

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 27 March 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.9 Midwifery Establishment Review	For noting	N	N	The Committee noted the interim midwifery establishment review. The recommendations had previously been approved by Trust Board.
2.10 Healthcare Support Worker Band Alignment	Yes	N	N	The Committee supported the approach to re-band Band 2 HCSW posts to Band 3 where the current job description met the Band 3 profile. This included all inpatient and outpatient areas. New recruits to a HCSW post who did not have the demonstrable experience would be recruited at Band 2 for 12 months while they undertook the HCSW preceptorship and completion of the Care Certificate. The work would be aligned to the ICB approach across acute organisations.
2.11 Safeguarding level 3 briefing paper	Yes	N	N	The Committee were assured in regards to the current level 3 safeguarding training position and the steps being taken to improve training compliance. It was noted there was to be an expected 20-30% increase in compliance at the next reporting period.
2.12 International Recruitment	For Information	N/A	N/A	The Committee received an update on the current international nurse recruitment position. This was to be discussed further at Private Board.
2.13 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16; the controls had been updated.
2.14 Health and Wellbeing Report	Yes	N	N	Recent health and wellbeing initiatives were noted including; re-established Schwartz round success and the funding for blue light cards for all staff. It was noted the Health Wellbeing Strategy would be presented to the Committee in May.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 27 March 2023

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
3.1 Communications Update	Yes	N	N	PC noted the recent communications activities. An update was provided on the recently commissioned communications review.
4.1 Gender Pay Gap Report	Yes	N	N	The Committee reviewed the Gender Pay Gap Report and noted the steps/actions being taken to address the gap. The gender pay gap as at 31 March 2022 reported men had higher mean and median average pay than women. The difference between mean pay of men and women was 24% and that of median average pay was 16%.
4.2 Workforce plan	For information	Y	N	The Committee noted the report for information which detailed the first draft workforce plan submitted in January.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 April 2023

5.2

Agenda item:	5.2
Presented by:	Ogechi Emeadi – Director of People
Prepared by:	Nathaniel Williams, People Information and Systems Manager
Date prepared:	18 January 2023
Subject:	Gender Pay Gap Reporting 2022

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	Gender pay gap reporting legislation is distinct from equal pay. Equal pay is concerned with men and women earning equal pay for the same or similar work. The gender pay gap is about the difference between men and women average pay within an organisation • The gender pay gap as at 31 March 2022 reports men have higher mean and median average pay than women • The difference between mean pay of men and women is 24% and that of median average pay is 16% • Whilst medical and dental staff are separated from agenda for change staff and very senior managers, the mean gap is that women earn 1% less than men and the median gap is in favour for women earning 5%more than men • The medical and dental mean and median pay gap is 10% and 15% in favour for men
Recommendation:	For information and discussion

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:	Equality and Inclusion Steering Group
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	The Trust is required by law to publish their gender pay gap report
Appendices:	

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The Princess Alexandra Hospital NHS Trust

5.2

1. Introduction

The gender pay reporting legislation requires all organisations employing more than 250 people to measure and publish their gender pay information based on earnings.
As at 31 March 2022, our gender profile is 78% women and 22% men.

2. Background & context

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

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

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

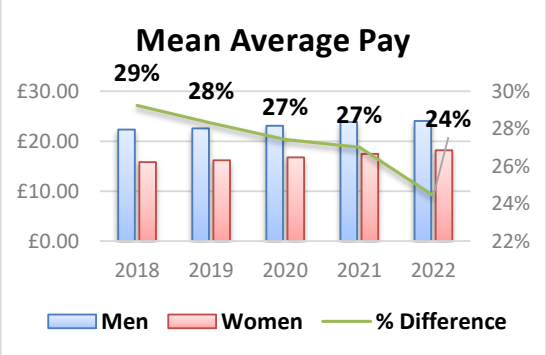
2.4 The gender pay reporting requirements were introduced to highlight the differences in pay between men and women giving more transparency across all industry sectors. This assists employers to consider the reasons for any differences and to take any corresponding action.

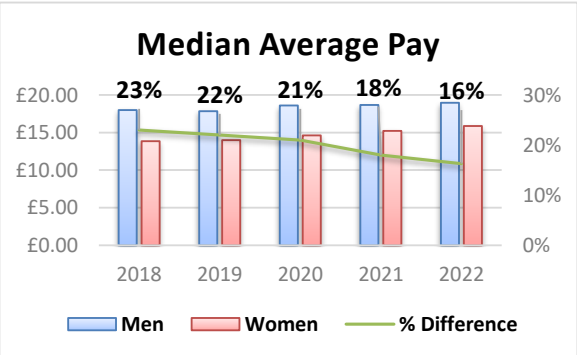
3. Requirements

Information taken as of 31 March 2022 looks at the following:

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

4. Mean and median ordinary pay





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The trust mean gender pay gap indicates that women earn 24% less than men for the reporting period compared to 29% in 2018. The median pay gap indicates that women earn 16% less than men, an improvement from the previous reporting periods. The high pay difference is partly due to medical & dental staff being the highest paid staff group.

The tables below give a clear separation of medical and dental staff group when compared to Agenda for Change (AFC) pay bands (inc very senior managers - VSM) for this reporting period only.

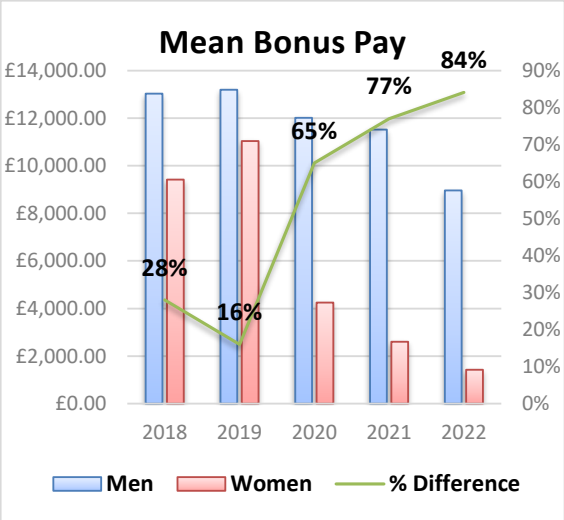
AFC &VSM	Mean Hourly Rate	Median Hourly Rate
Men	£17.08	£14.46
Women	£16.94	£15.21

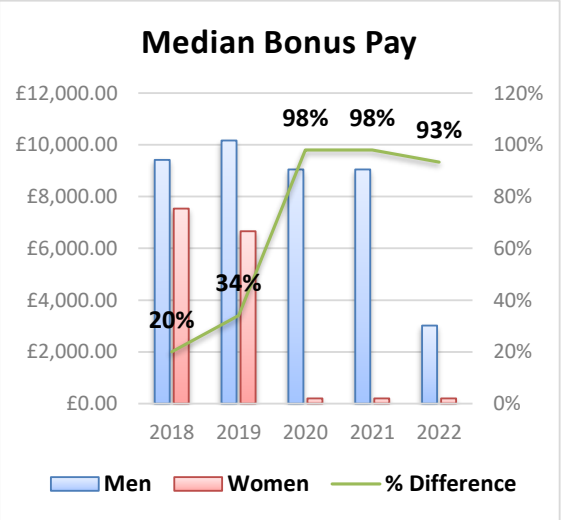
M&D only	Mean Hourly Rate	Median Hourly Rate
Men	£36.91	£35.44
Women	£33.09	£30.11

The mean pay gap for Agenda for Change pay band including VSM, show the mean hourly rate women earn is 1% less than men and the median pay shows that women earn 5% more than men. Within medical and dental staff, the mean and median pay gap indicates that women earn 10% and 15% less respectively than men.

5. Mean and median bonus pay gap

The Consultant staff group were the only staff group prior to this reporting period in receipt of bonuses (in line with NHS national terms and conditions for medical staff). This reporting period includes a welcome bonus payment for our international nurses. For the purposes of this report, bonuses are exclusively made up of local and national consultant clinical excellence awards, discretionary points and welcome bonus.





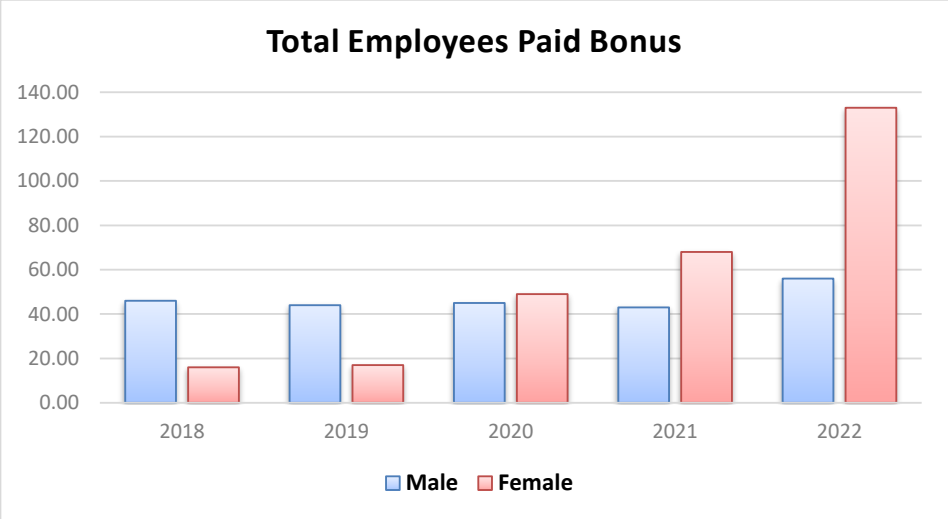
The tables below give a clear separation of the bonus paid to consultants and the welcome bonus paid to our international nurses for this reporting period.

M&D only	Mean Bonus Payment	Median Bonus Payment
Men	£13,082.23	£12,063.96
Women	£10,301.05	£6,717.90

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

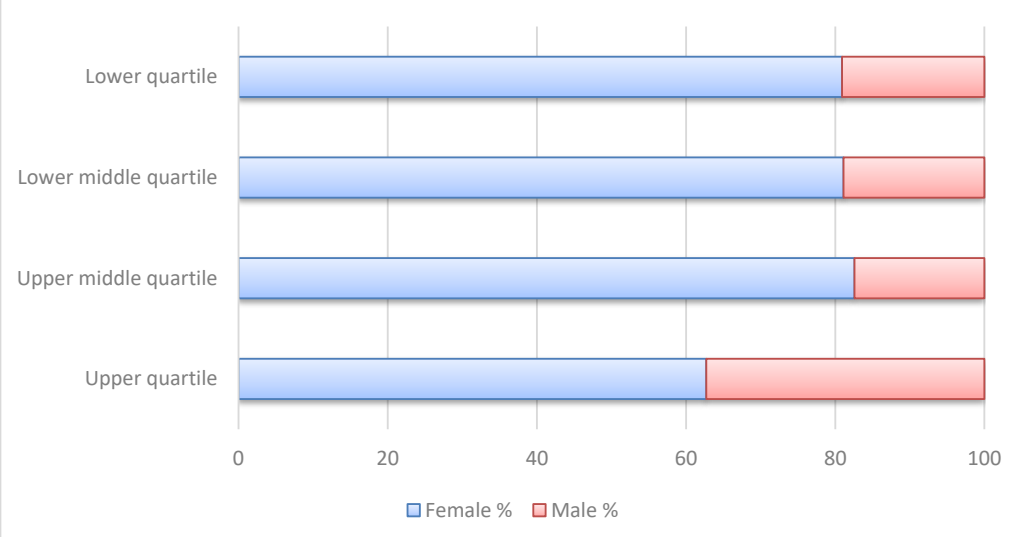
6. Total Employees paid bonus

The chart shows more women received the bonus payment in this reporting period than men. This is due to the one hundred and seventeen international staff who were women that received the £200 welcome bonus compared to only nineteen men who received the £200 welcome bonus.



7. Pay distribution by gender

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



8. Reducing the gender pay gap

The trust remains committed to ensuring equality within the workforce and on this basis, identified a number of actions for 2022/23:

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

For 2022/23 clinical excellence awards, the trust will continue to follow the national guidance of apportioning the available funds across all eligible consultants. The Equality, Diversity and Inclusion Steering Group will monitor delivery of these recommendations

9. Recommendations

The Board is asked to note the gender pay gap data including the publication date of this data and continue to support ongoing actions to address the gender pay gap

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 April 2023

5.3

Agenda item:	5.3
Presented by:	Ogechi Emeadi, director of people, organisational development (OD) and communications
Prepared by:	Mandi Osoba, associate director of learning and OD
Date prepared:	March 2023
Subject / title:	Annual NHS Staff Survey 2022: results and actions

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	This paper outlines the summary Staff Survey 2022 results, the approach to sharing the results across PAHT, and planned/underway actions to implement changes in response to the findings. Summary results include providing an overview of how we compare to our previous year's results (2021), and how we benchmark compared to the national average for our peer group. Actions include the specific Staff Survey Feedback to Action Programme, in addition to the wider programmes of existing initiatives connected to our staff survey improvement priorities.
Recommendation:	For review and discussion

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

Previously considered by:	
Risk / links with the BAF:	2.3 Inability to recruit and retain our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC - KLOE well led The Equality Act 2010
Appendices:	Appendix 1. Staff Survey 2022 key themes results compared to 2021 (trust-wide) Appendix 2. Staff Survey 2022 key themes results compared to 2021 (divisional) Appendix 3. This is Us dashboard, including divisional breakdown

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The Princess Alexandra Hospital NHS Trust

Annual NHS Staff Survey 2022: results and actions

1.0 Introduction

This paper sets out the results of the annual NHS staff survey 2022, how we are responding to the findings and what we are doing to ensure the feedback drives learning and improvement.

2.0 Background

The NHS Staff Survey is run independently of NHS England. The Picker Institute ran the 2022 survey on behalf of our organisation.

The survey aligns to the People Promise which sets out the things that most improve our experience of working within the NHS. The results are reported via the seven elements of the People Promise, as well the themes of staff engagement and morale.

3.0 Survey response rates

Our response rate to the survey was **49.5%,** a **2.2% increase** compared with 47.3% in 2021 and 38.1% in 2020.

4.0 Summary results – comparison to national benchmark

The national benchmark report was released on 09 March 2023 and aligns the organisation's survey results to the People Promise and overall staff engagement and morale themes, in addition to benchmarking us against organisations in our peer group (acute and community trusts).

Overall, we are below the national average for our peer comparison group across all key themes. Locally, scores on these themes have changed as shown below.
*Reference **appendix 1** for full trust-wide detail*
*Reference **appendix 2** for divisional detail*

Theme	2021	2022	Change
We are compassionate and inclusive	7.9	6.9	↓
We are recognised and rewarded	5.6	5.5	↓
We each have a voice that counts	6.4	6.4	↔
We are safe and healthy	5.6	5.6	↔

We are always learning	5.1	5.2	↑
We work flexibly	5.8	5.8	↔
We are a team	6.5	6.4	↓
Staff engagement	6.6	6.4	↓
Staff morale	5.4	5.3	↓

The table below demonstrates how our 2022 results compare with national trends. The trend analysis shows that overall, 46 questions showed improvement at PAHT (with 7 of these improving despite a national worsening), however 19 PAHT scores worsened despite a national improvement.

	PAHT worsened	PAHT stayed the same	PAHT improved
National average improved	19 (21%)	3 (3%)	36 (39%)
National average stayed the same	1 (1%)	0	0
National average worsened	25 (27%)	1 (1%)	7 (8%)

Our people have placed us as **better than the national average** for the following questions:

Questions scoring better than the national average	PAHT	National	Difference
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	52.90%	47.40%	5.50%
On what grounds have you experienced discrimination – gender	14.80%	20.30%	5.50%
On what grounds have you experienced discrimination – age	13.60%	18.80%	5.20%
Appraisal helped me to improve how I do my job	24%	21.50%	2.50%
On what grounds have you experienced discrimination – gender	2.10%	4.30%	2.20%
On what grounds have you experienced discrimination – religion	2.10%	4.30%	2.20%
On what grounds have you experienced discrimination – disability	6.60%	8.70%	2.10%
On what grounds have you experienced discrimination – other	22.80%	24.40%	1.60%
On what grounds have you experienced discrimination – sexual orientation	3.10%	3.90%	0.80%
I feel a strong personal attachment to my team	64.50%	64.20%	0.30%
I always know what my work responsibilities are	86.30%	86.90%	0.30%
I am trusted to do my job	91%	90.70%	0.30%
The last time you experienced physical violence at work, did you or a colleague report it?	68.50%	68.30%	0.20%
Appraisal helped me agree clear objectives for my work	32%	31.90%	0.10%

For all other questions, our people have placed us **worse than the national average**.

Questions scoring closest (within 3%) to the worst scores nationally	PAHT	National average	National worst	Difference from worst
During the last 12 months have you felt unwell as a result of work-related stress?	51.20%	45.10%	51.50%	0.30%
I have adequate materials, supplies and equipment to do my work	44.10%	53.50%	43.60%	0.50%
I have unrealistic time pressures	18.50%	22.20%	18.00%	0.50%
There are enough staff at this organisation for me to do my job properly	18.30%	25.10%	17.20%	0.90%
I feel safe to speak up about anything that concerns me in this organisation	50.20%	60.30%	49%	1.20%
I achieve a good balance between my work life and my home life	46%	51.70%	44.80%	1.20%
I have a choice in deciding how to do my work	46.70%	51.70%	45.40%	1.30%
How often, if at all, do you not have enough energy for family and friends during leisure time?	35.30%	32%	36.80%	1.50%
How often, if at all, do you feel that every working hour is tiring for you?	27.10%	22%	28.80%	1.70%
How often, if at all, do you feel burnt out because of your work?	40%	34.80%	42%	2%
Have you felt pressure from your manager to come to work (when unwell)?	28.90%	23.60%	30.90%	2%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	42.10%	61.90%	39.20%	2.90%
In the last month, have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	41.60%	35.20%	43.50%	2.90%

5.0 Summary results – PAHT (local) comparison

Compared to our results last year (2021), nine questions significantly improved, seven significantly worsened, and 76 showed no significant difference.

5.1 Significant score changes

The **nine questions which significantly improved** are:

Questions which have significantly improved	2018	2019	2020	2021	2022	Change (since 2021)

In the last 3 months have not come to work when not feeling well enough to perform duties	38%	30%	46%	32%	41%	9%
Last experience of harassment/bullying/abuse reported	46%	53%	42%	46%	52%	6%
Not felt pressure from managers to come to work when not feeling well enough	73%	69%	70%	66%	71%	5%
Colleagues show appreciation to one another	*	*	*	62%	66%	4%
Feel organisation respects individual differences	*	*	*	60%	64%	4%
Organisation offers me challenging work	*	*	*	63%	67%	4%
Feel supported to develop my potential	*	*	*	46%	50%	4%
Able to access the right learning and development opportunities when I need to	*	*	*	47%	51%	4%
Never/rarely worn out at the end of work	*	*	*	13%	15%	2%

The **seven questions which significantly worsened** are:

Questions which have significantly worsened	2018	2019	2020	2021	2022	Change (since 2021)
Satisfied with level of pay	34%	34%	31%	29%	23%	-6%
Don't work any additional paid hours per work for this organisation, over and above contracted hours	63%	63%	64%	60%	54%	-6%
Would feel secure raising concerns about unsafe clinical practice	72%	68%	67%	70%	65%	-5%
Received appraisal in the past 12 months	86%	87%	*	83%	79%	-4%
Care of patients/service users is organisation's top priority	80%	77%	75%	71%	67%	-4%
Organisation acts on concerns raised by patients/service users	77%	71%	69%	66%	62%	-4%
If friend/relative needed treatment would be happy with standard of care provided by organisation	62%	61%	60%	48%	42%	-6%

*Question not asked for the year shown

5.2 This is Us – local question comparison

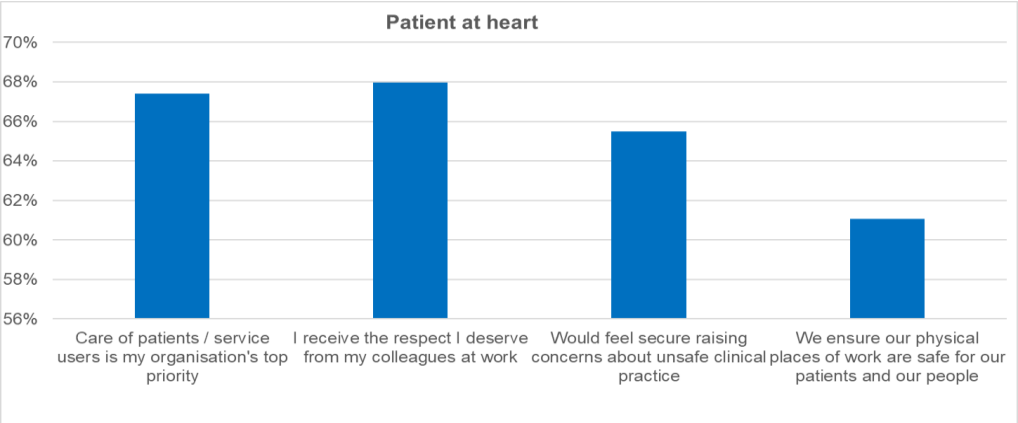
New for 2022, local questions linked to our This is Us values and behaviours were added to the survey.

A dashboard has been created, using a combination of national and local questions, which together provide indicators of our culture against each of the This is Us behaviours.

In summary, the trust-wide scores for each of the questions fall into the following categories.

	Number of survey questions in each quartile							
Score	Trust wide	Clinical support services	Corporate services	Estates & facilities	Child health & women's services	Medicine	Surgery & critical care	Urgent & emergency care
80% - 100%			5					
70%– 79%	1		9		7	9	1	
50% - 59%	22	22	11	13	19	14	19	13
25% - 49%	5	6	3	15	2	5	8	14
0% - 24%								1

The results at a trust-wide level are shown in the graphs below.
*Reference **appendix 3** for further details and divisional breakdown*.



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6.0 Responding to the results – sharing and discussing the findings

The results have been (and continue to be) shared at four core levels: trust board, senior management, trust-wide (all-staff) and at a divisional-level.

Level	Approach	Further information
Board	Local results discussed at Board	January
	Local results discussed at People Committee	January
	Full results discussed at People Committee	March
	Full results discussed at Board	April
	Board development session - Culture	July
Senior managers (during embargo period)	Local results discussed at EMT and SMT	January
	National results discussed at EMT and SMT – including divisional breakdown	March
	Thematic analysis of comments report discussed at EMT and SMT (trust-wide)	Including sub-themes and all comments
Trust-wide (all staff – after embargo lifted)	Email from Lance	Sent on 09 March
	Webinar hosted by Lance	Hosted on 09 March (recording available)
	In-person staff survey briefings	Dates to be determined
Divisional level (after embargo lifted)	Results to be explored in feedback to action groups – identifying improvement actions	(See section 7.0)
	Senior management team written response shared to all-staff within each division	March
	Division-led webinars open to all staff within division	Dates to be determined
	Divisional comments analysis with senior management teams	Dates to be determined
Department level	Department/team level results shared with departmental managers to incorporate into team meeting and/or culture huddle discussions	Dates to be determined

7.0 Acting on the results – Feedback to action… involving people in improvement planning

This section outlines the trust's core approach i.e., utilising the staff survey feedback to action. It should be noted that whilst the programme is coordinated and led overall by the learning and organisational development (L&OD) team, its success is dependent on accountability and responsibility being taken within the divisions for implementing the programme.

Building on previous approaches to how the staff survey results have been used to drive improvement, the L&OD team proposed a different approach for our 'response plan' to the 2022 results – the introduction of a '**staff survey feedback to action'** programme. This trust-wide programme offers a structured framework in which to leverage the benefits and strengths of collaborative efforts to improve staff engagement.

To further inform *Feedback to action* we will be orchestrating a deep dive into our best and worst performing departments using additional key metrics i.e., turnover, attrition/vacancy rate, stat/mandatory training compliance, and appraisal compliance.

7.1 Key roles

Role	Requirement
Divisional sponsors	Accountable for the delivery of the programme
Feedback to action facilitators	Facilitate an assigned group through the programme
Feedback to action group members	Work within a feedback to action group, with mixed representation across teams (aiming for at least one representative from every department to be involved).

7.2 Programme activities

Element	Information
Timescale	Core programme runs from February – May
Modules / sessions	Each facilitator runs a series of 8 modules / sessions with their group, using a step-by-step facilitator toolkit. The modules combine developmental and action planning activities.
Improvement actions	Each feedback to action group proposes several improvement actions aligned to trust-wide improvement priorities and any additionally identified divisional priorities, which are then shared with the divisional sponsor. Divisional sponsors review the proposals and agree which actions to take forward and support the groups to implement these

7.3 Programme benefits:

- **Collaboration and inclusion** - each division has several feedback to action groups running, enabling colleagues to work together across teams, roles and levels.
- **Shared responsibility –** ownership for developing and implementing staff survey improvement plans is spread across the feedback to action groups.
- **Development of knowledge, skills and experience** - the cohort of people involved in this programme will all build their capabilities in relation to staff engagement and implementing change.
- **Development and delivery of action plans** – each division will have identified and initiated implementation of improvement opportunities that will make a real difference to colleagues.

7.4 Where we are now

To date, the programme has been established as follows:

- Divisional programme sponsors in place across all divisions (and corporate sub-divisions)
- 30 facilitators trained across the divisions
- Between 3-12 group members in place for most feedback to action groups
- 100 feedback to action group members in place so far
- Feedback to actions Microsoft Teams channels running to target information to programme sponsors, facilitators and group members
- Modules 1-4 toolkits released for facilitators to utilise

Challenges identified and being addressed via divisional programme sponsors:

- Struggles in some areas to recruit feedback to action group members
- Wider factors impacting pace of progress i.e., industrial action and year-end activities

8.0 Acting on the results - connected programmes of work

In addition to the core staff survey feedback to action programme there are wider programmes of work, planned and underway. These are outlined below.

Staff survey improvement priority	Connected programme of work
1. Improving the physical and mental health and wellbeing of our people	• Introducing wellbeing checks and smoking cessation support • Reintroduction of Schwartz rounds • Working with staff networks to create tailored & wellbeing support for each protected characteristic • Accreditation for disability confident scheme • Development of health and wellbeing competencies with the ICS for manager and supervisors

	• Review of employment assistance provider to increase usage within the Trust • Introduction of menopause cafés • Launch of Trust wellbeing strategy
2. Improving our learning and safety culture, encouraging people to openly share feedback or concerns and ensure this is acted upon - improving psychological safety	• **Freedom to Speak Up Guardians** (F2SUGs) - 11 newly appointed guardians from diverse backgrounds • **Just and restorative culture programme** – trust representatives undergoing training to then embed core principles of approach within our organisational policies, processes and development offerings.

3. Embedding our This is Us management practices and leadership promise in our ways of working	The success of all initiatives aimed at improving our managers' capabilities is dependent on managers taking personal accountability for their actions and their team's effectiveness.
	The following outlines a suite of resources and tools to support managers:
	• **Ready to Manage programme** launched February 2023
	• **Ready to Learn programme** launched January 2023 (for all staff, including leadership topics)
	• **New 'This is Me - My Performance' approach**, including:
	  ○ enhanced appraisal and 360-degree feedback framework
	  ○ requirement for quarterly 'thrive' conversations
	• **Increasing visibility of senior management team** – through a series of initiatives targeted at creating meaningful touch points between executive and senior managers with staff at all levels across the organisation
	• **Quarterly People Pulse survey** to include local 'This is Us' questions from April 2023.
	• **Strengthening performance review meetings (PRMs) –** including culture metrics (e.g., People Pulse) with the requirement for divisions to evidence improvement actions.

4. Ensuring our workforce plans support teams being effectively staffed to deliver high quality services	• **New rostering system** • **Consultant job planning** process revision • **Review of medical rotas** • **System-wide workforce planning**, supported by appointment of a system-wide workforce planner • **AHP strategic workforce plan**

In addition, the L&OD team are actively seeking to connect with and learn from trusts who have seen positive survey results and/or substantially improved survey results.

Trusts scoring positively in the 2022 survey	Trusts showing substantial improvement between 2021 - 2022
• Milton Keynes University NHS Foundation Trust • Guy's and St Thomas' NHS Foundation Trust • University College London Hospitals NHS Foundation Trust • Chesterfield Royal Hospital NHS Foundation Trust • Sherwood Forest Hospitals NHS Foundation Trust • South Warwickshire University NHS Foundation Trust • Northumbria Healthcare NHS Foundation Trust • Sheffield Children's NHS Foundation Trust • Yeovil District Hospital NHS Foundation Trust • Somerset NHS Foundation Trust • University Hospital Southampton NHS Foundation Trust • St Helens and Knowsley Teaching Hospitals NHS Trust • Alder Hey Children's NHS Foundation Trust • Royal Berkshire NHS Foundation Trust	Data research underway to identify Trusts

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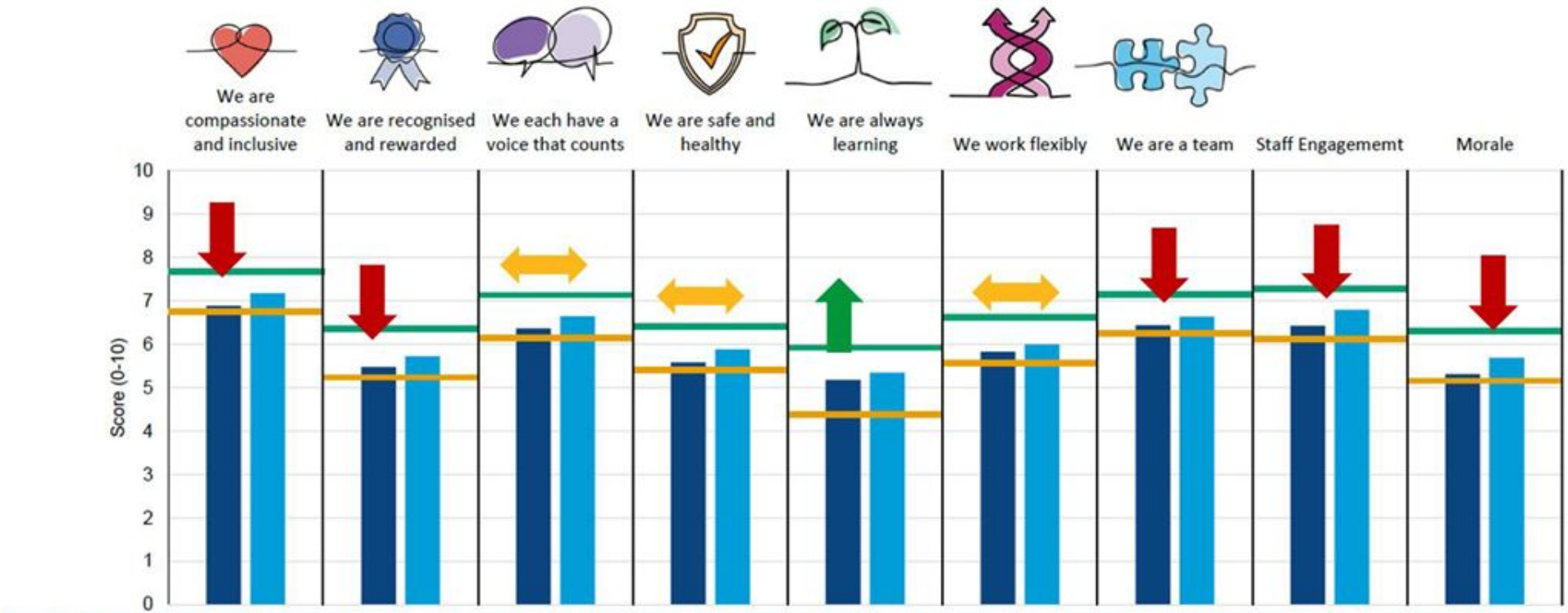
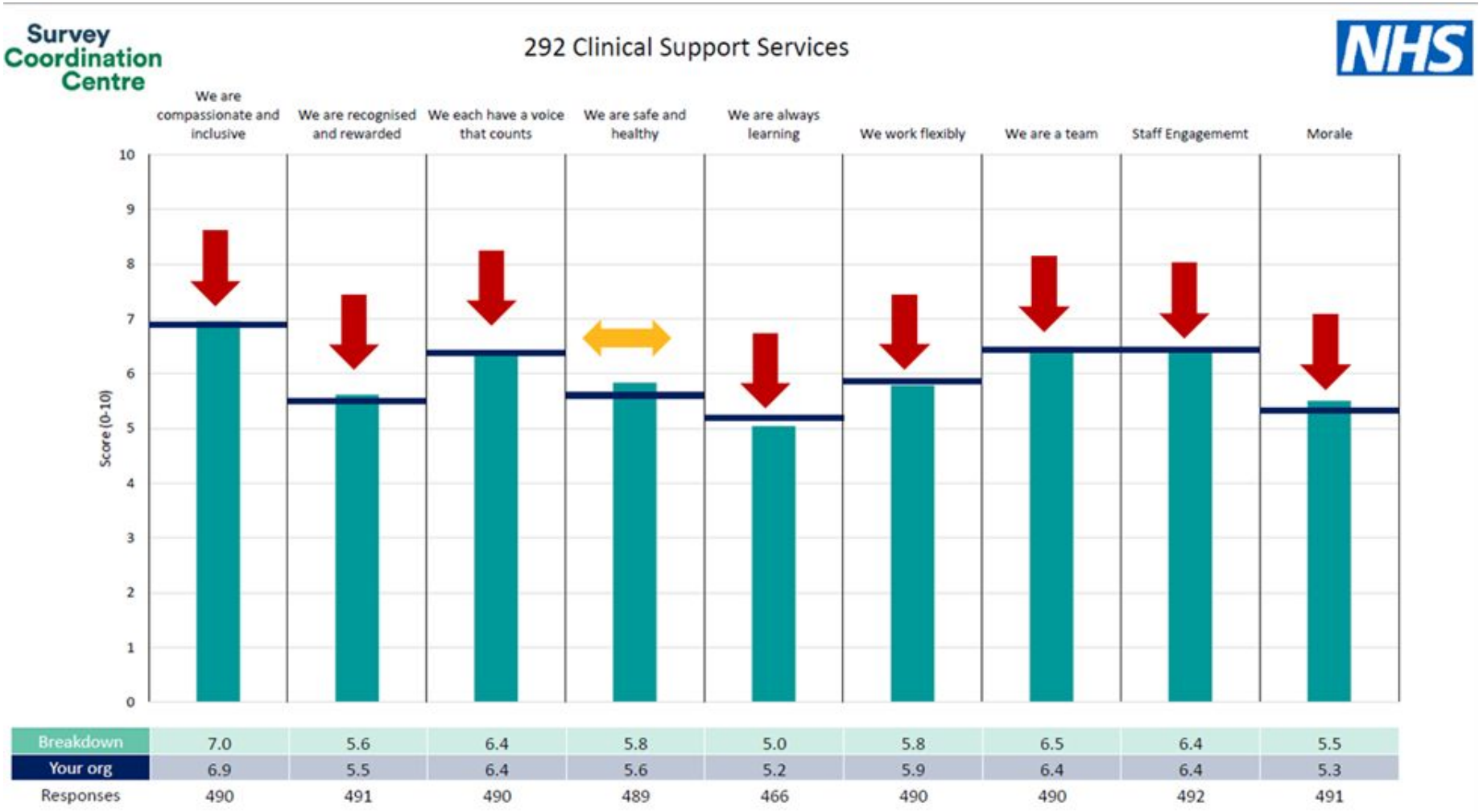
Appendix 1. Staff Survey 2022 key themes results compared to 2021 (trust-wide)



	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 Engagememt	Morale
Your org	6.9	5.5	6.4	5.6	5.2	5.8	6.4	6.4	5.3
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1868	1874	1860	1846	1771	1866	1865	1875	1873

Appendix 2. Staff Survey 2022 key themes results compared to 2021 (divisional)



	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 Engagememt	Morale
Breakdown	7.0	5.6	6.4	5.8	5.0	5.8	6.5	6.4	5.5
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	490	491	490	489	466	490	490	492	491

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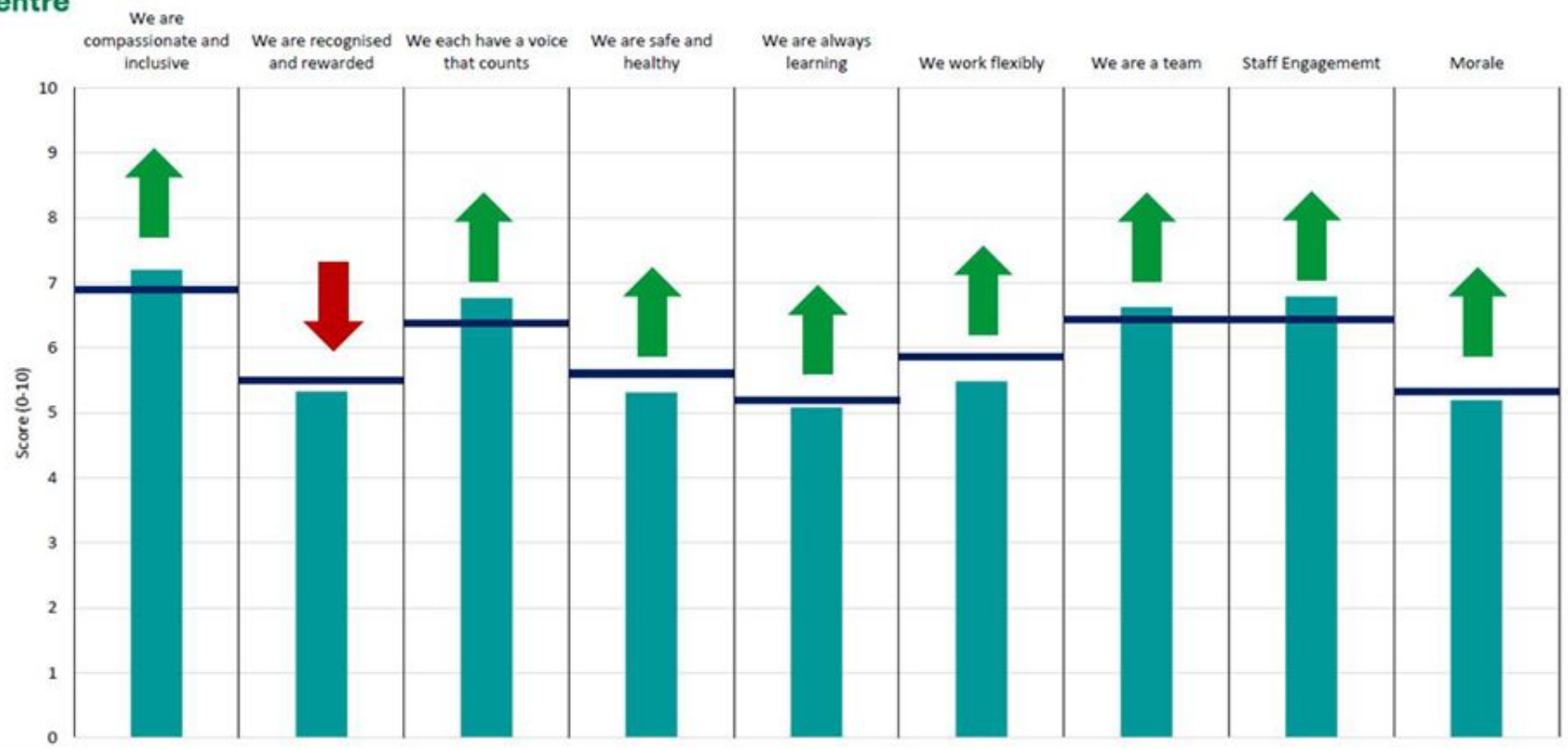
292 Family & Women's Service



	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 Engagememt	Morale
Breakdown	7.2	5.3	6.8	5.3	5.1	5.5	6.6	6.8	5.2
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	218	216	218	218	212	217	218	218	218

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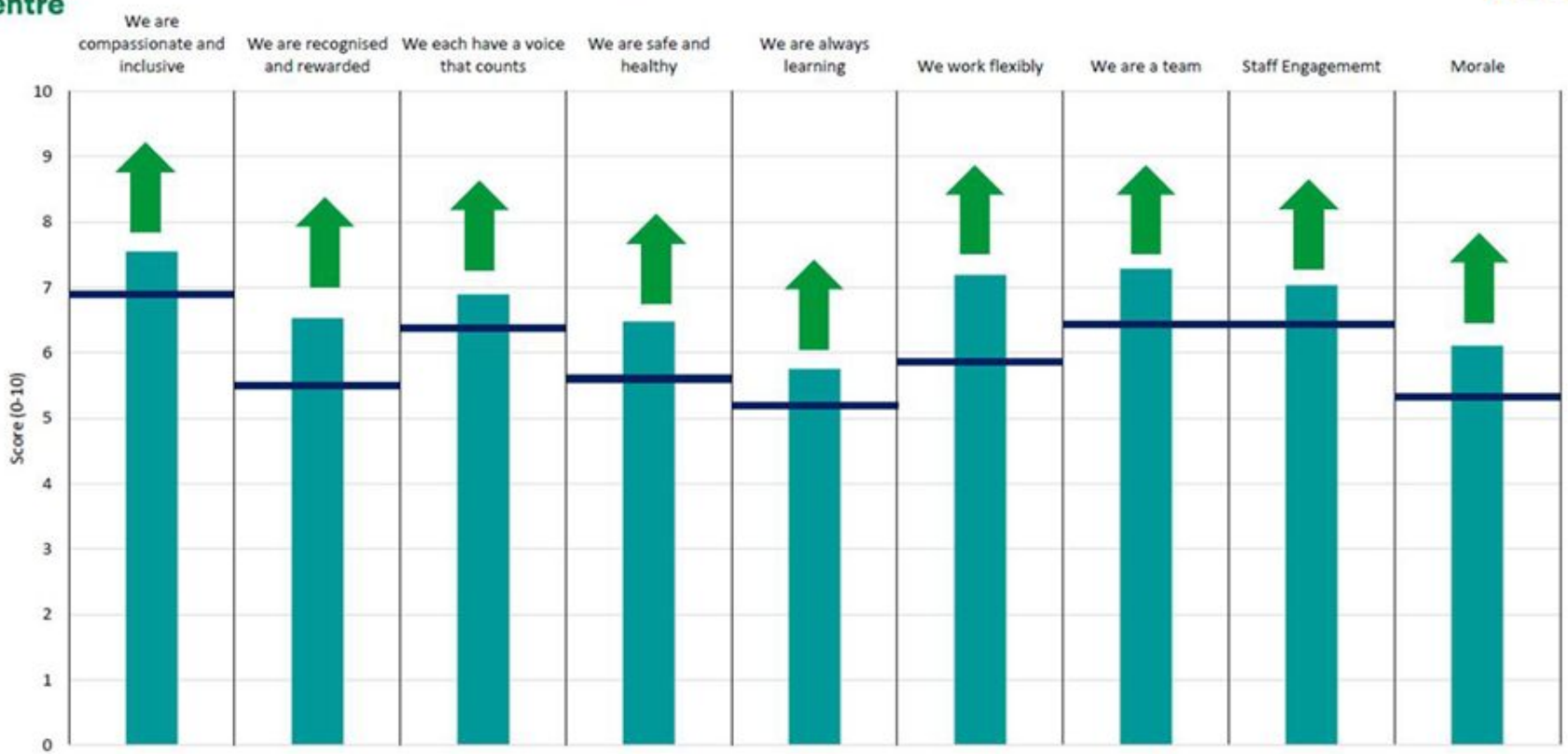
292 Corporate Services



	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 Engagememt	Morale
Breakdown	7.5	6.5	6.9	6.5	5.8	7.2	7.3	7.0	6.1
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	323	323	322	319	314	323	323	323	323

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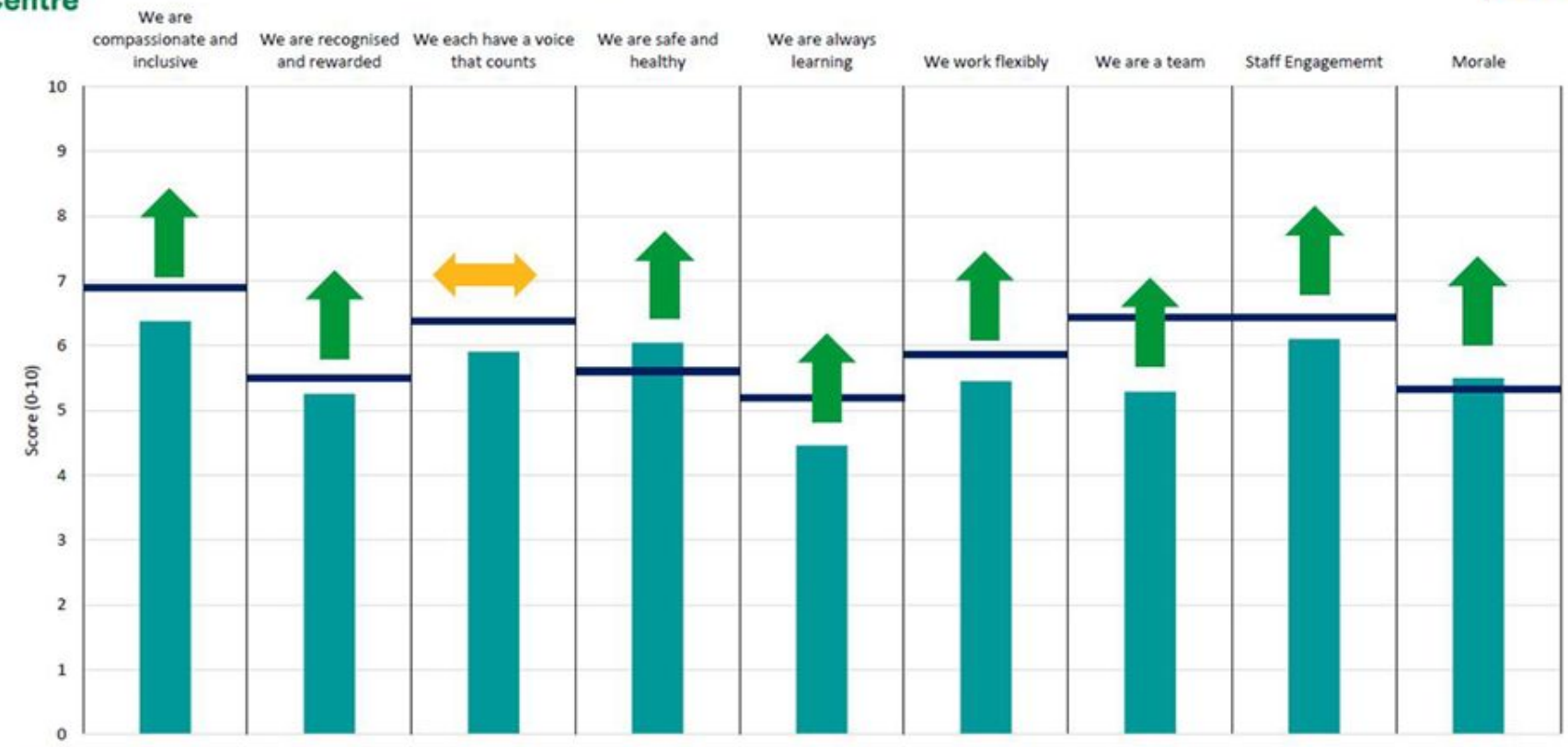
292 Estates & Facilities



	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 Engagememt	Morale
Breakdown	6.4	5.3	5.9	6.0	4.5	5.5	5.3	6.1	5.5
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	157	161	153	144	139	156	155	159	159

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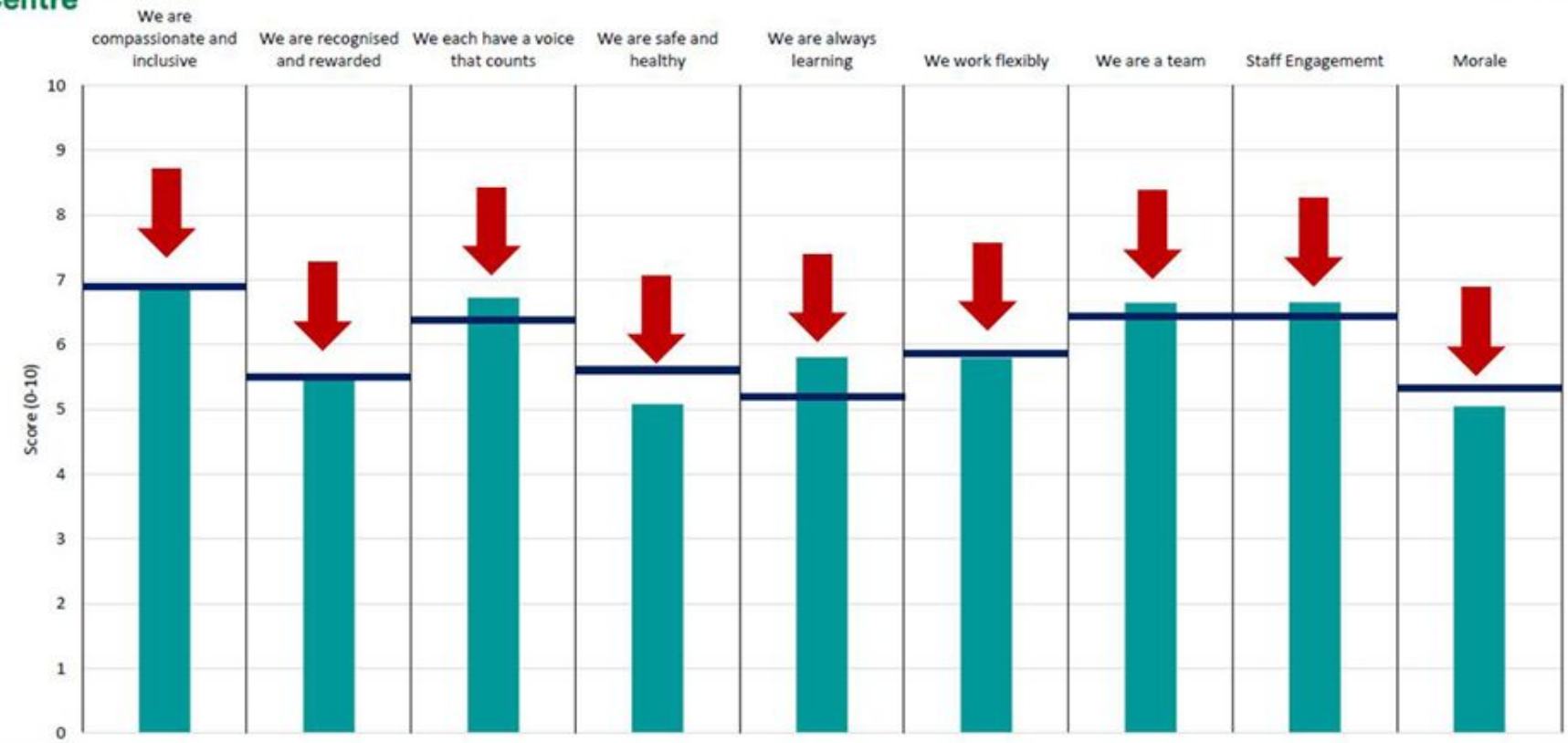
NHS

292 Medicine



	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 Engagememt	Morale
Breakdown	6.9	5.5	6.7	5.1	5.8	5.8	6.6	6.7	5.1
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	201	201	201	201	187	200	201	201	201

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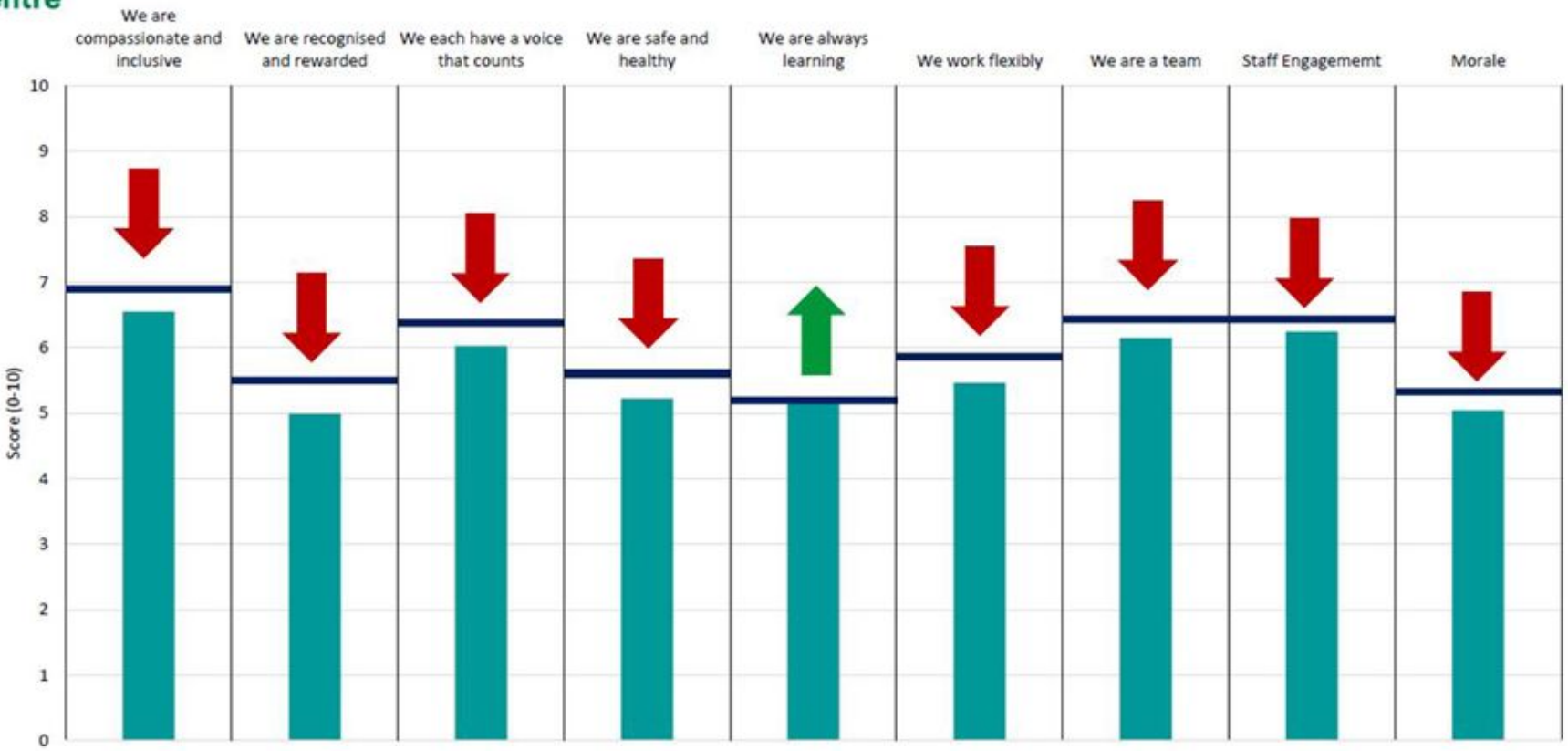
292 Surgery & Critical Care



	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 Engagememt	Morale
Breakdown	6.5	5.0	6.0	5.2	5.2	5.5	6.1	6.2	5.0
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	301	304	299	300	288	303	300	304	303

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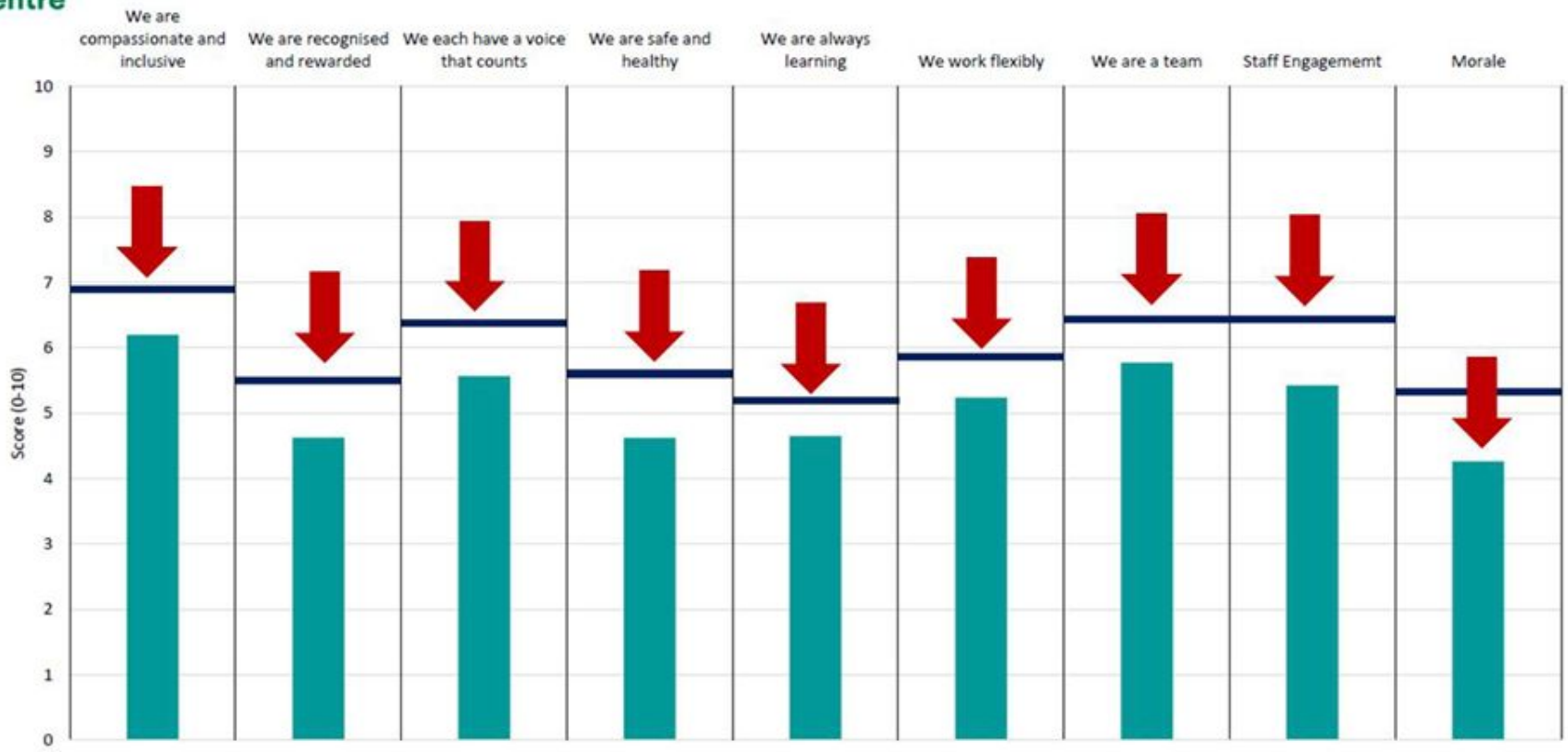
292 Urgent and Emergency Care



	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 Engagememt	Morale
Breakdown	6.2	4.6	5.6	4.6	4.6	5.2	5.8	5.4	4.3
Your org	6.9	5.5	6.4	5.6	5.2	5.9	6.4	6.4	5.3
Responses	178	178	177	175	165	177	178	178	178

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Appendix 3 – This is Us culture dashboard

This is Us element	Related behaviour	Question type	Question	Overall	Clinical Support Services	Corporate Services	Estates & Facilities	Child health & women's services	Medicine	Surgery & Critical Care	Urgent and Emergency Care
Patient at heart	We put patients first in all that we do: ensuring the goal of our work is always to enable high quality patient care	National	Care of patients / service users is my organisation's top priority	67%	67%	75%	62%	76%	74%	61%	52%
Patient at heart	We are compassionate and respectful, responding with kindness to our patients' needs	National	I receive the respect I deserve from my colleagues at work	68%	69%	76%	54%	69%	72%	64%	63%
Patient at heart	We feel safe and confident to speak up when we believe we can do things better	National	Would feel secure raising concerns about unsafe clinical practice	65%	65%	66%	53%	77%	72%	64%	60%
Patient at heart	We ensure our places of work are safe for our patients and our people	Local	We ensure our physical places of work are safe for our patients and our people	61%	61%	71%	66%	59%	61%	58%	47%
Everyday excellence	We embrace change by understanding the need to improve and grow	Local	We embrace change by understanding the need to improve and grow	56%	53%	64%	62%	60%	66%	51%	43%
Everyday excellence	We recognise, thank and value our colleagues for excellence in their work	National	The extent to which my organisation values my work	51%	51%	59%	54%	61%	49%	44%	32%
Everyday excellence	We are committed to challenging ourselves to being the best that we can be	National	Able to make improvements in my area of work	52%	51%	65%	44%	53%	63%	47%	34%
Everyday excellence	We are always learning and developing to be more effective in our work	National	Able to access the right learning and development opportunities when I need to	51%	46%	61%	41%	58%	59%	53%	39%
Creative collaboration	We support each other as one team: working together to create a great place to work	Local	Across the organisation, we work together as one team	37%	34%	40%	38%	36%	46%	34%	31%
Creative collaboration	We support each other as one team: working together to create a great place to work	National	Teams within this organisation work well together to achieve their objectives.	44%	43%	47%	36%	51%	50%	41%	35%
Creative collaboration	We learn from each other, by creatively combining our skills and knowledge	Local	We learn from each other, by creatively combining our skills and knowledge	50%	46%	52%	50%	51%	60%	50%	45%
Creative collaboration	We ask for people's views and suggestions both internally and externally, making better decisions together	National	My manager.. asks for my opinion before making decisions that affect my work	54%	55%	68%	31%	57%	61%	46%	44%
Creative collaboration	We are inclusive, ensuring everyone feels they are an important part of their team	National	I feel valued by my team	68%	69%	75%	53%	75%	71%	66%	55%
Creative collaboration	We are inclusive, ensuring everyone feels they are an important part of their team	National	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc	64%	63%	76%	61%	73%	66%	56%	53%
Management practices	We prioritise health and wellbeing, ensuring our people feel safe, rested and have access to support	National	My manager takes a positive interest in my health and well-being	65%	66%	80%	44%	69%	63%	63%	53%
Management practices	We are approachable: encouraging people to feel free to speak to us openly and honestly	Local	My immediate manager encourages me to feel free to speak openly and honestly	70%	70%	83%	54%	70%	74%	65%	59%
Management practices	We are approachable: encouraging people to feel free to speak to us openly and honestly	National	I feel safe to speak up about anything that concerns me in this organisation	51%	51%	59%	54%	61%	49%	44%	32%
Management practices	We share feedback: giving praise, offering suggestions and celebrating success	National	My manager gives me clear feedback on my work	61%	60%	75%	41%	63%	67%	57%	54%
Management practices	We are visible and part of the team, being there when our team face challenges, and supporting individuals through 1-1s and team meetings	Local	My immediate manager is visible and part of the team, being there when my team face challenges	68%	64%	80%	54%	66%	76%	64%	63%
Management practices	We enable people to develop, through coaching and learning opportunities	National	I feel supported to develop my potential	50%	47%	64%	37%	50%	55%	50%	34%
Management practices	We take accountability for our teams' work and support individuals to achieve their goals	Local	My immediate manager supports me to achieve my goals	62%	60%	74%	44%	64%	65%	60%	57%
Leadership promise	We lead by listening to our people with compassion, seeking to understand their experiences and challenges	National	My manager is interested in listening to me when I describe challenges I face.	67%	68%	81%	45%	71%	71%	62%	58%
Leadership promise	We lead inclusively, seeking the views and input of others to inform our decisions and progress	Local	My immediate manager supports me in my decision-making regardless of the outcome	57%	55%	71%	40%	59%	62%	53%	49%
Leadership promise	We lead by empowering our people, trusting their judgement and giving assurance that we treat all outcomes as learning opportunities	National	There are frequent opportunities for me to show initiative in my role	70%	66%	80%	54%	78%	74%	73%	58%
Leadership promise	We lead by inspiring people to help shape and be a part of our future vision	Local	My immediate manager inspires me to help shape and be a part of our vision	56%	51%	68%	38%	57%	66%	54%	48%
Leadership promise	We lead by championing culture: we act on staff feedback to create a culture of trust, respect and inclusivity	National	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	62%	59%	65%	52%	74%	70%	56%	57%
Leadership promise	We lead by championing culture: we act on staff feedback to create a culture of trust, respect and inclusivity	Local	My immediate manager creates a culture of trust through being open to receiving feedback	61%	58%	74%	47%	64%	68%	57%	48%
Leadership promise	We lead by championing culture: we act on staff feedback to create a culture of trust, respect and inclusivity	National	I am confident that my organisation would address my concern.	39%	39%	45%	37%	46%	47%	34%	22%

Key
0% - 24%
25% - 49%
50% - 69%
70% - 79%
80% - 100%

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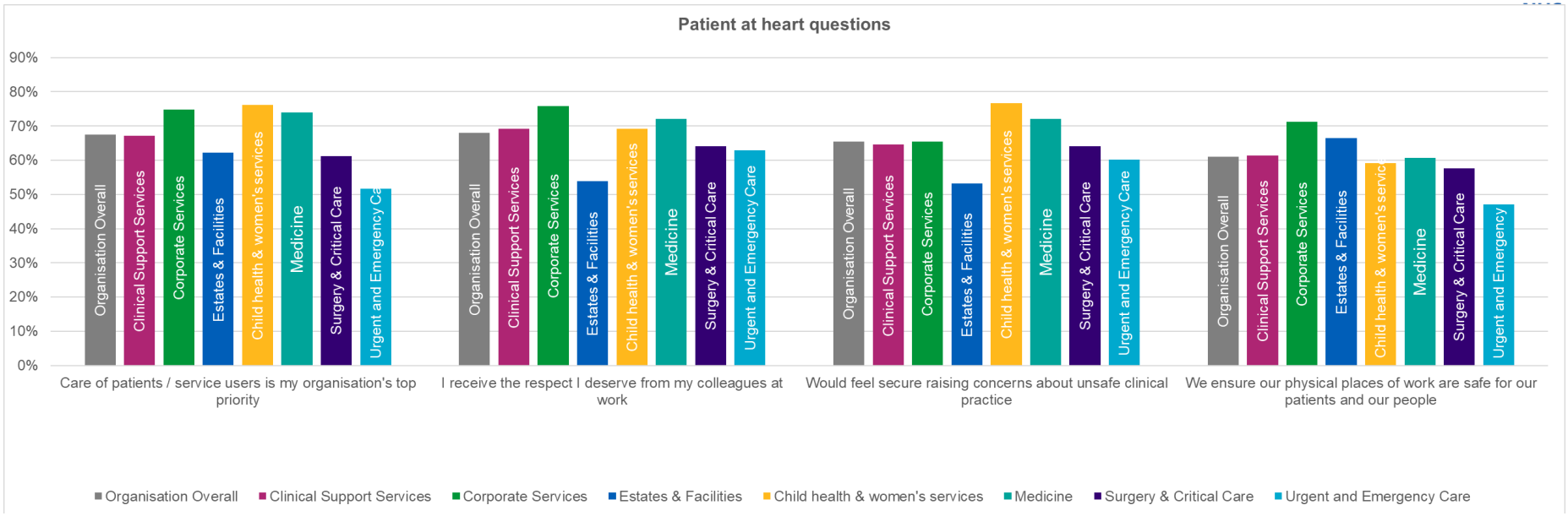

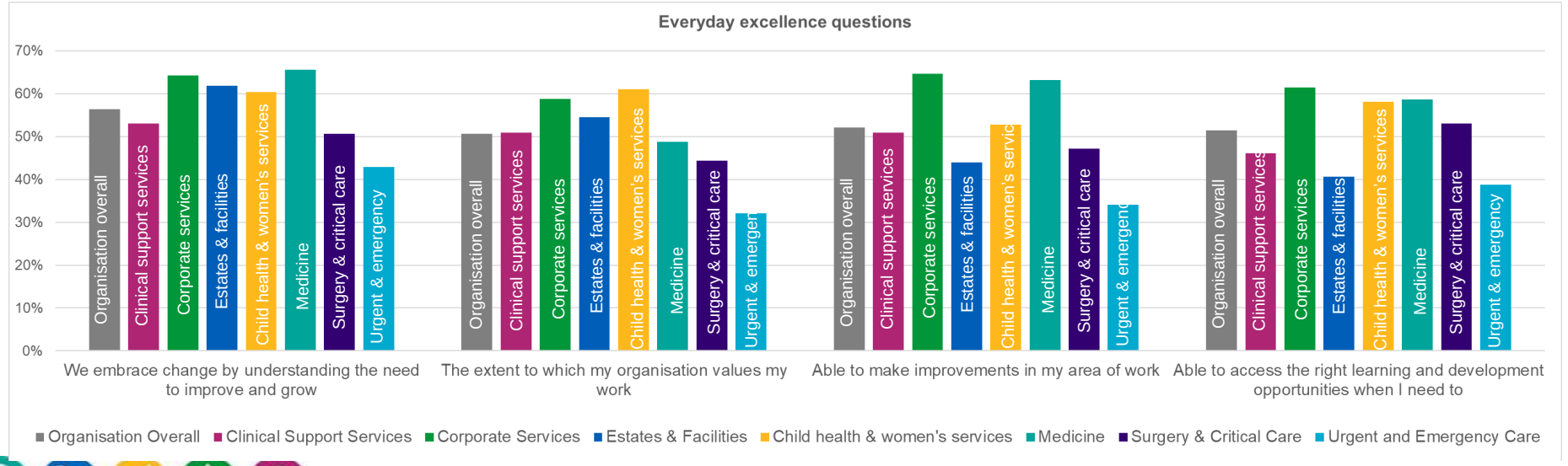

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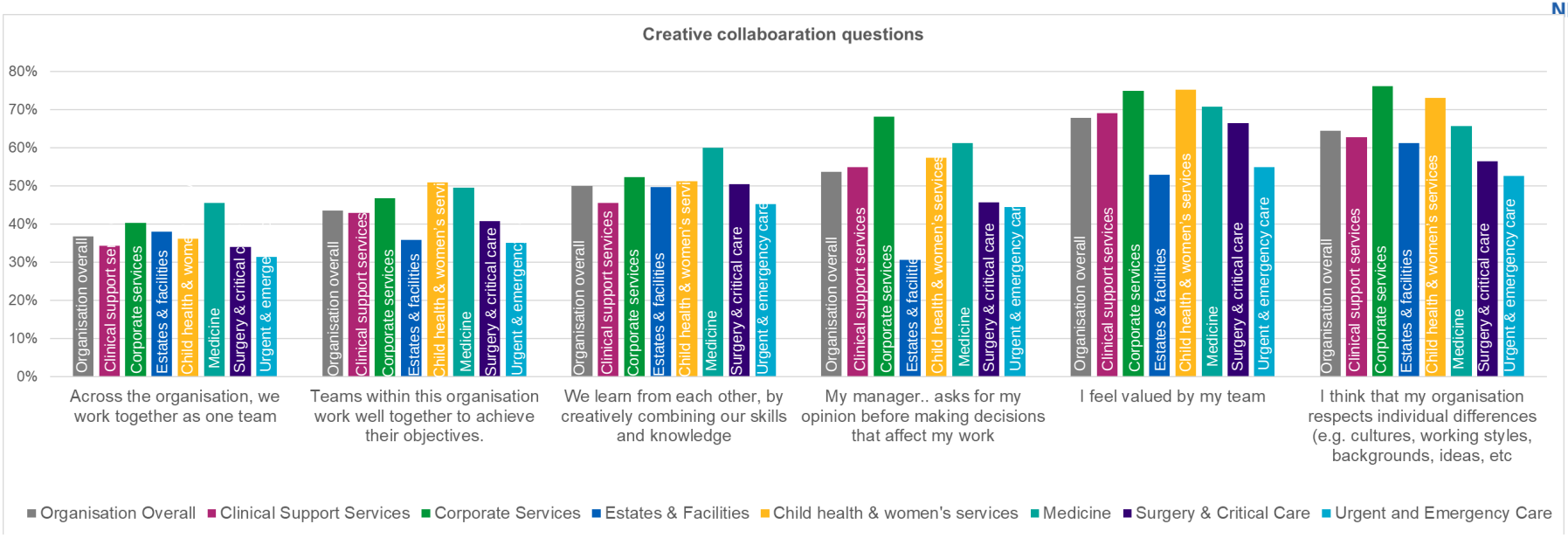

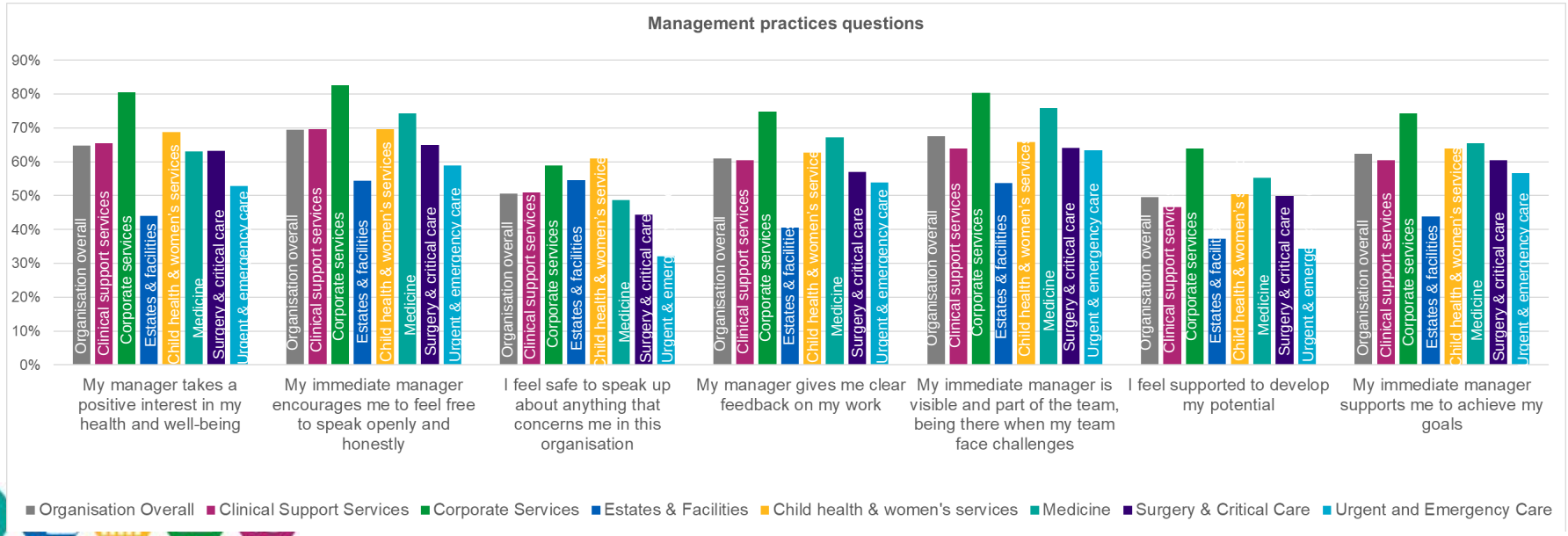

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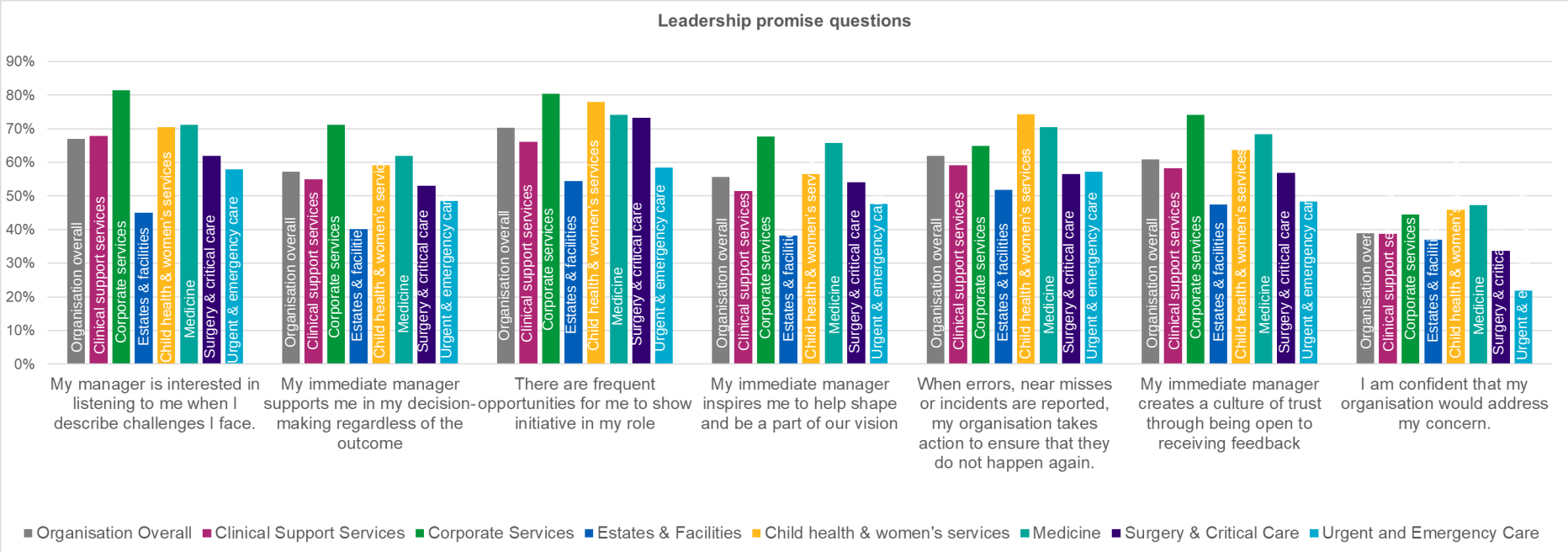

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BOARD OF DIRECTORS:	**Trust Board (Private) – 6 April 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**30 March 2024**	

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	Y	N	The Trust reported a deficit of £0.7m in-month and £15.9m YTD. The financial position in month 11 had shown an improvement in the monthly run-rate. The Trust's agency costs, particularly medical staff, remained at levels higher than previous years. The Trust's FY deficit forecast had improved to £12.7m - the £1.5m movement reflected an ICS income reallocation for Mental Health and Community Support recognising the winter pressures and bed capacity challenges through the delayed discharging of patients. There was also a detailed discussion on the debtor analysis including the element of overseas patients and further detail will be provided at the next meeting.
2.2 Financial Forecast / Year-End	Y	Y	N	At Month 11 the Trust has a deficit of c. £15.9m. Whilst the run rate has recently slowed, the Trust will end 22/23 in a deficit position. To support financial recovery Moorhouse Consultancy have been employed to lead a 'financial recovery and productivity' piece of work to expedite financial transformation and develop a faster and more comprehensive assessment of service improvement. The organisation anticipates a year-end outturn at £12.7m deficit (after the release of non-recurrent measures in-year and an additional £1.5m income from the ICS

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DATE OF COMMITTEE MEETING:	**30 March 2024**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Capital Update	Y	Y	N	The Trust total CRL 2022-23 is £14.1m. The organisation has been awarded additional capital funding from the centre to the value of £13.9m and additional donated funding of £0.3k. This has increased the total capital allocation for the year to £28.4m which requires the Trust to spend £3.3m within M12 to achieve the CRL. The Trust remains under-committed by £30k. The Trust has spent £12.3m YTD, has £12.8m of commitments at Month 11 and is forecasting to spend an additional £3.3m in March 2023. All in, the Trust is forecasting to achieve its 22/23 CRL.
2.4 Patient Quality & Productivity (PQP) Programme Update	Y	Y	N	This report detailed the first full report under the new PQP Programme for 2022/23. The new dashboard report was included within the pack and evidenced both the extent of delivery against the 2022/23 programme and the identification against the plans for 2023/24. As reported previously, it was noted that the Trust would achieve the majority of its CIP target in-year but mainly non-recurrently.
2.5 Business Planning Update	Y	Y	N	The paper highlighted the current position of the Finance Business Plan for 2023/24 based on latest planning guidance

BOARD OF DIRECTORS:	**Trust Board (Private) – 6 April 2023**			**AGENDA ITEM: 6.1**
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DATE OF COMMITTEE MEETING:	**30 March 2024**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				and after first iteration. The plan continued to evolve and be triangulated. The first formal submission was made nationally on 23.02.23 with a further submission is due by 30.03.23. The final submission is likely to be in April. PAF approved the submission. The Trust has a financial planning position of £13.4m deficit after £16.6m (4.5%) of CIP and has submitted a compliant activity plan (which requires the Trust to deliver 103% of the activity delivered in 2019/20).
2.6 ICS Update	Y	Y	N	(This item was included within the discussions above).
2.7 BAF Risk 5.1 (Finance/Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.
2.8 Opportunities around Procurement/Contracts Management	Y	Y	Y	PAF discussed in detail how to get the best value from the regional Procurement service and it was agreed, following the next Procurement Governance Board, that the DoF would present a 'way forward' for procurement which may also, subsequently, require a PAH NED session. Standardisation in

BOARD OF DIRECTORS:	**Trust Board (Private) – 6 April 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 March 2024**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				terms of contract management within the ICS would be key going forward.
3.1 M11 Integrated Performance Report	Y	Y	N	Key headlines at M11 were: • Performance against the ED four hour standard remained in special cause variation highlighting the continued pressure on the service. • Whilst diagnostic performance remained in special cause variation, a second month of improvement back towards the mean had been seen. • Cancer 2WW remained in special cause variation although performance remained near the mean.
3.2 BAF Risk 4.1 (Winter Resilience)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.
3.3 BAF Risk 1.3 (Recovery Programme)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.

BOARD OF DIRECTORS:	**Trust Board (Private) – 6 April 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**30 March 2024**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.4 BAF Risk 4.2 (4 Hour ED Constitutional Standard)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
4.1 New Hospital Update (bi-monthly)	Y	Y	N	The formal announcement on the New Hospital Programme expected that day had now been delayed to May. The national NHP team had recently visited the Trust.
4.2 BAF Risk 3.1 (Estate & Infrastructure)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
5.1 Energy Contract	Y	Y	N	In line with the recommendation, PAF received and noted the additional information requested by the Board relating to the Trust's current energy contract and price hedging to occur from 2023 to 2025.
5.2 Linen Contract	Y	Y	N	In line with the recommendation and following the Herts and Essex ICS procurement exercise, PAF endorsed for Board

BOARD OF DIRECTORS:	**Trust Board (Private) – 6 April 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 March 2024**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				approval the award for the renewal of the organisation's linen contract.
5.3 Healthcare Support Worker Band Alignment	Y	Y	N	In line with the recommendation, PAF endorsed for Board approval the following recommendations: • Band 2 HCSW posts to be re-banded to Band 3 where the current job description met the Band 3 profile. This would include all inpatient/outpatient areas. • New recruits to a HCSW post who did not have the demonstrable experience would be recruited at Band 2 for 12 months whilst they undertook HCSW preceptorship and completion of the Care Certificate. This work would be aligned to the ICB approach across acute organisations.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 April 2023

Agenda item:	6.2
Presented by:	Tom Burton, DoF
Prepared by:	Mark Pockett, DDoF and Wole Ajiboye, Head of FM
Date prepared:	21 March 2023
Subject / title:	Month 11 Financial Performance

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	**X**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report provides an update on the Trust's financial performance for to February 2023 (Month 11). The Trust reported a deficit of £0.7m in month and £15.9m YTD. The financial position in month 11 has shown an improvement in the monthly run rate. The Trust's agency costs, particularly Medical staff, remain at levels higher than previous years. The Trust's FY deficit forecast has improved to £12.7m, the £1.5m movement reflects an ICS income reallocation for Mental Health and Community support recognising the winter pressures and bed capacity challenges through the delayed discharging of patients.								
Recommendation:	The Board is asked to note the month 10 financial results.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	X	**X**	**X**	**X**	**X**				

Previously considered by:	Verbal update at EMT, PAF in Mar 22
Risk / links with the BAF:	BAF risks 5.1 and 5.2
Legislation, regulatory, equality, diversity and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

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The Princess Alexandra Hospital NHS Trust

Summary finance notes

- Nationally Trust's are being tasked with reducing patient waiting times and delivering elective recovery activity. The Trust has seen a significant reduction in income from the previous years but also seen it's operating costs grow in response to the elective recovery challenges.

- PAHT has reported a deficit of £0.7m in month and £15.9m YTD. With the additional income accrued in month 11 from the ICS there were no further non-recurrent amounts released into position in month 11. All non-recurrent flexibilities are being analysed and will be released as necessary to deliver the ICS agreed Trust deficit for 22/23.

- We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position. There has been a comprehensive review of the forecasts with Budget Holders at Month 11 and renewed oversight of the current deficit drivers is being undertaken as part of the Moorhouse Phase 2 commission.

- The monthly financial position indicated the actions to reduce and slow down the run rate have reduced the deficit. These include Elective recovery activity including stopping outsourcing\insourcing and Estates maintenance costs. As part of the efforts to trim the run rate into 2023/24, additional efforts have been made with existing outsourced contracts e.g. Commisceo to reduce charges.

- The Trust's agency costs, particularly Medical staff, remain at the levels seen in previous months. This month's report includes an analysis of some of the drivers of the underlying price and volume variance around pay spend.

- Pay is overspent by £2.2m in month and £15.3m year to date against plan. The pay award for months 1-6 was paid in September to all staff. The initially anticipated 2% pay award was not included in our reported financial position in previous months, the arrears adversely impacted the month 6 pay spend by £1.5m. The substantive pay spend continues to increase reflecting the drive for increased permanent recruitment and is additionally impacted by the CEA accounted for in month 11. Bank and agency spend remains higher than forecast.

- Cash balance is £42.7m as at month 11. The movement from the closing 21/22 cash balance reflects the Trust's YTD deficit together with working capital movements. Overall, the Trust is still in a position to meet its short-term cash obligations but with an increasing deficit, additional oversight is being provided of the cash balance in this time.

Performance & Finance

The Princess Alexandra Hospital NHS Trust

February - Month 11

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

	FY Budget	Month 11			YTD - Feb		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS Clinical SLA Income	318.4	26.5	26.5	**0.0**	291.9	290.6	**(1.2)**
Non NHS Clinical Income	12.4	1.0	2.6	**1.6**	11.4	15.9	**4.5**
Non Clinical Income	1.2	0.1	0.1	**(0.0)**	1.1	2.9	**1.8**
Income Total	**332.0**	**27.7**	**29.2**	**1.6**	**304.4**	**309.4**	**5.1**
Pay							
Substantive	(203.2)	(17.0)	(16.2)	**0.8**	(186.3)	(170.7)	**15.6**
Bank	(5.0)	(0.4)	(2.5)	**(2.1)**	(4.6)	(26.2)	**(21.7)**
Agency	(5.9)	(0.5)	(1.4)	**(0.9)**	(5.5)	(14.7)	**(9.3)**
Pay Total	**(214.2)**	**(17.8)**	**(20.0)**	**(2.2)**	**(196.4)**	**(211.6)**	**(15.3)**
Non-Pay							
Drugs & Medical Gases	(27.9)	(2.1)	(2.1)	**0.0**	(25.4)	(23.8)	**1.6**
Supplies & Services - Clinical	(18.4)	(0.6)	(1.9)	**(1.2)**	(16.8)	(18.7)	**(1.9)**
Supplies & Services - Genera	(5.0)	(0.3)	(0.4)	**(0.1)**	(4.6)	(4.8)	**(0.3)**
All other non pay costs	(48.0)	(4.9)	(4.5)	**0.4**	(44.0)	(51.6)	**(7.6)**
Non-Pay Total	**(99.4)**	**(8.0)**	**(8.9)**	**(0.9)**	**(90.7)**	**(98.9)**	**(8.2)**
Financing & Depn							
Non NHS Clinical Income	(4.7)	(0.4)	0.1	**0.5**	(4.3)	(3.3)	**1.0**
All other non pay costs	(14.0)	(1.2)	(1.0)	**0.1**	(12.8)	(11.5)	**1.3**
Financing & Depn Total	**(18.7)**	**(1.6)**	**(1.0)**	**0.6**	**(17.2)**	**(14.8)**	**2.3**
Grand Total	**(0.3)**	**0.3**	**(0.7)**	**(1.0)**	**0.1**	**(15.9)**	**(16.1)**

Workforce

The Princess Alexandra Hospital NHS Trust

	FY Budget	Month 11 Budget £'000	Month 11 Actual £'000	Month 11 Variance £'000	YTD - Feb Budget £'000	YTD - Feb Actual £'000	YTD - Feb Variance £'000
Pay							
Substantive	203,246	17,008	16,168	(839)	186,298	170,680	(15,618)
Bank	4,983	359	2,494	**2,134**	4,564	26,214	**21,651**
Agency	5,948	459	1,351	**891**	5,489	14,746	**9,258**
Total Pay Cost	**214,177**	**17,826**	**20,012**	**2,186**	**196,350**	**211,640**	**15,290**

	Month 11 Permanent £'000	Month 11 Bank £'000	Month 11 Agency £'000	Month 11 Total £'000	YTD - Feb Permanent £'000	YTD - Feb Bank £'000	YTD - Feb Agency £'000	YTD - Feb Total £'000
Pay								
Medical	5,019	702	1,036	**6,757**	50,290	7,976	10,310	**68,576**
Nursing	5,831	1,291	197	**7,319**	62,936	12,888	2,056	**77,880**
Scientific, Therapeutic & Tech	1,968	92	66	**2,126**	21,074	972	1,351	**23,397**
Ancillary	623	211	(0)	**834**	7,058	2,543	53	**9,653**
Admin & Clerical	1,640	198	56	**1,893**	18,031	1,835	980	**20,845**
Snr Managers	1,030	0	(3)	**1,027**	10,776	0	(3)	**10,772**
Maintenance & Works Staff	56	0	0	**56**	517	0	0	**517**
Total Pay Cost (Actual)	**16,168**	**2,494**	**1,351**	**20,012**	**170,680**	**26,214**	**14,746**	**211,640**

- Total staff cost of £20.0m in month and £211.6m year to date. The in month staff cost is £0.5m higher than the previous month. The increase is mainly due to the provision of £0.5m for the 22/23 consultants' clinical excellence awards payment in month 11.
- Substantive Pay continues to underspend due to vacancies, these are backfilled using bank and agency staff often at higher costs .
- Medical staffing accounts for £10.3m (69.9%) of the total agency staff cost of £14.7m year to date.

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

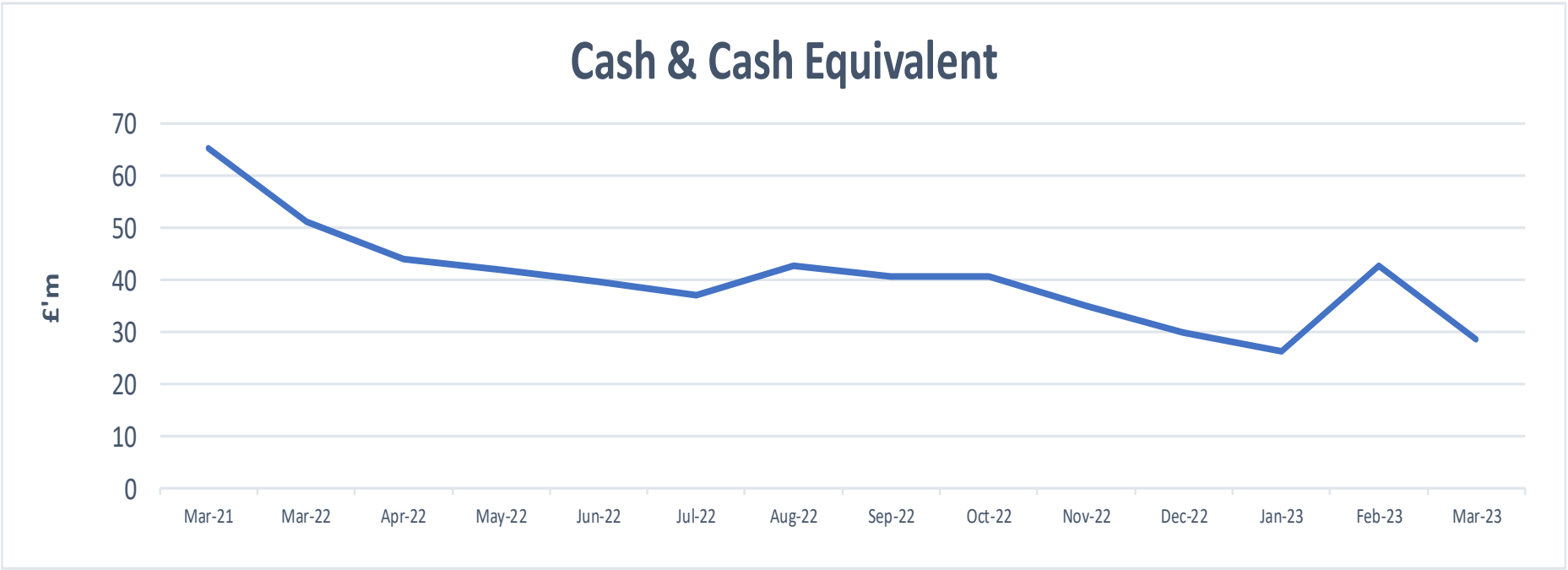
Statement of Financial Position	31 January 2023 £m	28 February 2023 £m	In Month Variance £m	YTD Variance £m
Non-current assets				
Property, plant & equipment	149.6	151.3	1.7	2.2
Intangible assets	9.5	9.6	0.1	(1.4)
Trade & other receivables	0.6	0.6	0.0	0.0
Total non-current assets	**159.7**	**161.5**	**1.8**	**0.8**
Current assets				
Inventories	5.2	5.2	0.0	0.0
Trade & other receivables	14.0	12.6	(1.4)	0.6
Cash & cash equivalents	26.4	42.7	16.3	(8.4)
Total current assets	**45.5**	**60.5**	**15.0**	**(7.7)**
Total assets	**205.3**	**222.0**	**16.8**	**(6.9)**
Current liabilities				
Trade & other payables	(37.1)	(42.1)	(5.0)	3.6
Provisions	(1.3)	(1.3)	0.0	0.3
Borrowings	0.0	0.0	0.0	0.0
Total current liabilities	**(38.4)**	**(43.5)**	**(5.0)**	**3.9**
Net current assets/ (liabilities)	**7.1**	**17.0**	**9.9**	**(3.8)**
Total assets less current liabilities	**166.8**	**178.6**	**11.7**	**(3.0)**
Non-current liabilities				
Trade & other payables	0.0	0.0	0.0	0.0
Provisions	(1.0)	(1.0)	0.0	0.6
Borrowings	0.0	0.0	0.0	0.0
Total non-current liabilities	**(1.0)**	**(1.0)**	**0.0**	**0.6**
Total assets employed	**165.8**	**177.6**	**11.8**	**(2.4)**
Financed by:				
Public dividend capital	327.7	340.1	12.4	12.3
Income and expenditure reserve	(163.1)	(163.8)	(0.7)	(16.0)
Revaluation reserve	1.2	1.2	0.0	1.2
Total taxpayers' equity	**165.8**	**177.6**	**11.8**	**(2.4)**

- **Non Current Assets** have increased in month by £1.8m representing capital expenditure.
- **Trade and Other Receivables**, improvement due to payment of outstanding debts.
- **Cash balances** increase in month 11 due to PDC capital allocation received by the Trust
- **Trade and Other Payables** have increased as reflecting higher volume of POs and expenditure accruals as we approach the end of the 22/23.

Cashflow

The Princess Alexandra Hospital NHS Trust

Mar-21	Mar-22	<----------YTD---------->										Fcast	1 month trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
65,242	51,075	44,051	42,022	39,522	37,129	42,725	40,667	40,741	35,112	29,943	26,352	42,699	28,615	↑



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 April 2023

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	29 March 2023
Subject / title:	M11 Integrated Performance Report (IPR)

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

Key issues:
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Patients		
Patients	**Complaints**	Eighth month in common cause variation which is now statistically significant, following a single month in deteriorating special cause variation in June 2022
	Falls per 1000 bed days	Performance has remained in positive special cause variation
People		
People	**Appraisals**	Remains in common cause variation for the fourth consecutive month
	Statutory and Mandatory Training	In special cause variation, with performance back to 86%
	Sickness Absence	Has returned to common cause variation following a return to performance below the mean
Performance		
Performance	**RTT**	Performance remains in special cause variation, awith performance static at a similar level for over 12 months. Recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Remains in special cause variation, but performance remains near the mean
	Cancer 62 day pathway	Returned to special cause variation due to the last data point being below the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
	Diagnostics	Whilst performance remains in special cause variation, we have seen the second month of improvement back towards the mean
	52 week waits	Still in special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for the last eight months following a small increase in July.
	Stranded Patients	The number of patients with a length of stay over 7 days continues to be at or near the upper control limit for the last six months and remains in special cause variation
Pounds		
Pounds	Surplus	The Trust reported a deficit of £0.7m in February (Month 11) and year to date deficit of £15.9m. We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position
	CIP	The 22/23 CIP target is £11.7m with a YTD planned savings at month 11 of £10.3m. The FY forecast waste\efficiency is currently £11.7m with the YTD indentified savings at £9.8m, of which £8.9m are non-recurrent. Work continues within each divsion to deliver additional schemes and savings.
	Capital Spend	The Trust total revised Capital resourcing for 2022/23 is £28.4m, this includes external PDC including the new hospital project, CDC, EHR, Hardware refresh, Digital funding and others. As at Month 11 the year to date capital spend total is £12.3m, excluding the impact of IFRS 16. It is fully anticipated the capital programme will be fully utilised in 22/23.
	Cash	The Trust's cash balance is £42.7m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit in 2022/23. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.
Places		
Places		

6.3

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.30.03.23 QSC.31.03.23
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity
Appendices:	

6.3

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report for February 2023

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Performance Summary

Patients

Patients	Pressure Ulcers	Eighth month in common cause variation which is now statistically significant, following a single month in deteriorating special cause variation in June 2022
Patients	Falls per 1000 bed days	Performance has remained in positive special cause variation

Pounds

Pounds	Surplus	The Trust reported a deficit of £0.7m in February (Month 11) and year to date deficit of £15.9m. We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position
Pounds	Cost Improvement Programme	The 22/23 CIP target is £11.7m with a YTD planned savings at month 11 of £10.3m. The FY forecast waste\efficiency is currently £11.7m with the YTD indentified savings at £9.8m, of which £8.9m are non-recurrent. Work continues within each divsion to deliver additional schemes and savings.
Pounds	Capital Spend	The Trust total revised Capital resourcing for 2022/23 is £28.4m, this includes external PDC including the new hospital project, CDC, EHR, Hardware refresh, Digital funding and others. As at Month 11 the year to date capital spend total is £12.3m, excluding the impact of IFRS 16. It is fully anticipated the capital programme will be fully utilised in 22/23.
Pounds	Cash	The Trust's cash balance is £42.7m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit in 2022/23. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.

Places

Places	Domestic Services (cleaning) high risk	Performance has reduced towards the lower control limit for October and November

People

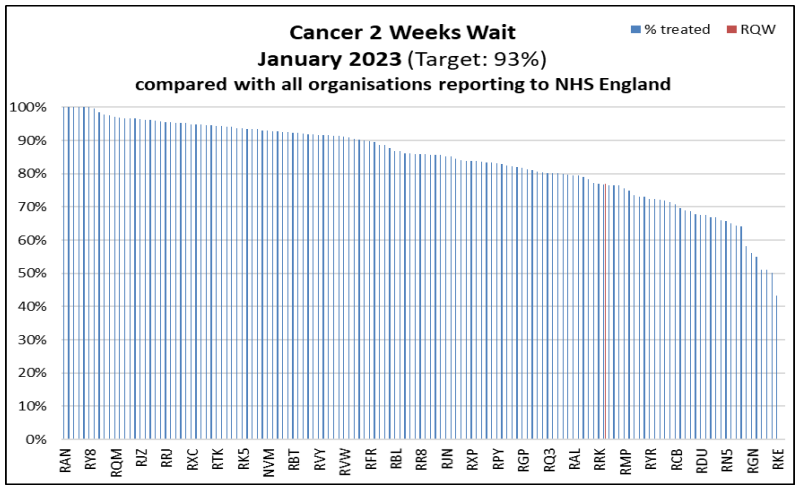
People	Appraisals	Remains in common cause variation for the fourth consecutive month
People	Statutory and Mandatory Training	In special cause variation, with performance back to 86%
People	Sickness Absence	Has returned to common cause variation following a return to performance below the mean

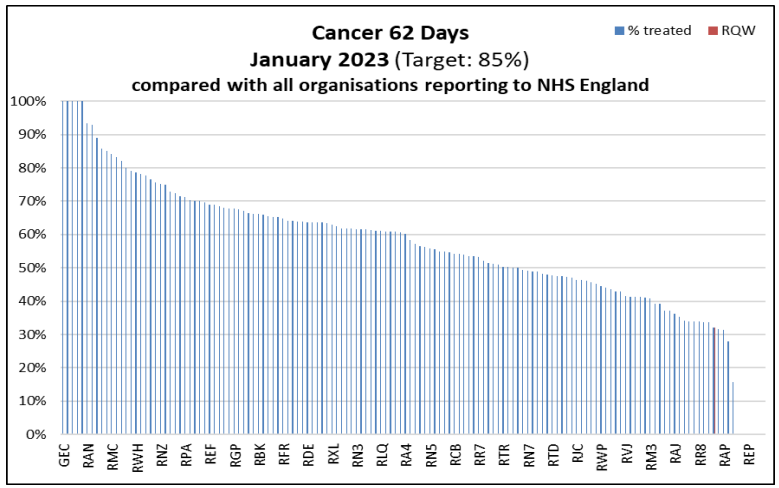
Performance

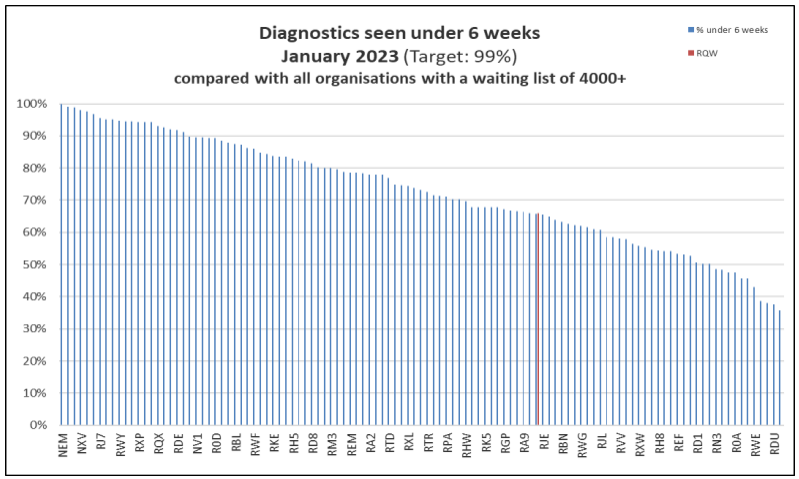
Performance	Referral to Treatment	Performance remains in special cause variation, awith performance static at a similar level for over 12 months. Recovery actions continue to be in place, with patients being treated in clinical priority.
Performance	Cancer 2 week wait	Remains in special cause variation, but performance remains near the mean
Performance	Cancer 62 day pathway	Returned to special cause variation due to the last data point being below the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
Performance	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
Performance	Diagnostics	Whilst performance remains in special cause variation, we have seen the second month of improvement back towards the mean
Performance	52 week waits	Still in special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for the last eight months following a small increase in July.
Performance	Stranded Patients	The number of patients with a length of stay over 7 days continues to be at or near the upper control limit for the last six months and remains in special cause variation

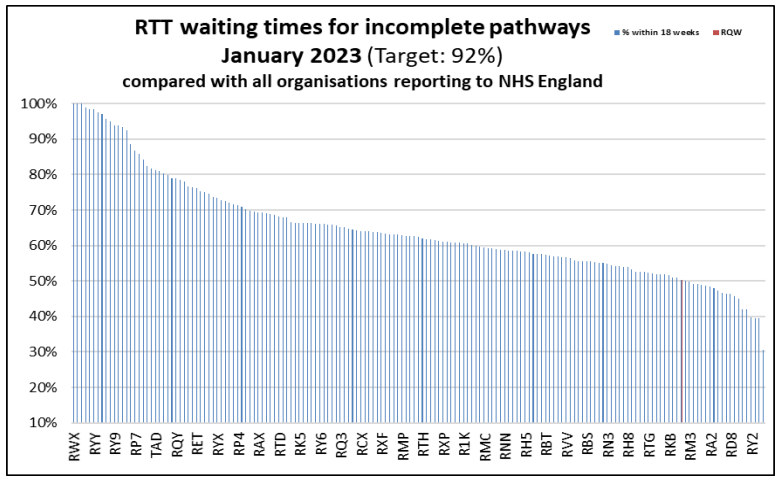
Summary

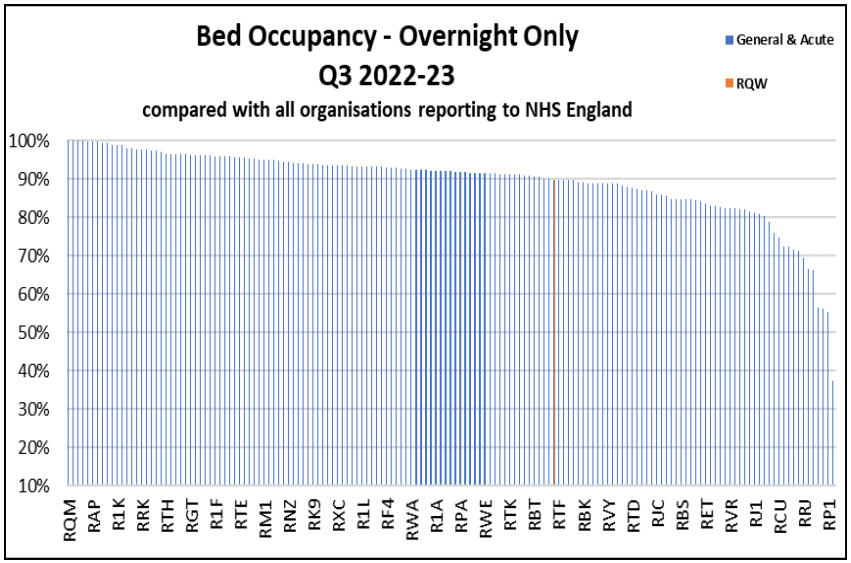
National Benchmarking

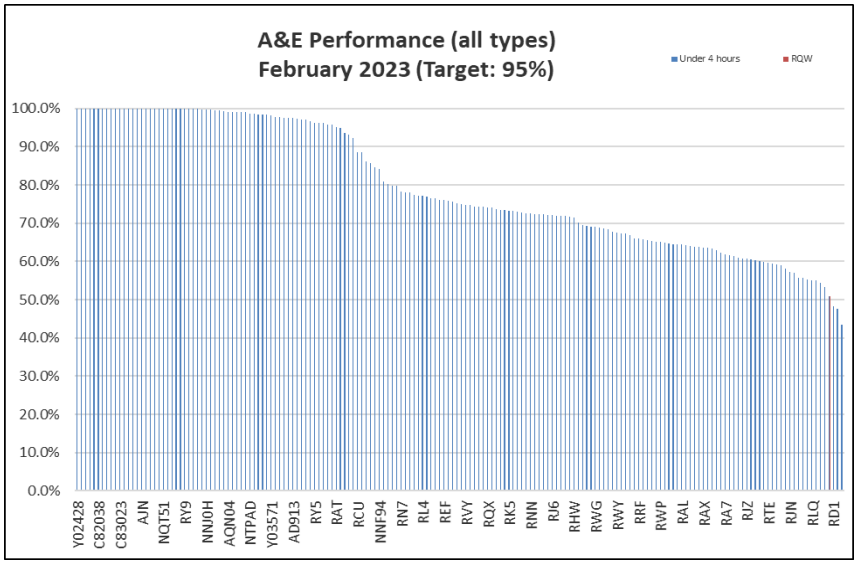


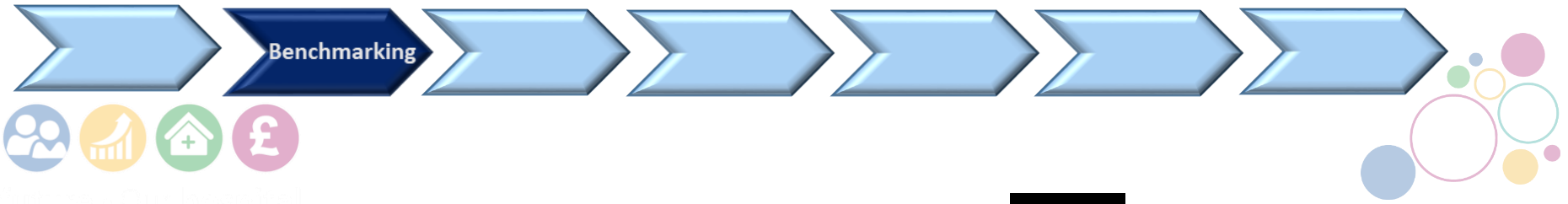







Bed Occupancy - Overnight Only
Q3 2022-23
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RQM RAP R1K RRK RTH RGT R1F RTE RM1 RNZ RK9 RXC R1L RF4 RWA R1A RPA RWE RTK RBT RTF RBK RVY RTD RJC RBS RET RVR RJ1 RCU RRJ RP1


A&E Performance (all types)
February 2023 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Y02428 C82038 C83023 AJN NQT51 RY9 NNJ0H AQN04 NTPAD Y03571 AD913 RY5 RAT RCU NNF94 RN7 RL4 REF RVY RQX RK5 RNN RJ6 RHW RWG RWY RRF RWP RAL RAX RA7 RJZ RTE RJN RLQ RD1


Benchmarking

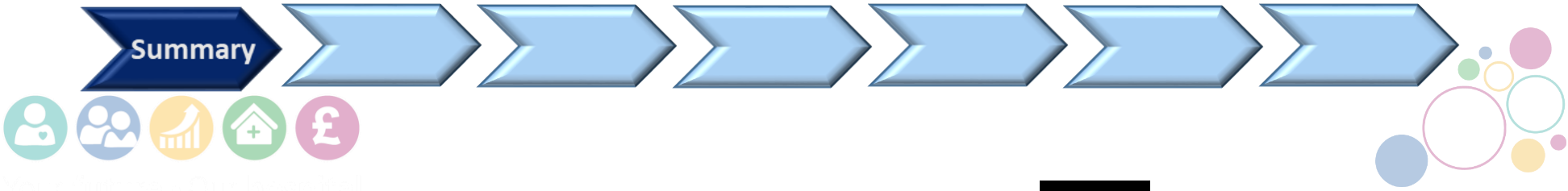
The difference between common and special cause variation

Common Cause Variation

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

Special Cause Variation

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



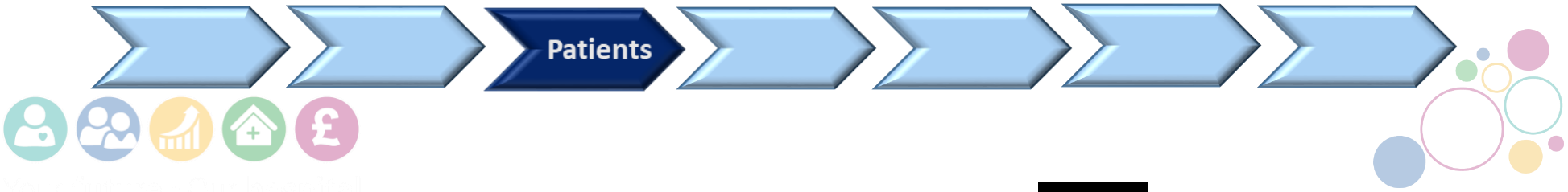
How is special cause variation defined and identified

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

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

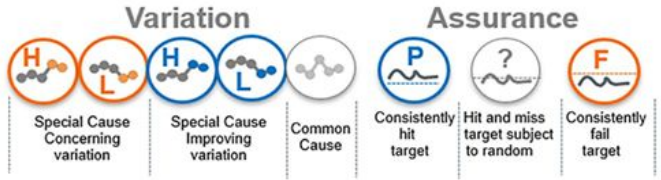
Patients

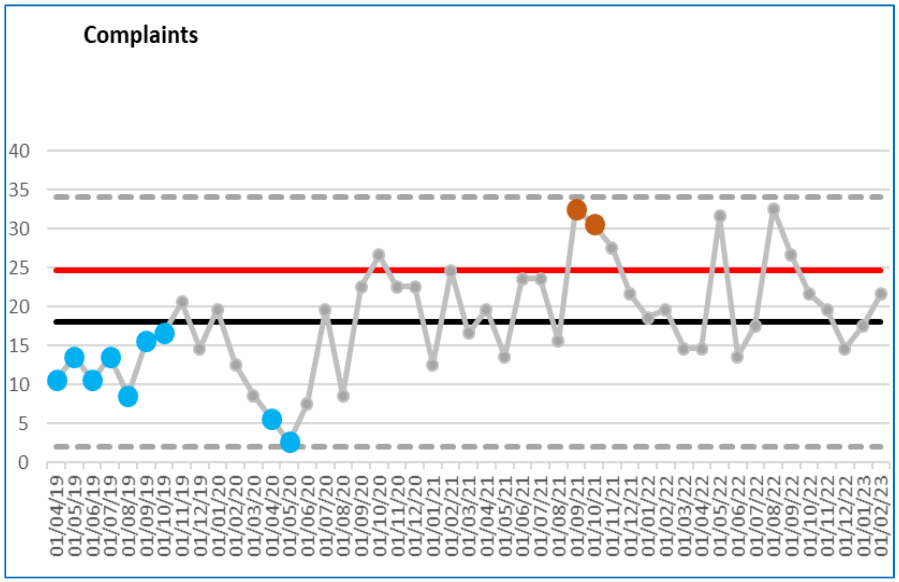
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*



KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Feb 23	22	25			18	2	35
Compliments	Feb 23	78	50			111	-76	298
PALS	Feb 23	366	none			294	154	435
Complaints closed within target	Feb 23	4	none			6	-3	14
% of complaints where an extension has been agreed	Feb 23	64%	none			45%	14%	75%
Mixed Sex Accommodation Breach	Feb 23	4	0			7	-4	18
Serious Incidents	Feb 23	2	none			4	-4	12
MSSA	Feb 23	2	none			1	-1	3
CDIFF	Feb 23	4	none			5	-3	13
Hand Hygiene	Feb 23	91%	none			92%	78%	106%
eColi	Feb 23	0	3			1	-2	5
Klebsiella	Feb 23	1	2			1	-1	3
Pseudomonas	Feb 23	2	1			0	-1	2
Falls per 1000 bed days	Feb 23	7	9			8	5	11
Falls total minor, moderate & severe	Feb 23	19	13			23	10	37
Pressure Ulcers per 1000 bed days	Feb 23	3	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Feb 23	4	3			5	-3	12
Total number of mothers delivering in birthing unit/home	Feb 23	13%	20%			10%	-2%	22%
Number of mothers delivering in Labour Ward/Theatres	Feb 23	86%	75%			89%	76%	103%
Number of women due to deliver at PAH adjusted for misc/TOPs	Feb 23	307	375			328	273	382
Smoking rates at booking	Feb 23	7%	none			9%	3%	14%
Smoking rates at delivery	Feb 23	8%	6%			9%	5%	14%
Breast feeding rates at delivery	Feb 23	72%	74%			75%	67%	84%

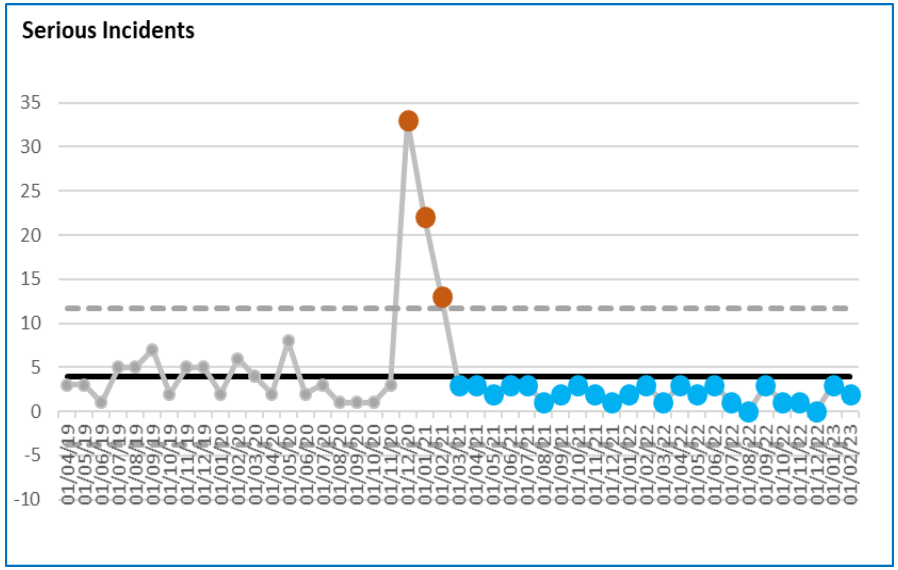
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
Postpartum Haemorrhage over1500 mls	Feb 23	4%	none			4%	1%	7%
CTG training compliance midwives	Feb 23	96%	85%	H	?	75%	58%	92%
CTG training compliance doctors	Feb 23	91%	85%		?	76%	53%	99%
Still births	Feb 23	2	none			1	-1	3
Patients detained under MHA	Feb 23	0	none			0	-1	2
Patients detained under section 136	Feb 23	1	none	H		1	-2	3
Mental health patient incidents	Feb 23	9	none			12	-1	24
Mental health patient complaints	Feb 23	0	none			0	-1	1
Mental health patient PALS	Feb 23	0	none			2	-1	5
Patients with LD and Autism accessing inpatient services	Feb 23	26	none			25	5	46
C-DIFF Hospital onset healthcare associated	Feb 23	3	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Feb 23	0	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Feb 23	0	none			1	-1	2
C-DIFF Community onset community associated (No acute conta	Feb 23	1	none			1	-2	5
Covid-19 new positive inpatients	Feb 23	123	none			137	-88	362
MRSA	Feb 23	0	0	L	?	0	0	0
Births	Feb 23	251	none	L		318	263	373
Instrumental births	Feb 23	18	none			25	5	45
Pre- term births	Feb 23	18	none			21	4	39
Continuity of carer	Feb 23	9%	none	L		21%	10%	31%
Women booked in month	Feb 23	372	none			364	298	429





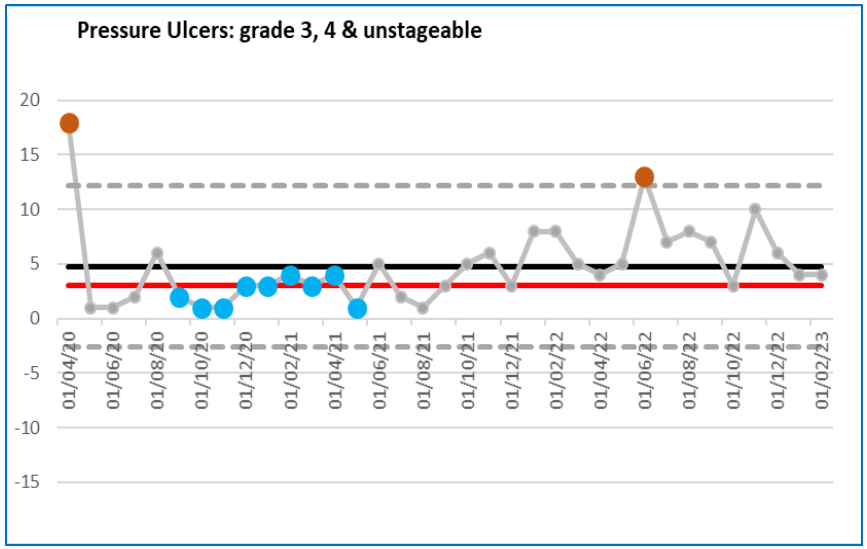
Feb-23
22
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation	Complaints increases reflects operational issues, now settling into a consistent pattern post pandemic changes.	Early resolution meetings with patients and carers introduced by divisions. The Trust have established weekly complaints oversight meetings with all teams. Complaints management workshops planned in April.	Reduce the recurring themes in line with our patient experience quality improvement plan.



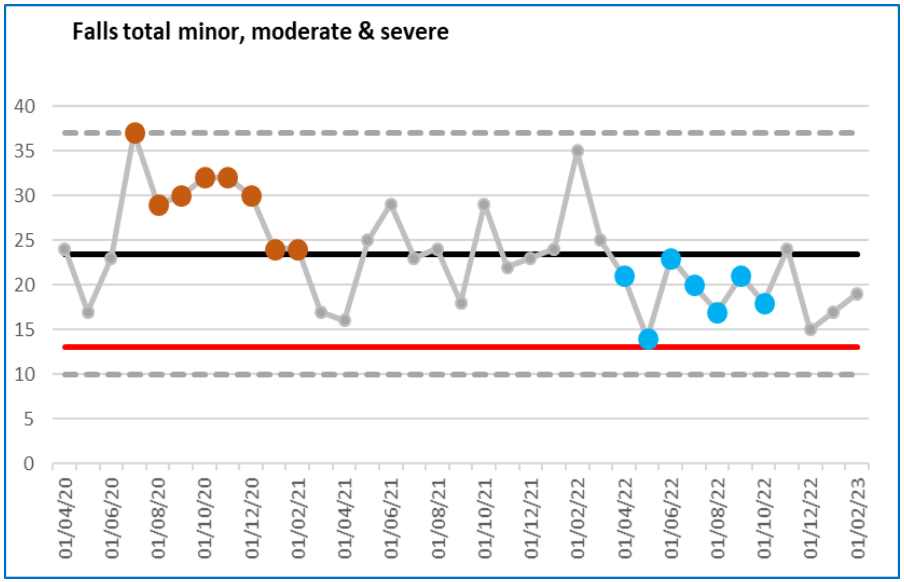
Feb-23
2
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & month on month	Where an incident meets the national reporting criteria to be raised externally as a serious incident (SI) it will be raised. There is no internally set target	Incident management group meets twice a week to review new incidents & those with completed investigations. Two serious incidents were raised during February 2023. Three SI's were closed in this month. The trust had 15 serious incident investigations 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.



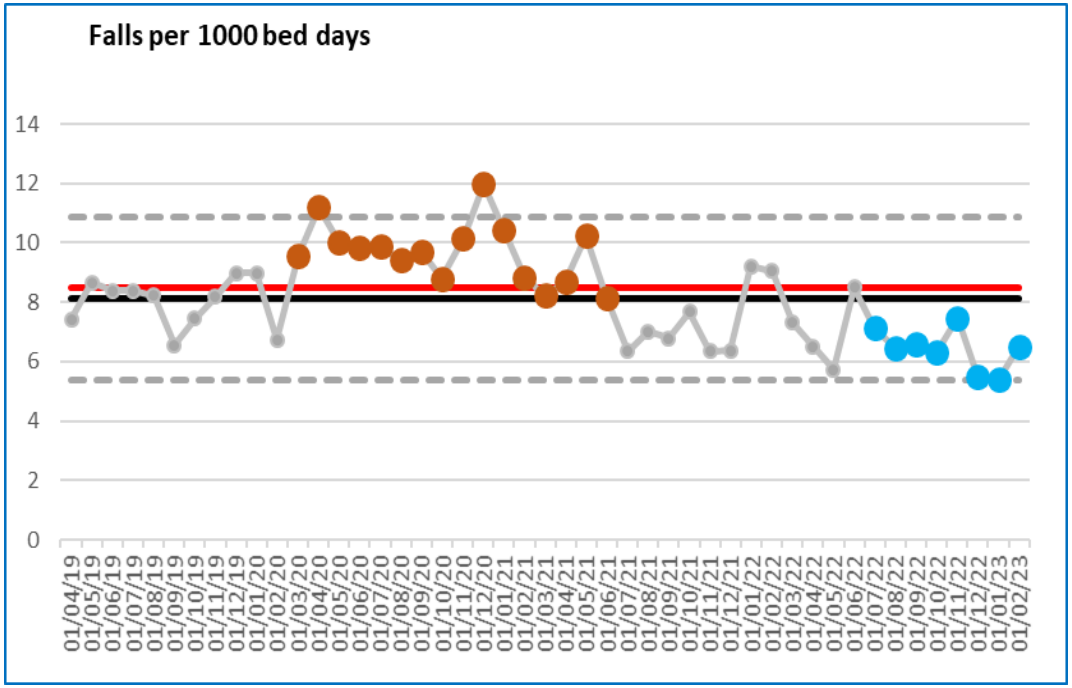
Feb-23
4
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

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



Feb-23
19
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

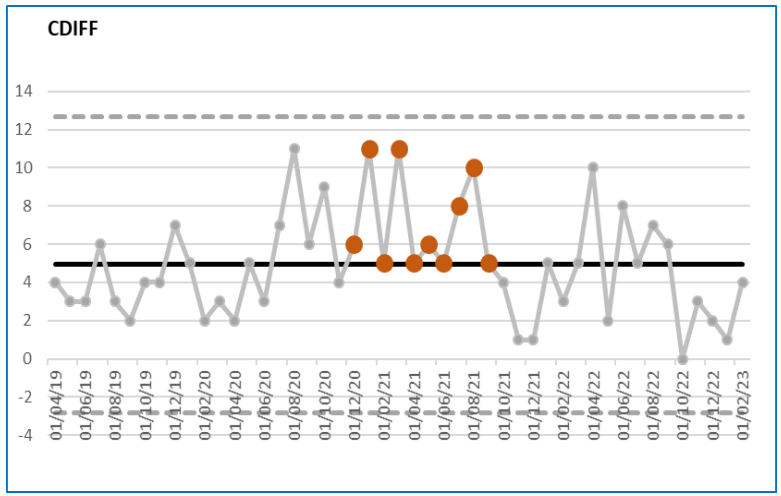
Background	What the chart tells us	Issues	Actions	Mitigation
Falls total minor, moderate & severe	Common cause variation & hit and miss target subject to random variation	A new falls prevention strategy has been developed for the financial year 2022/23. The Trust remains committed to reducing falls with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



Feb-23
6.51
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

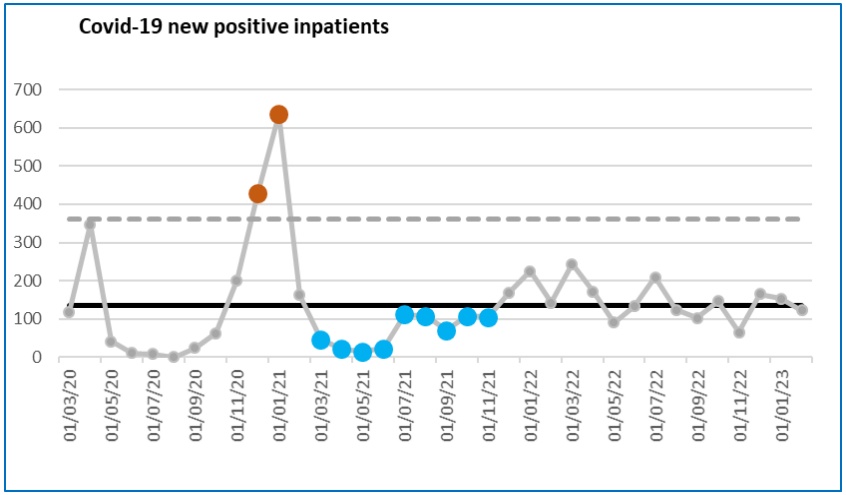
Background	What the chart tells us	Issues	Actions	Mitigation
Falls per 1000 bed days	Common cause variation & hit and miss target subject to random variation		Please see Falls by Harm narrative	

Patients



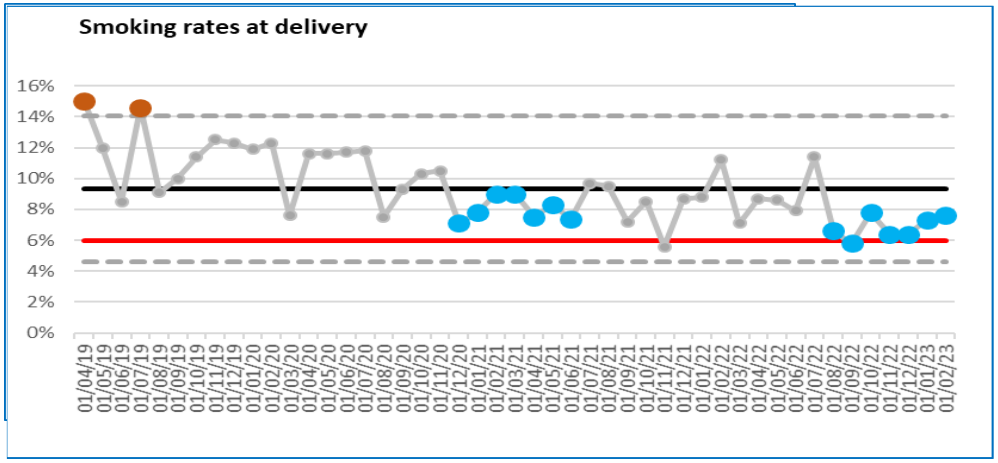
Feb-23
4
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

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



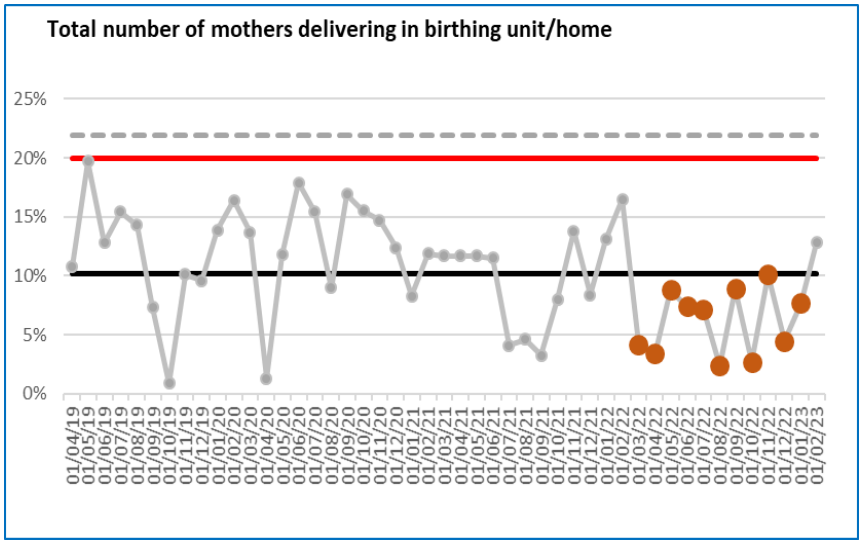
Feb-23
123
Variance Type
Common cause variation
Target
Target Achievement
Hit & miss target subject to random variation

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.



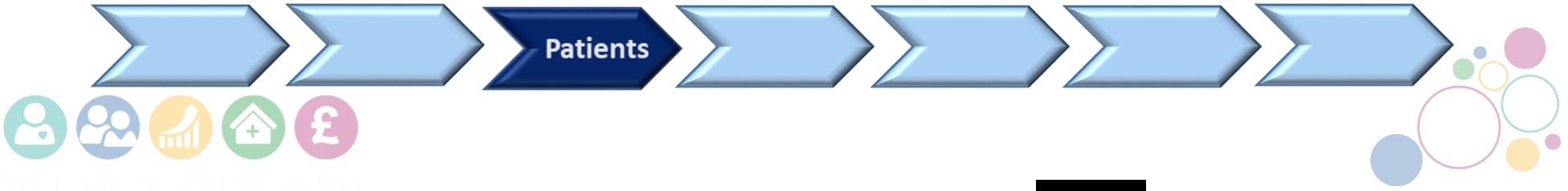
Feb-23
7.6%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

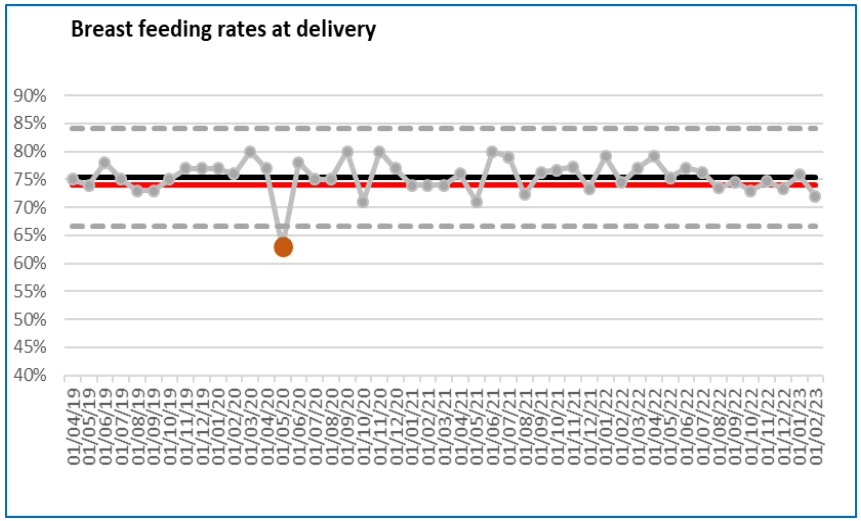
Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking rates at delivery	A new in house Maternity Stop Smoking Advisor is now in post and is offering face to face appointments with women to assist them to stop smoking	A daily Report is generated to enable the Advisor to identify women who may benefit from early intervention and contact them straight after their initial Midwife Booking Appointment. Advice and support, to assist them to stop smoking is via telephone outpatient clinics or face to face for maternity in-patients A daily Report is generated to enable the Advisor to identify women who may benefit from early intervention and contact them straight after their initial Midwife Booking Appointment. Advice and support, to assist them to stop smoking is via telephone outpatient clinics or face to face for maternity in-patients A daily Report is generated to enable the Advisor to identify women who may benefit from early intervention and contact them straight after their initial Midwife Booking Appointment. Advice and support, to assist them to stop smoking is via telephone outpatient clinics or face to face for maternity in-patients



Feb-23
12.8%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

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

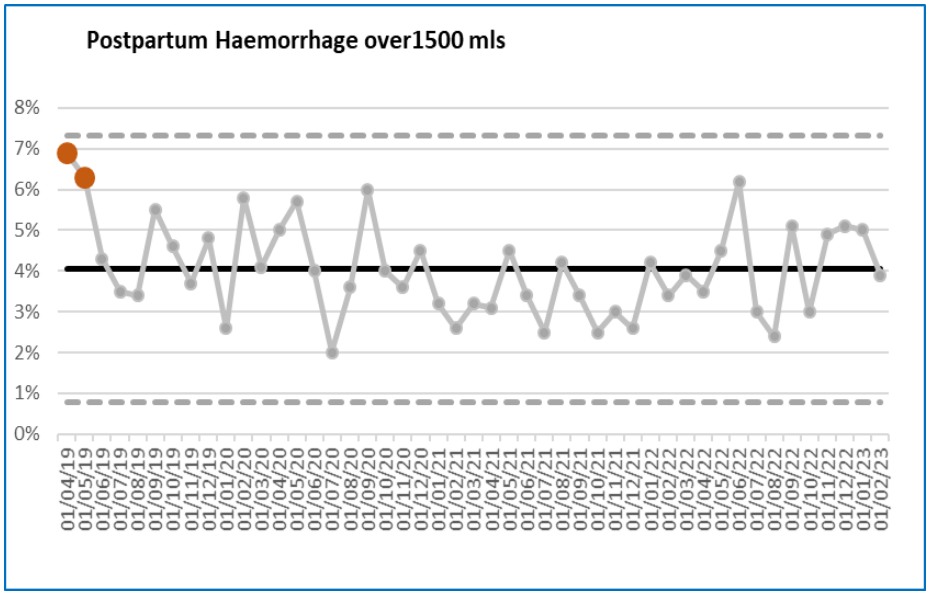




Feb-23
72.0%
Variance Type
Common cause variation
Target
74%
Target Achievement
Hit & miss target subject to random variation

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

Patients



Feb-23
3.90%
Variance Type
Common cause variation
Target
Not set
Target Achievement

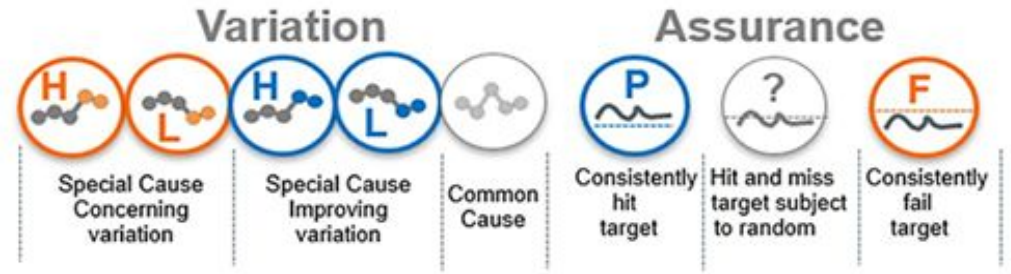
Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	All massive obstetric haemorrhages are reviewed to ensure the appropriate management was followed, including a thematic review of high risk factors	Themes and learning identified, from the Datix reviews, are continuously shared with staff. These include the identification of women with a prolonged second stage as a particularly high risk group, The labour admission risk assessment tool has been reviewed to ensure it is as effective as possible and a new

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**
Estates	The new system MICAD is currently being implemented, once this is up and running we will be able to report the required figures	For information	
Catering	Increase in meals due to the hospital patient numbers. Currently using the Cook Chill whilst the kitchen was refurbished. In house meal preparation restarted beginning of December.	For information	
Facilities	The current monitoring system for the domestics which produces the NSC scores has being failing regularly, the decision has been made to give notice and to move to a new system which encorporates Domestics, Portering and Catering. This new system will be ensure that all areas have a full auditing too	For information	

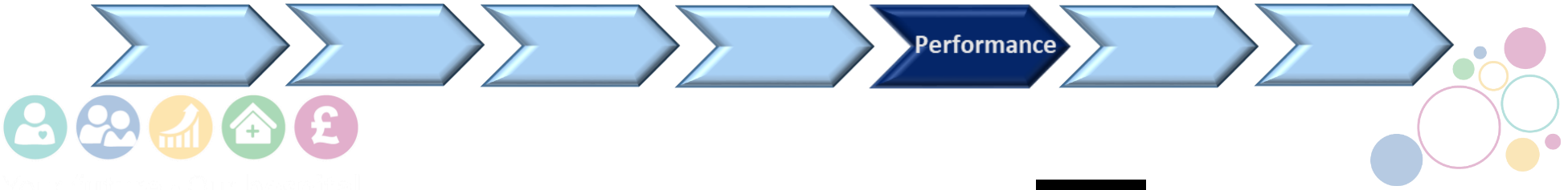
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Sep 22	93%	95%			95%	91%	99%
Meals Served	Nov 22	50170	42120	H		38705	27190	50221
Catering Food Waste	Sep 22	2%	4%	L		5%	-1%	10%
Domestic Services (Cleaning) Very High Risk	Oct 22	97.6%	98.0%			97.7%	94.7%	100.7%
Domestic Services (Cleaning) High Risk	Oct 22	93.4%	95.0%			96.7%	93.2%	100.1%



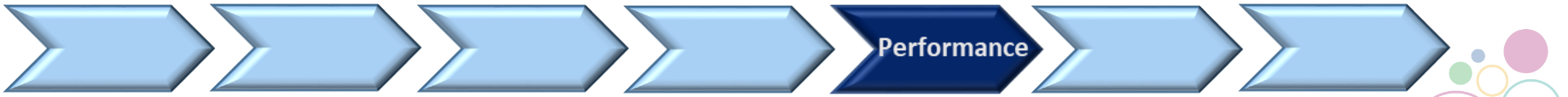
Performance

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

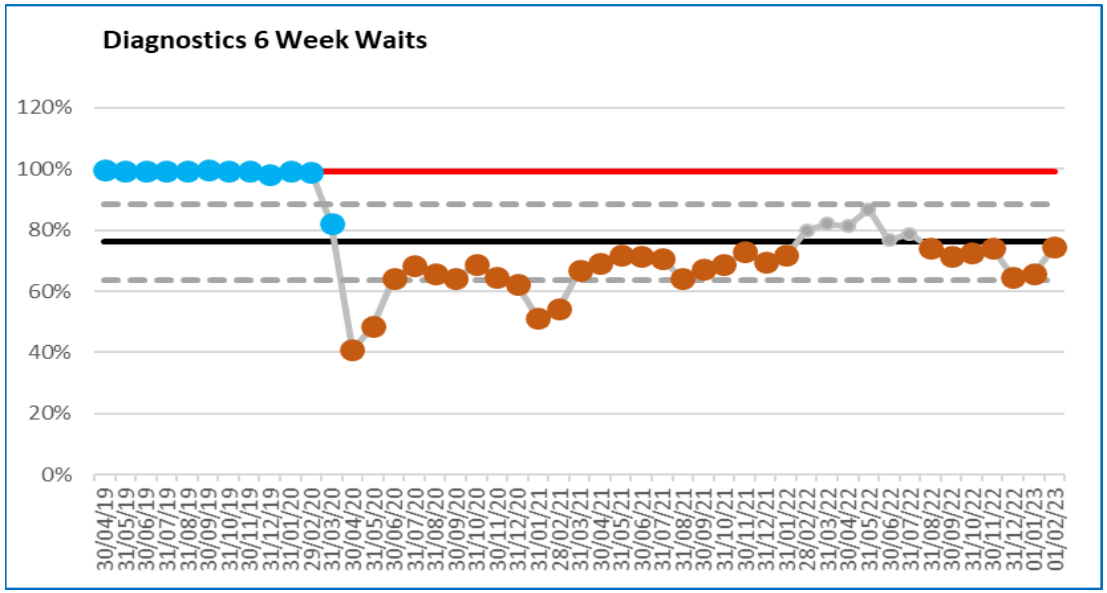
Performance	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
RTT - 18week performance	Significant improvement in the numbers of long waiting routine patients, expecting to be close to the national requirement for no 78 week breaches by 31/3/23.	For recognition	31/03/2023
6 week diagnostics	The number of patients waiting longer than 6 weeks for a diagnostc significantly improved, CT has met the national standard for 3 months.	For recognition	31/03/2025
Urgent Care	Contunied poor 4 hour and ambulance handover performance however improvements in two clinical safety standards, triage in <15 minutes and 12+ hour waits for admission from ED.	For increased visibility and awareness	
Cancer	Significant improvement in the 28 day diagnosis standard and the reduction in the number of patiets waiting longer than 62 days. Expected to reduce the number of patients wiating over 62 days to pre-Covid levels by 31/3/23	For recognition	31/03/2023



KPI	Latest month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
Referral to treatment Incomplete	Feb 23	51%	92%			67%	63%	71%
Referral to treatment Admitted	Feb 23	37%	90%			50%	27%	72%
Referral to treatment Non-Admitted	Feb 23	74%	95%			84%	81%	87%
RTT PTL vs RTT PTL & ASIs	Feb 23	80%	none			91%	88%	94%
Cancer 31 days First	Jan 23	91%	96%			93%	84%	102%
Cancer 31 days Subsequent Drugs	Jan 23	96%	98%			98%	90%	106%
Cancer 31 days subsequent surgery	Jan 23	90%	94%			91%	55%	127%
Cancer 2 Week Wait	Jan 23	77%	93%			80%	60%	100%
Cancer 62 day shared treatment	Jan 23	33%	85%			64%	41%	88%
Cancer 62 day screening	Jan 23	71%	90%			64%	5%	123%
Cancer 62 Day Consultant Upgrade	Jan 23	67%	90%			81%	58%	105%
Cancer 28 day faster diagnosis	Jan 23	72%	75%			67%	53%	82%
4 Hour standard	Feb 23	51%	95%			70%	62%	78%
Emergency Department attendances	Feb 23	10315	none			9492	7439	11546
Emergency Department Admitted performance	Feb 23	10%	95%			42%	25%	58%
Emergency Department non admitted performance	Feb 23	58%	95%			78%	70%	86%
Emergency Department Arrival to Triage	Feb 23	32	15			45	27	63
Emergency Department Triage to examination	Feb 23	130	60			112	68	156
Emergency Department Examination to referral to specialty aver	Feb 23	88	45			101	82	120
Seen by specialty to Decision to Admit	Feb 23	116	60			101	77	124
Decision to Admit to departure	Feb 23	259	30			246	113	379
Ambulance handovers less than 15 minutes	Feb 23	11%	100%			23%	12%	34%
Ambulance handovers between 15 and 30 mins	Feb 23	27%	0%			39%	29%	48%
Ambulance handovers between 30 and 60 mins	Feb 23	24%	0%			23%	14%	33%

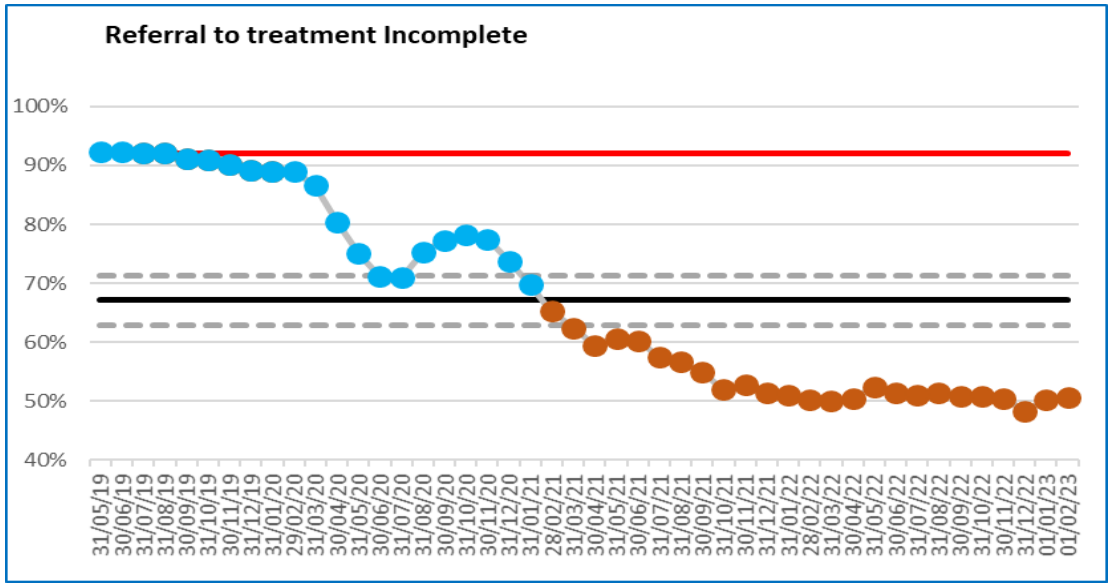


KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Feb 23	37%	0%	H	F	15%	4%	27%
Diagnostics 6 Week Waits	Feb 23	75%	99%	L	F	76%	63%	89%
Patients with a Length of Stay more than 7 days	Feb 23	202	80	H	F	161	111	211
Bed occupancy	Feb 23	88%	85%		?	89%	82%	96%
Discharges between 8am and 5pm	Feb 23	801	none			721	491	952
Discharges between 5pm and 8am	Feb 23	734	none	H		717	481	953
Length of Stay non elective	Feb 23	5.0	5.1	H	P	4.2	3.4	5.1
Length of Stay elective	Feb 23	2.7	4.2		P	2.5	0.9	4.0
Out Patient new to follow up ratio	Feb 23	2.1	2.3		?	2.1	1.8	2.5
Out Patient Did Not Attend Rate	Feb 23	5.5%	8.0%	H	P	5.1%	3.9%	6.3%
Referral to treatment 52 week waits	Feb 23	1817	0	H	F	1009	738	1279
Proportion of Majors Patient treated within 4 hours in ED Paeds	Feb 23	36%	95%	L	F	71%	56%	87%
Patients with a Length of Stay more than 21 days	Feb 23	50	25	H	?	48	24	73
12 Hour waits in ED from Arrival	Feb 23	906	0	H	F	686	287	1084
12 Hour Trolley waits in ED from DTA	Feb 23	48	0		?	90	-6	186



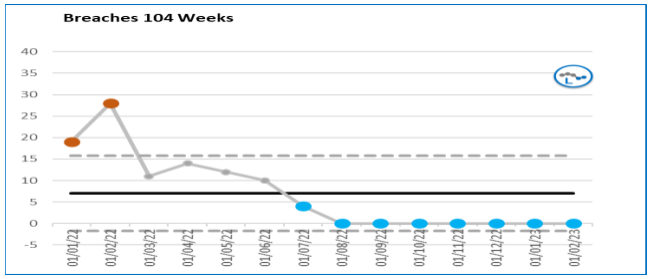
Feb-23
74.64%
Variance Type
Special cause variation
Target by 31/3/25
95.00%
Target Achievement
Consistently failing target

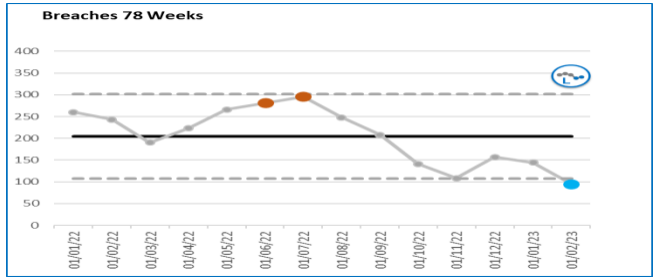
Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	There is a backlog of diagnostic requests which have built up as a result of covid restrictions. Increased referral levels (+20%) continuing.	Additional 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 of waiting list. Radiology modalities showing significant improvement, CT>95% for 3 months running. New recovery trajectory developed to aim to achieve national 95% standard in the summer 2023.

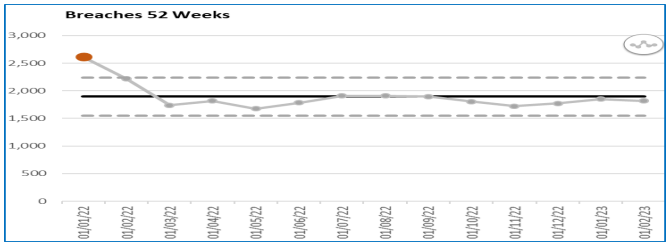


Feb-23
50.7%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

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. Virtual & face to face clinics & additional sessions being put on where possible. Weekly oversight from healthcare groups & focus on reducing the longest waits to under 78 weeks by 31/3/23. 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 put into place.

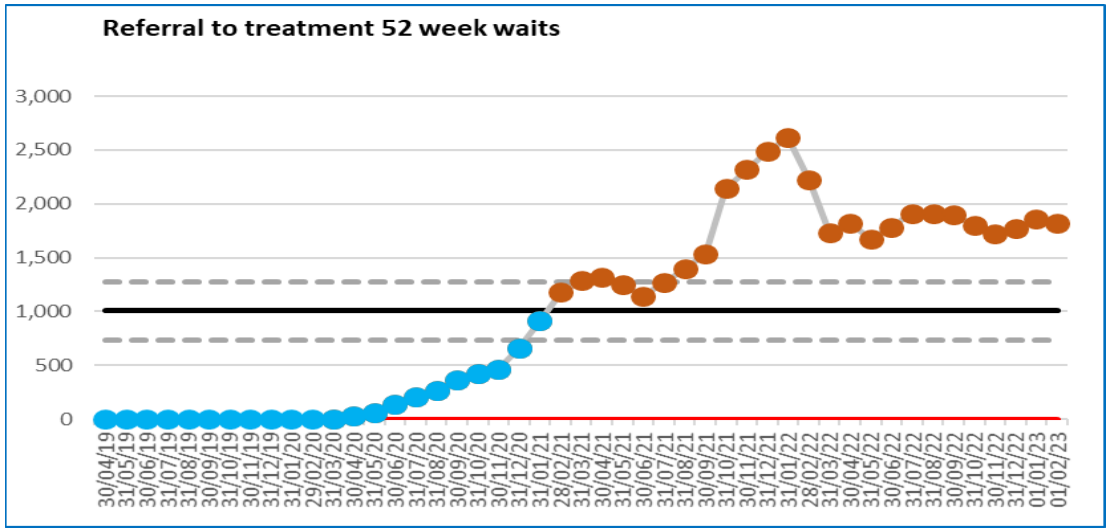






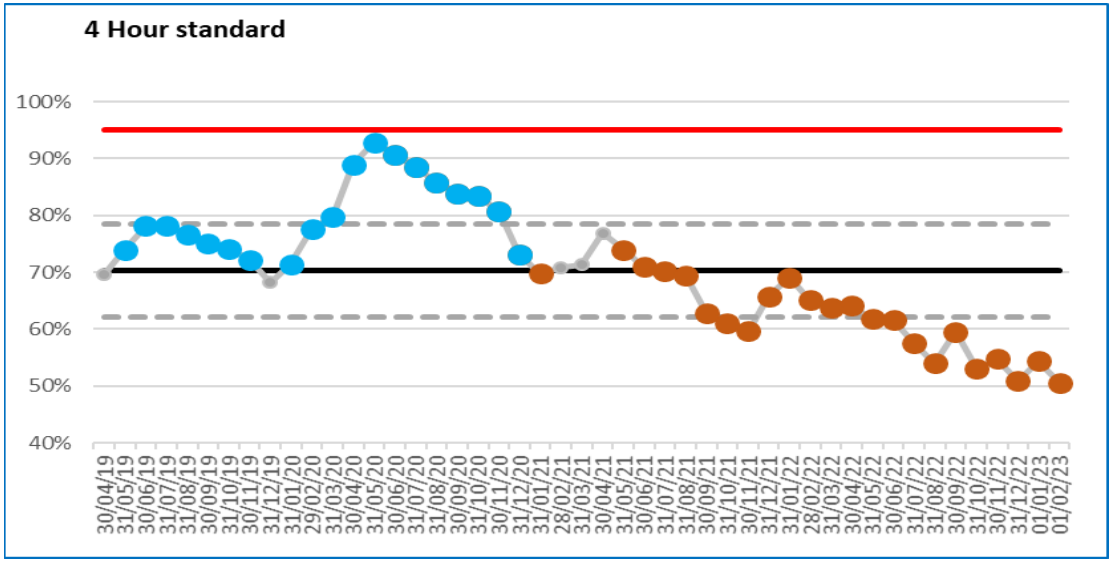
Feb-22
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Breaches	Special cause concerning variation and consistently failing target	Covid-19 created a backlog of routine patients waiting for diagnosis & treatment. Limited elective capacity which is allocated by clinical priority impacts the clearance rates of this waiting list.	Weekly PTL tracking and daily escalation within divisions to ensure that the longest waiting patients are being offered appointments in a timely manner.	Clinical review of long waiting patients implemented with interim & treatment harm review process to monitor for potential harm. Numbers of patients over 78 weeks reducing & on track to reduce to minimum by 31/3/23



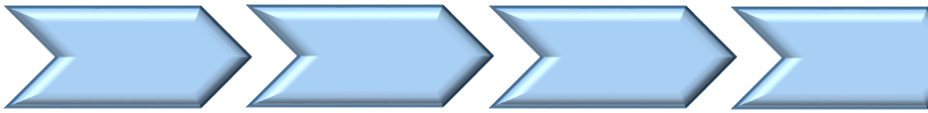
Feb-23
1817
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

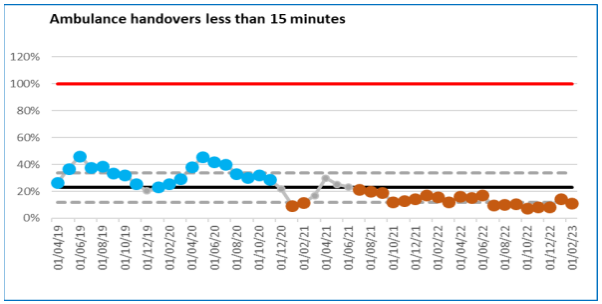
Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Balance between emergency & elective capacity is an ongoing challenge. Challenge of anaesthetic workforce availability restricting the number of elective lists.	Patients that will be over 78 weeks by 31/3/23 booked along with urgent & cancer patient as a priority. Weekly PTL meetings and daily divisonal review of longest waiting patients.	Clinical review of long waiting patients implemented with interim & treatment harm review process to monitor for potential harm. Numbers of patients over 78 weeks reducing & on track to reduce to minimum by 31/3/23

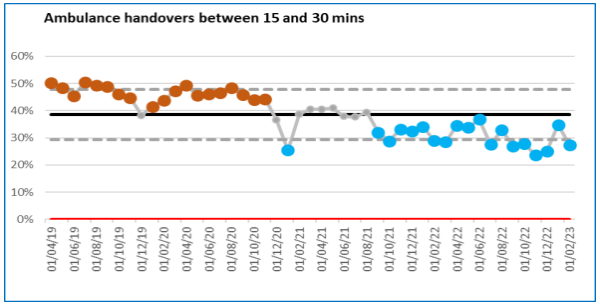


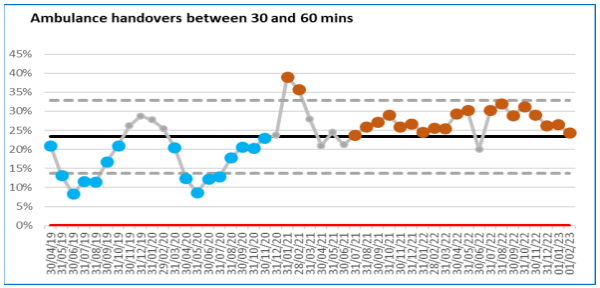
Feb-23
50.61%
Variance Type
Special cause variation
Target by 31/3/24
76%
Target Achievement
Consistently failing target

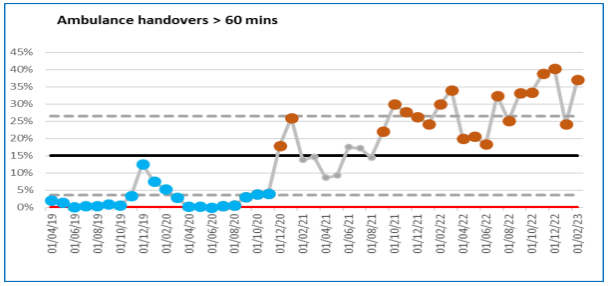
Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and divisional oversight continues through the Urgent Care Board & Performance Review Meetings. Internal, Regional and national discharge projects in place. Implementation of NerveCentre successful & improving triage and allocation of patients to correct location.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Additional UTC hours & services. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.





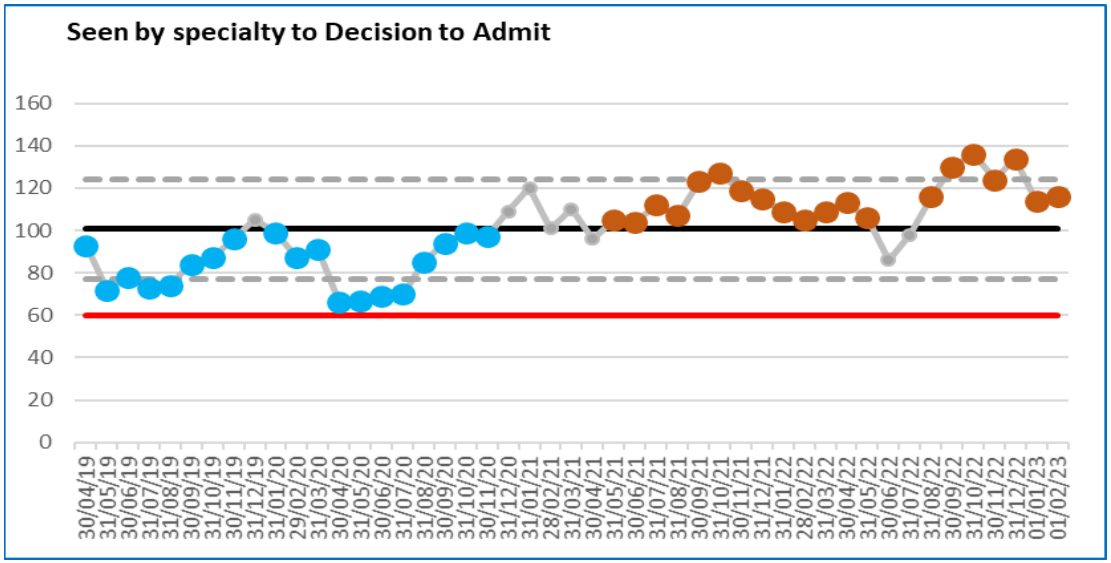






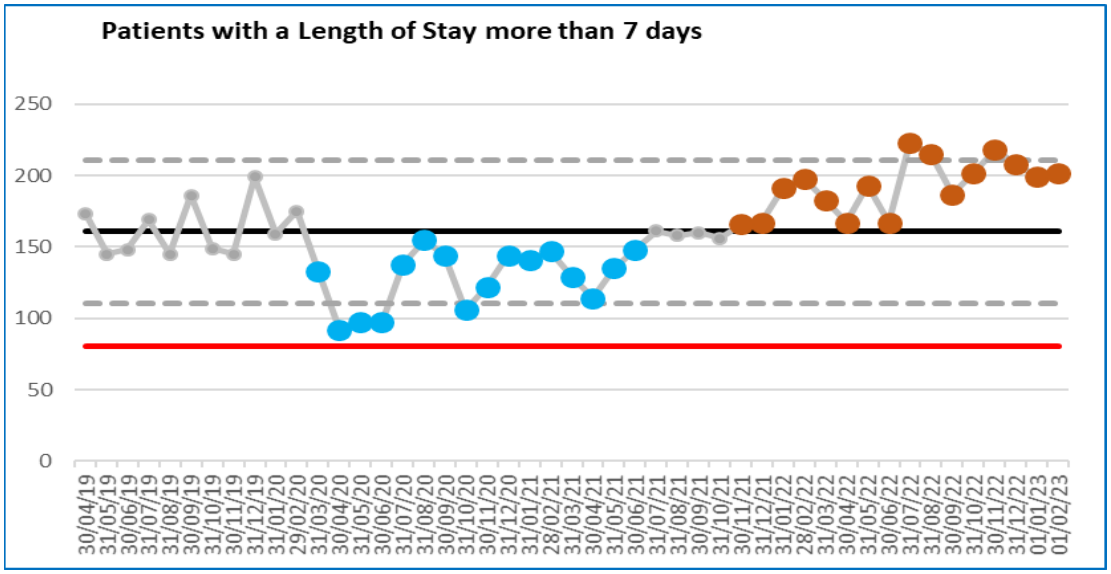
Feb-23
24.4% 30-60 min
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

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



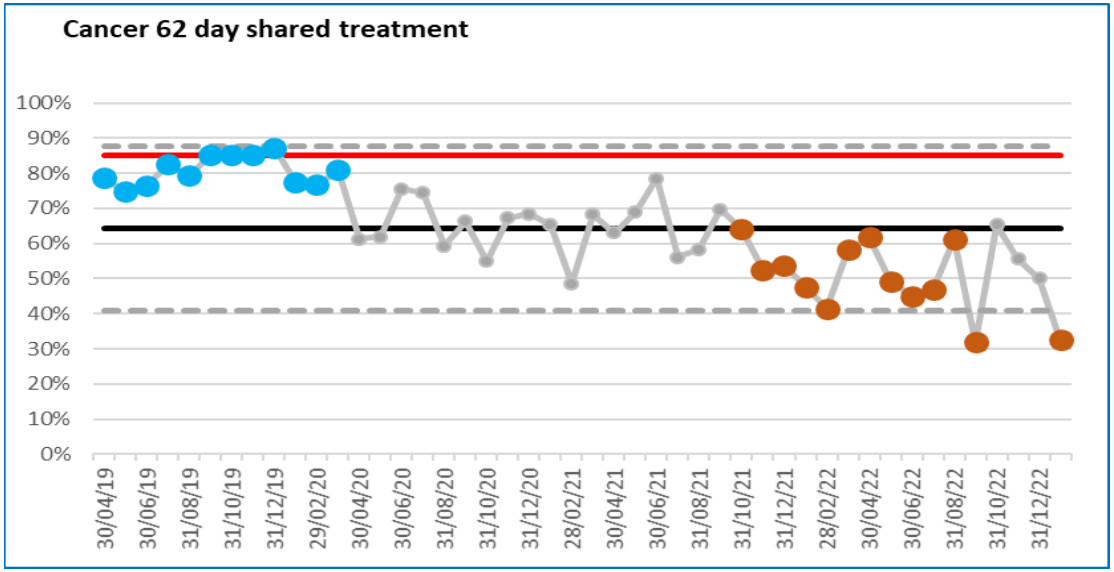
Feb-23
116 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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



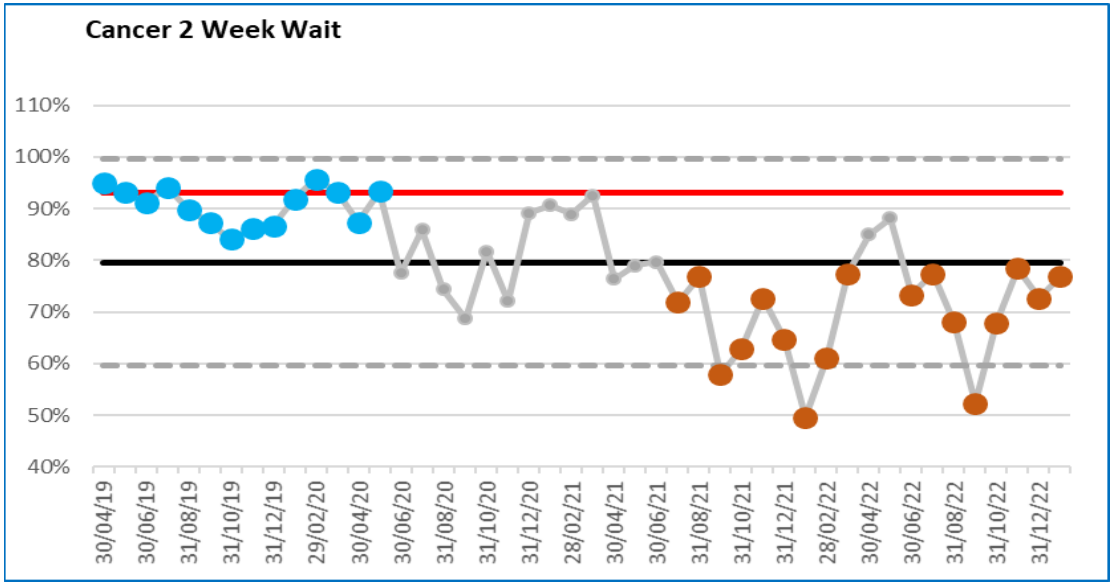
Feb-23
202
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

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	HIT Team review of patients appropriate for discharge extended across weekends. Close working with community bed providers & commissioners ensuring effective bed usage. National improvement programme continues, with focus on partner organisations. Focus on using NerveCentre for accurate ED recording and Pathway notation. Future improvements in discussion for 23/24	Review via daily bed meetings, daily system meetings & weekly capacity planning meetings.



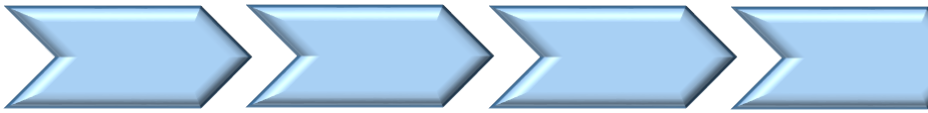
Jan-23
32.61%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

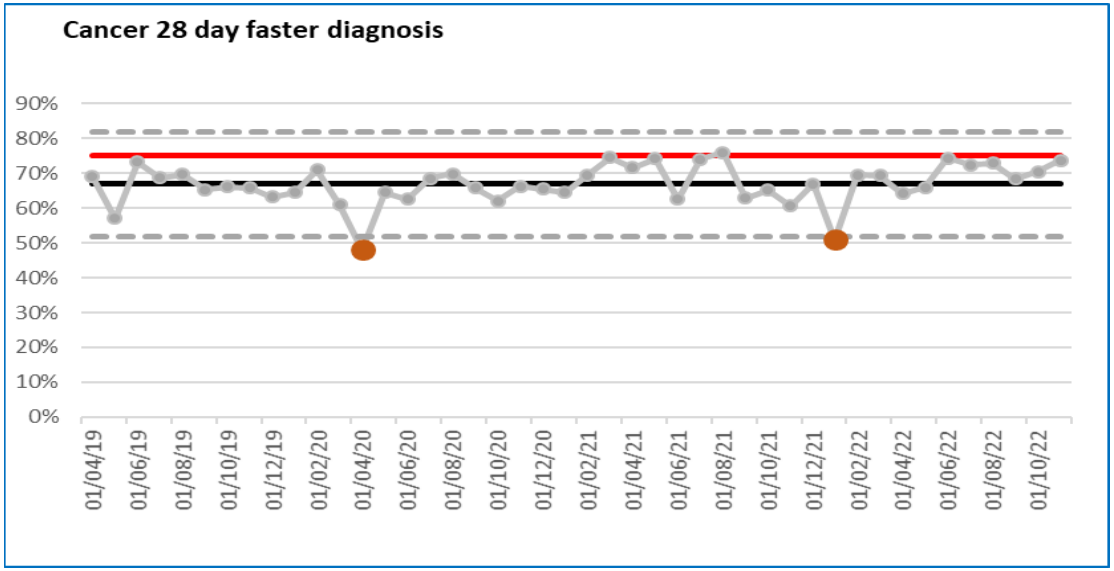
Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Special cause concerning variation and consistently failing target	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. The backlog of patients over 62 days continues to decrease and is ahead of the 22/23 plan trajectory and expected to achieve the national requirement of pre-Covid backlog by 31/3/23.	Weekly tracking meetings and review of performance at Elective Care Operational Group. 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-23
76.82%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

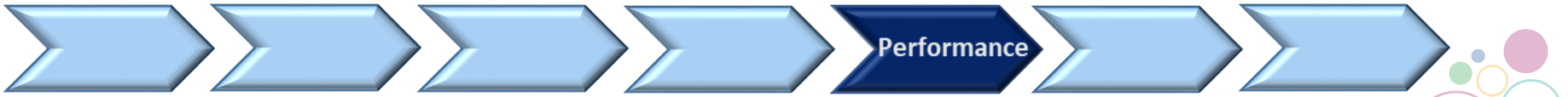
Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target	Significant increases in referral rates alongside backlog clearance from Covid-19 impact.	Tumour site demand & capacity modelling, close monitoring of Appointment Slot Issues and escalation of weekly potential breaches.	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.

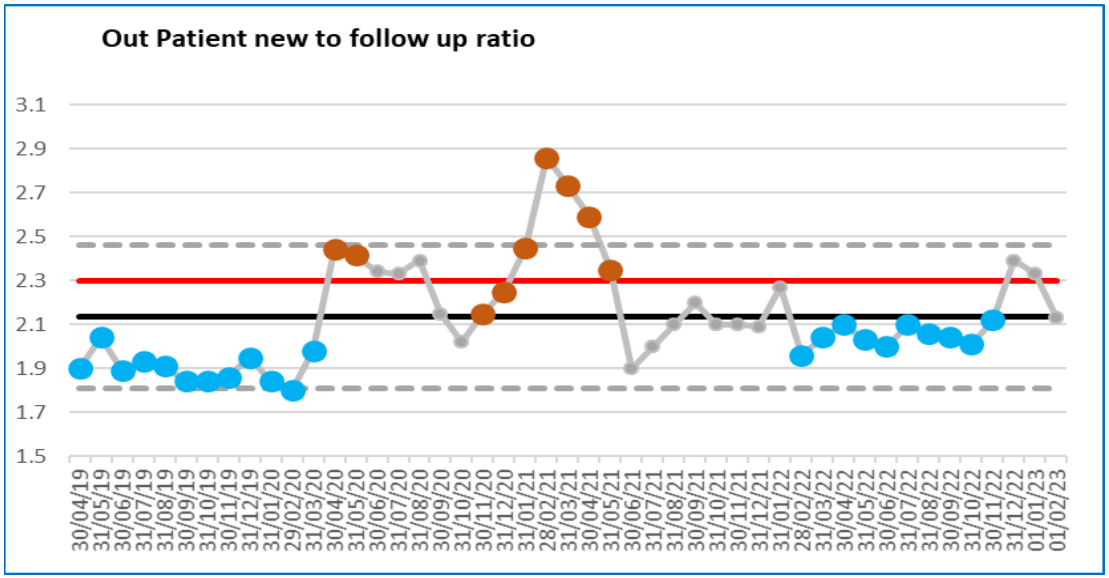




Nov-22
73.67%
Variance Type
Common cause variation
Target
Target Achievement
Consistently failing target

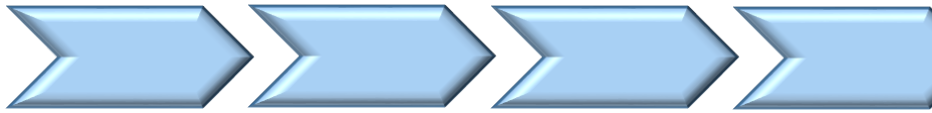
Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 28 day faster diagnosis	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	28 day Faster Diagnosis Improvement Manager delivering Frailty pathway, success with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





Feb-23
2.10
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	consistently meeting the target	The Trust is booking additional overdue follow-up appointments that have built up during Covid-19 pauses in activity	Out-patient pathway imprvement programme that focusses on clinical review & letters to patients, Patient Initiated Follow-up discharges, assessment of new to follow-up ratios compared to professional body guidance.	N/A

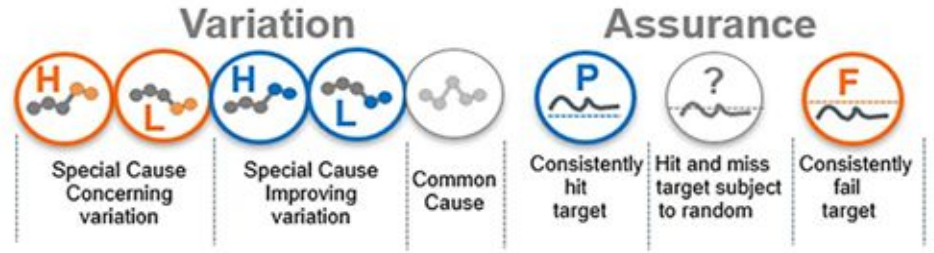


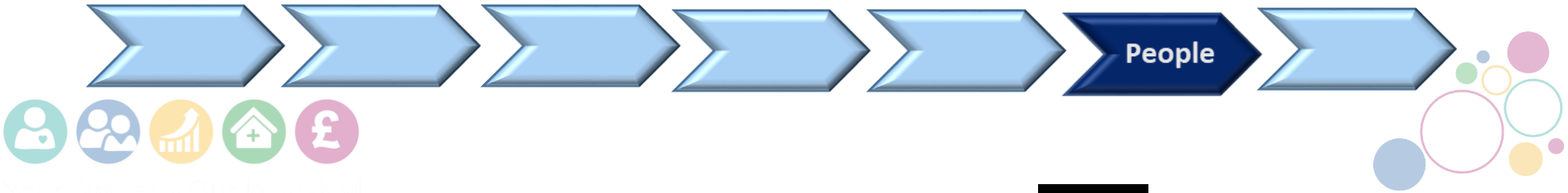
People

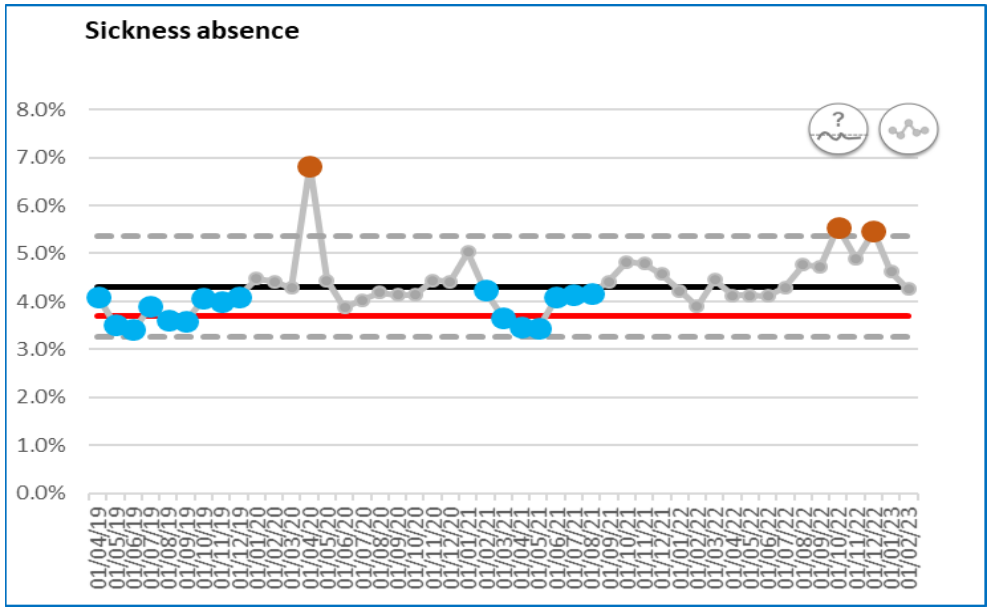
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

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

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Feb 23	82.0%	90.0%		F	81.5%	77.0%	85.9%
Agency staffing spend	Feb 23	6.8%	15.0%		P	5.5%	2.7%	8.2%
Bank staffing spend	Feb 23	12.5%	15.0%	H	P	11.9%	9.6%	14.2%
Vacancy Rate	Feb 23	10.1%	8.0%	H	F	9.5%	8.1%	10.9%
Staff turnover - voluntary	Feb 23	16.8%	12.0%	H	?	12.9%	12.0%	13.8%
Sickness absence	Feb 23	4.3%	3.7%		?	4.3%	3.3%	5.4%
Statutory and Mandatory training	Feb 23	86.0%	90.0%	L	?	88.0%	85.2%	90.8%



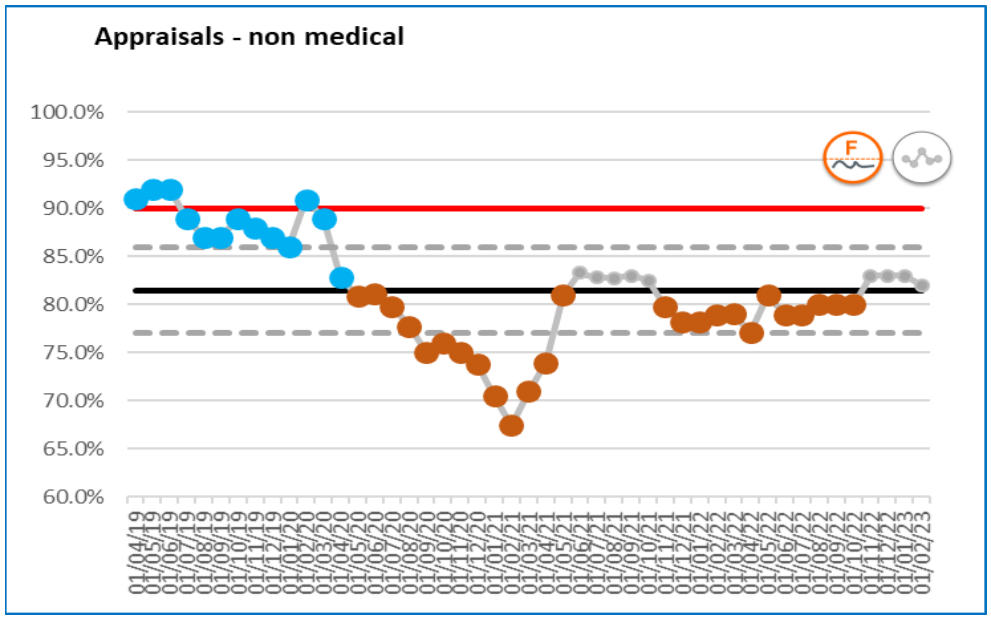




Feb-23
4.26%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

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

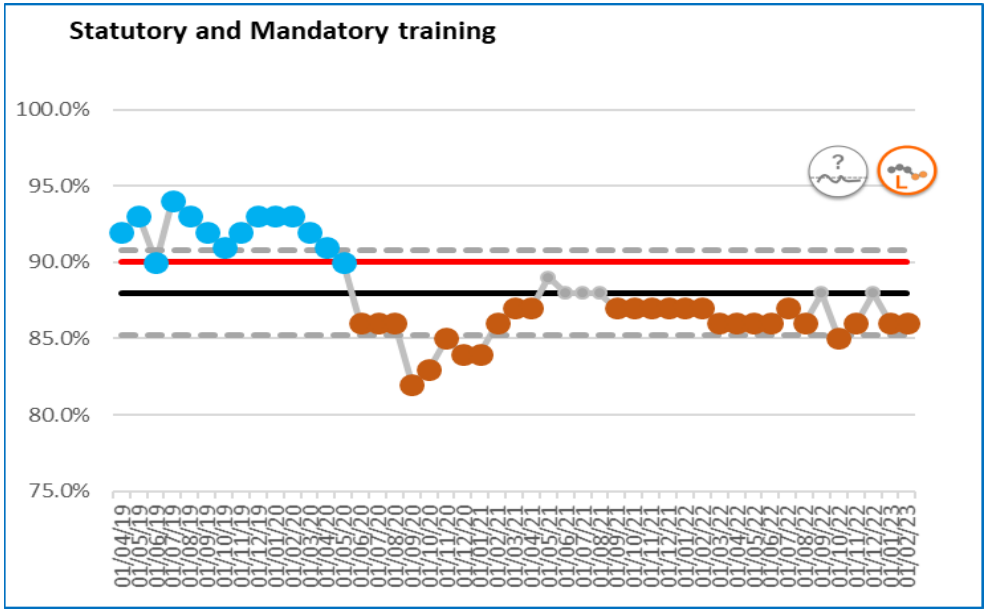
People



Feb-23
82.00%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

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

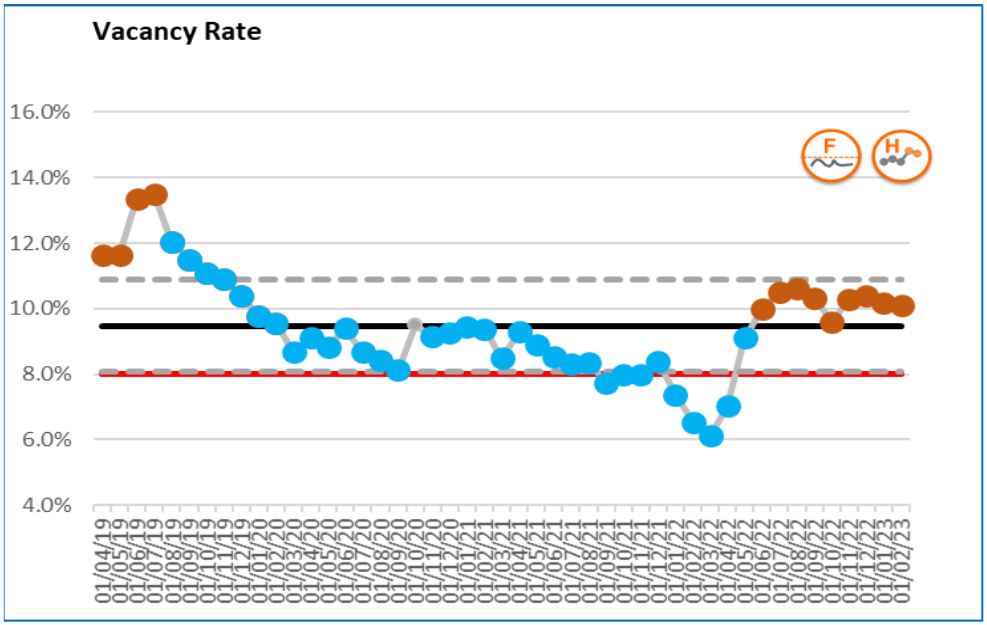
People



Feb-23
86%
Variance Type
Special cause variation
Target
90%
Target Achievement
Consistently failing target

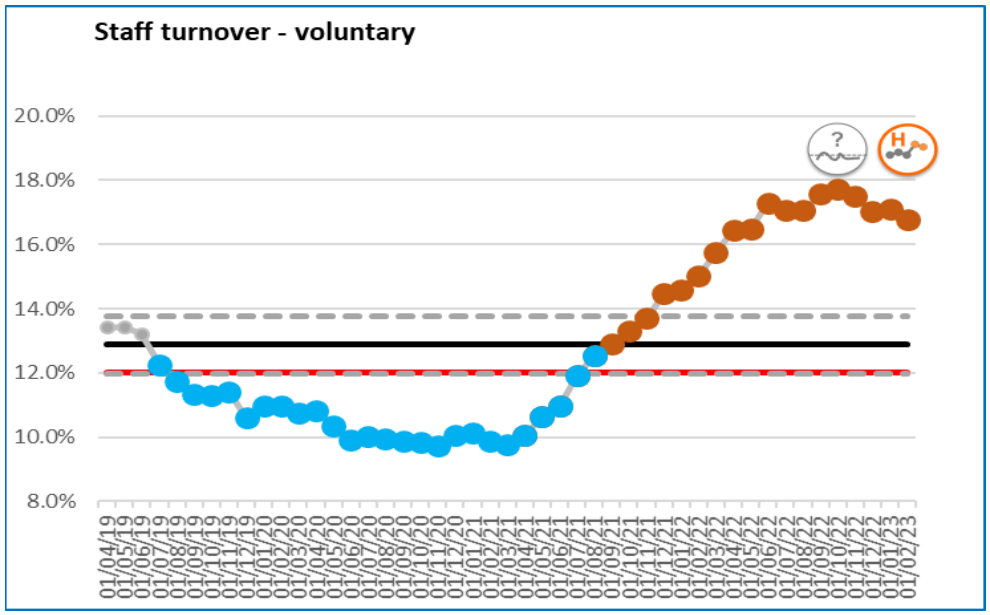
Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Special cause concerning variation & consistently failing target	Compliance remains static, challenges of protected time to complete training cited.	There is a blended approach to training, delivered both via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

People



Feb-23
10.09%
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	Over all trust establishment has increased by approx 20 posts. Increase in vacancy rate is reflected by the overall establishment increase. Midwifery, Nursing and A&C hold the highest vacancy rates	Recruitment days planned for ED and Estates and Facilities	Vacancy rates are discused in monthly divisional meetings and PRMs



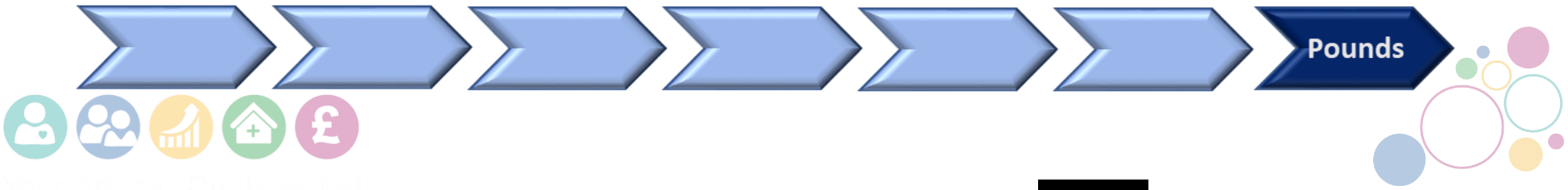
Feb-23
16.77%
Variance Type
Special cause variation
Target
12.00%
Target Achievement
Consistently failing

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

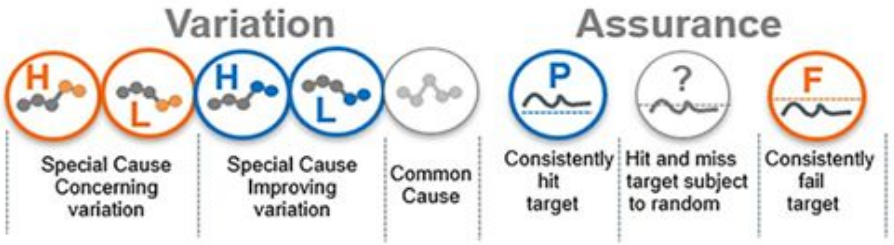
Pounds

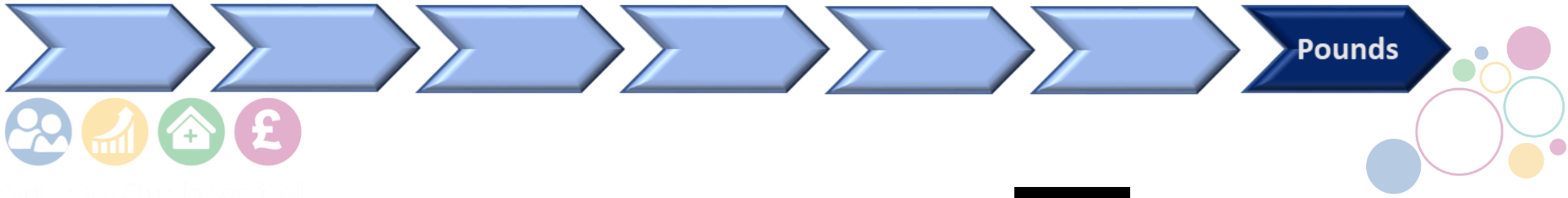
*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

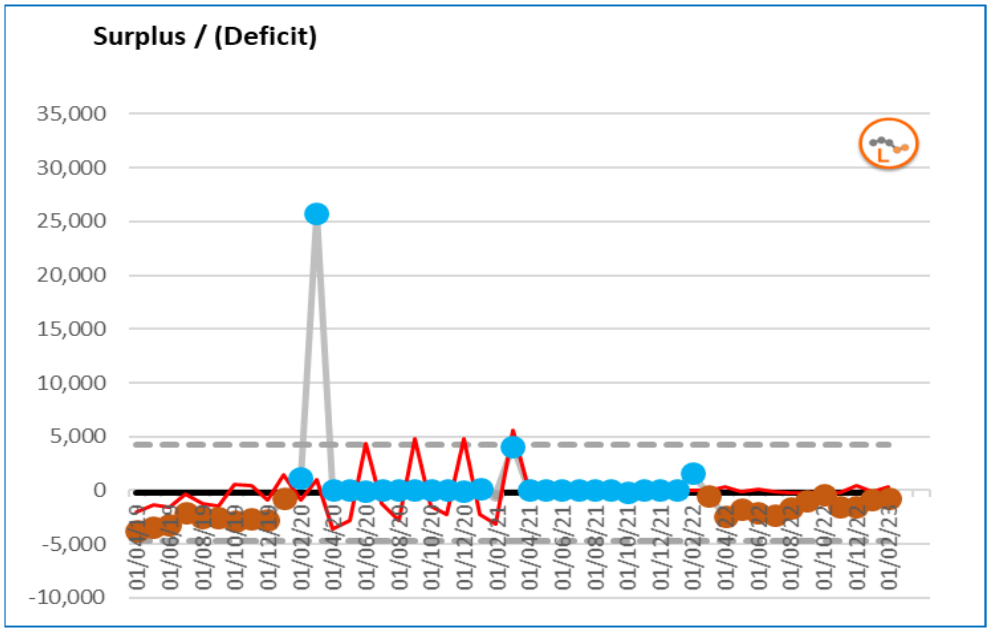
Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus \ Deficit	The Trust reported a deficit of £0.7m in February (Month 11) and year to date deficit of £15.9m. We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position.	For information	
CIP	The 22/23 CIP target is £11.7m with a YTD planned savings at month 11 of £10.3m. The FY forecast waste\efficiency is currently £11.7m with the YTD indentified savings at £9.8m, of which £8.9m are non-recurrent. Work continues within each divsion to deliver additional schemes and savings.	For information	
Capital Spend	The Trust total revised Capital resourcing for 2022/23 is £28.4m, this includes external PDC including the new hospital project, CDC, EHR, Hardware refresh, Digital funding and others. As at Month 11 the year to date capital spend total is £12.3m, excluding the impact of IFRS 16. It is fully anticipated the capital programme will be fully utilised in 22/23.	For information	
Cash	The Trust's cash balance is £42.7m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit in 2022/23. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.	For information	



KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Feb 23	-675	0			-221	-4723	4281
Cost Improvement Plan	Feb 23	1200	0			662	-750	2075
Income	Feb 23	29232	0			26812	17920	35704
Operating Expenditure	Feb 23	-28923	0			13407	4708	22107
Bank Spend	Feb 23	-2494	0			971	11	1931
Agency Spend	Feb 23	-1351	0			347	-266	960
Capital Spend	Feb 23	2850	0			2238	-3413	7889
Cash Balance Actual	Feb 23	42699	75000000			3840150	-1161578	8841878

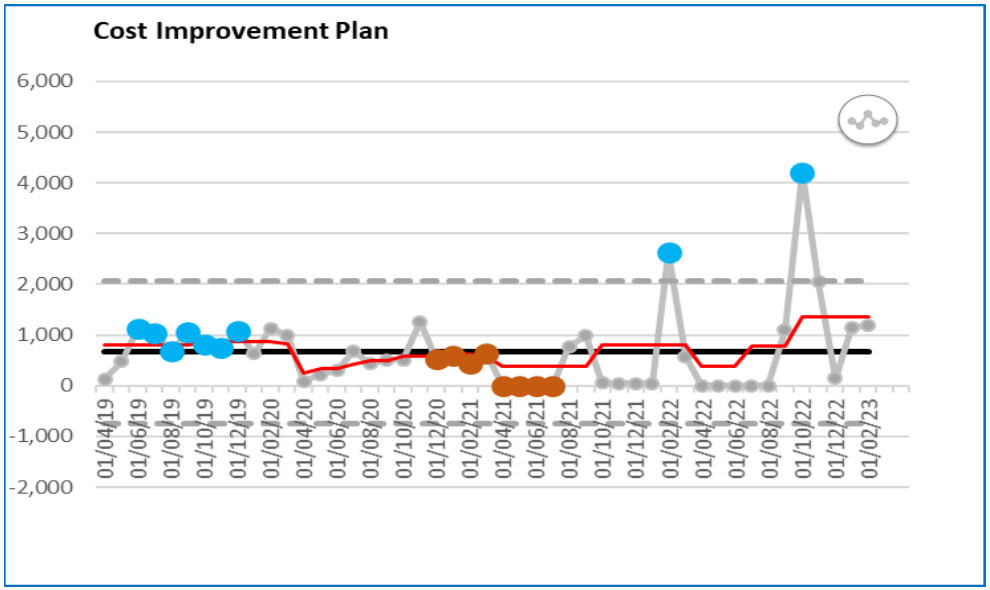






Feb-23
-675
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

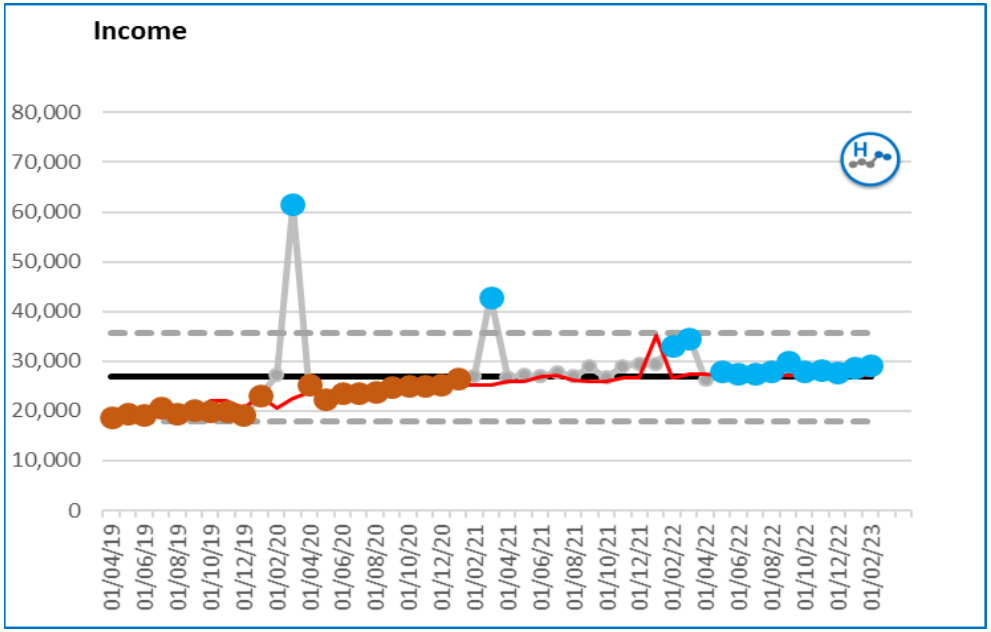
Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target			



Feb-23
1200
Variance Type
Common cause variation
Target
801
Target Achievement
Inconsistently passing and falling short of the target

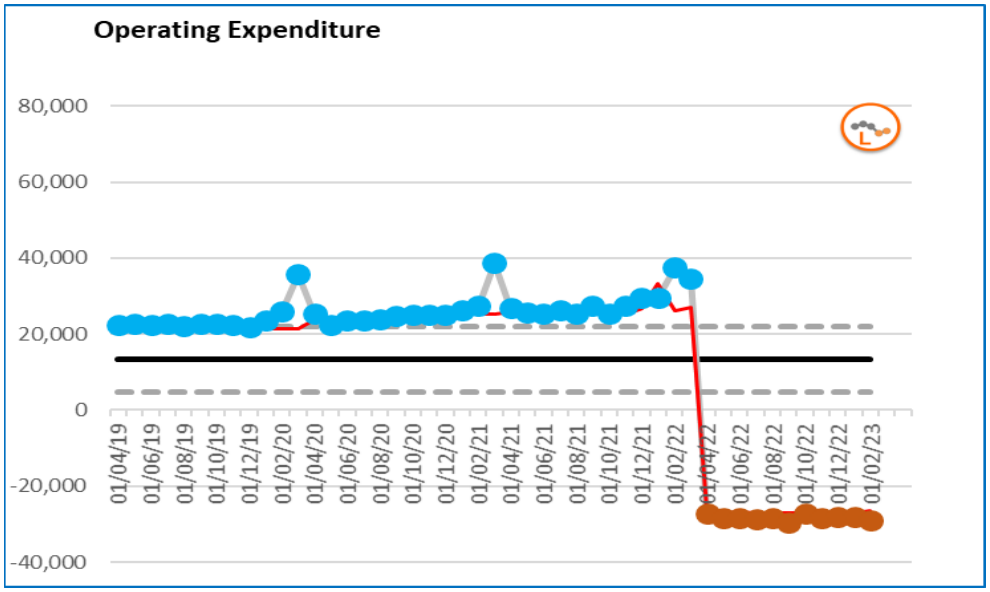
Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target			

Pounds



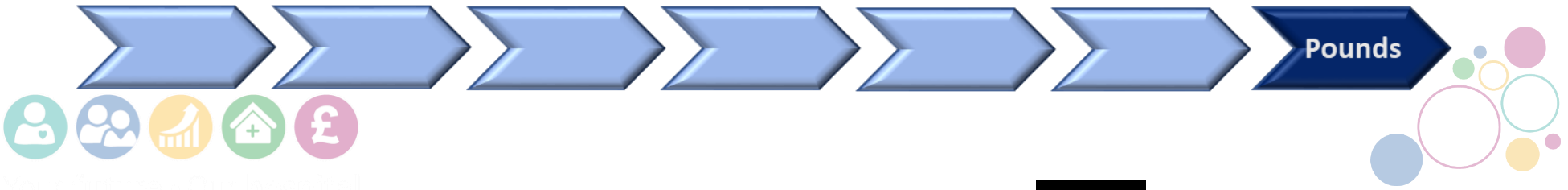
Feb-23
29232
Variance Type
Special cause improving variation
Target
26684
Target Achievement

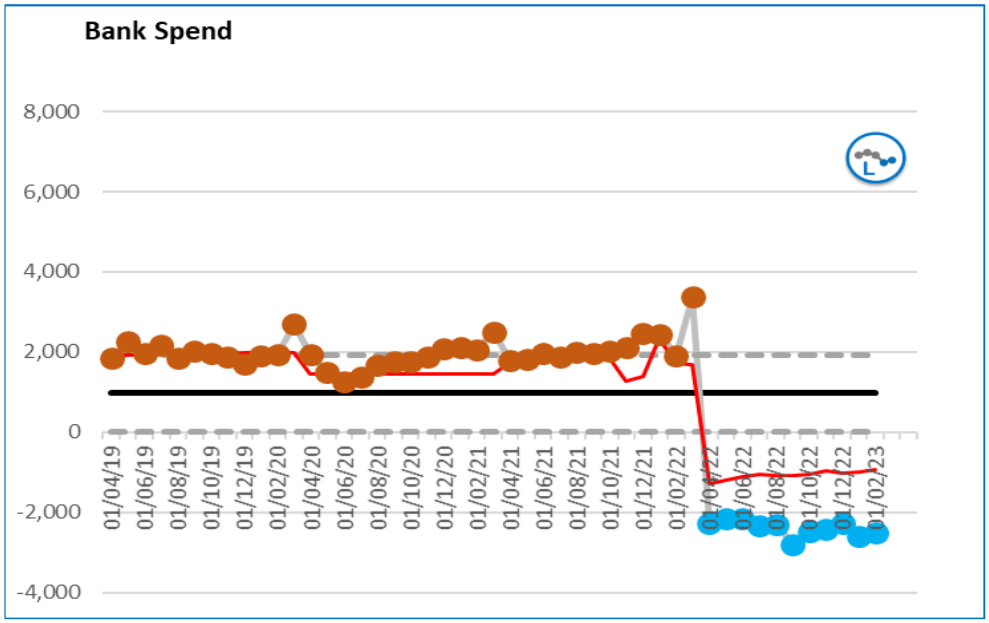
Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation			



Feb-23
-28923
Variance Type
Common cause variation
Target
26709
Target Achievement

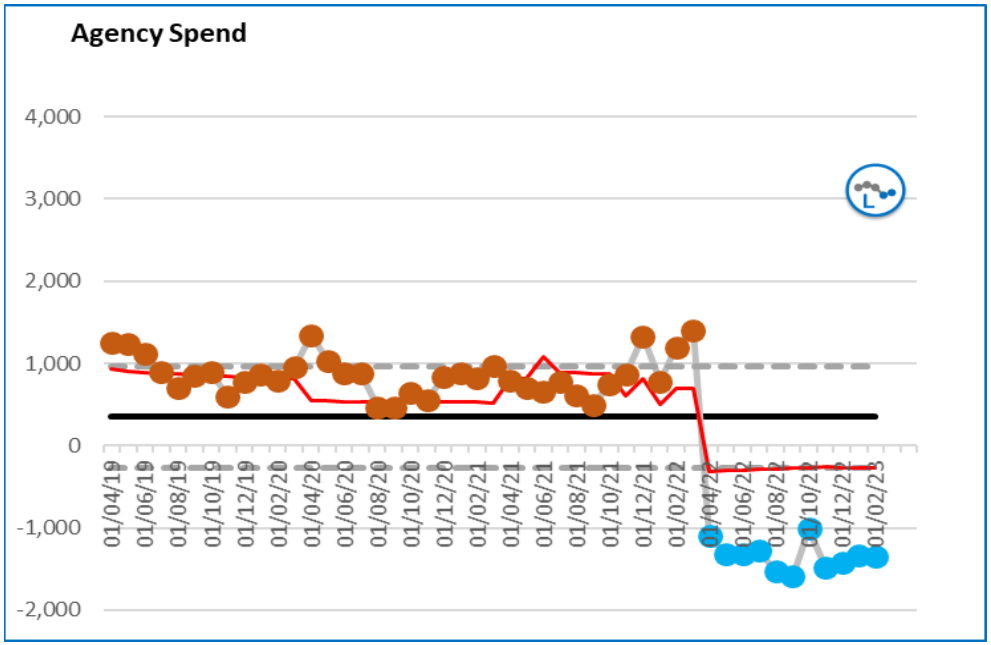
Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Common cause variation			





Feb-23
-2494
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

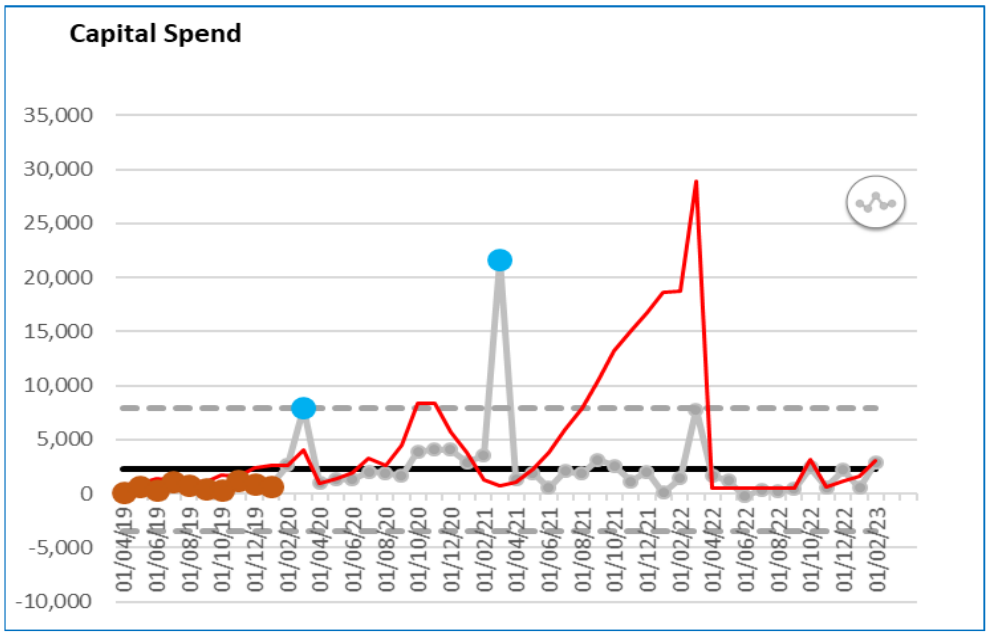
Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation & inconsistently passing and falling short of the target			



Feb-23
-1351
Variance Type
Common cause variation
Target
1107
Target Achievement
Inconsistently passing and falling short of the target

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

Pounds



Feb-23
2850
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			

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**6 April 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:	**27 March 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
1.5 Annual Work Plan	Y	Y	N	Members agreed that going forward the agenda for the meetings would be divided into two. The first session would address core agenda items and the second would be an opportunity for a more in-depth/detailed discussion on a pre-agreed topic with the chance to invite external stakeholders/partners/subject matter experts to speak. The purpose of the above would be to move the Committee's collective understanding forward on various topics and could be used as a way to upskill members and to take conversations forward. Where a topic required further scrutiny that could be taken forward to the Trust Board/Board Development sessions.
2.1 PAHT2030 Update	Y	Y	N	The Committee noted that generally, good progress had been made. The only items not currently rated as green were 'Transforming Our Care' and 'New Hospital' with the former rated amber and the latter red. 'Corporate Transformation' was now rated as green. The Trust Chair raised that the 'Impacts on EDI' were still not routinely being assessed on reporting cover sheets and any Trust Strategy needed to reference equalities implications. This would be addressed moving forward.
2.2 Transformation	Y	Y	N	The Digital Strategy continued to progress well with multiple technologies being deployed and enhanced as the organisation prepared itself for a new electronic

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:			**6 April 2023**	**AGENDA ITEM: 7.1**
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REPORT FROM:			**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:			**27 March 2023**	
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Project Showcase (including Digital Transformation Update)				health record in autumn 2024. The paper also provided a summary of developments and updates on two specific technological initiatives.
2.3 Transforming Our Care Quarterly Update	Y	Y	N	The main targets for this work-stream had been the 27 Clinical Strategies. STC was pleased to note that twelve were now signed off, nine were awaiting divisional sign-off, four were in progress and two were on hold. A new sign-off check-list had now been devised to avoid overwhelming colleagues with too much detail. Each of the strategies would go onto PM3 in terms of tracking progress.
2.4 Patient Quality & Productivity (PQP) Update	Y	Y	N	The report marked the start of a move to a change in reporting for the PQP programme. It set out some of the transition work that was being undertaken by the team including the latest opportunity analysis and detailed some of the high-level work that was being undertaken. As reported previously, it was noted that the Trust would achieve the majority of its CIP target in-year but mainly non-recurrently. It was noted that STC would receive updates going forward that

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:			**6 April 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:			**Strategic Transformation Committee (STC)**	
REPORT FROM:			**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:			**27 March 2023**	
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				aligned with the Trust's strategic direction with PAF focussing on the detail of the plan including delivery.
2.5 New Hospital Update	Y	Y	N	A formal announcement on the New Hospital Programme was expected later that week and it was noted the national team had recently visited the Trust.
2.7 BAF Risk 3.5 (New Hospital)	Y	N	N	In line with the recommendation it was agreed that the risk score should remain at 20.
2.8 Electronic Health Record Update	Y	Y	Y	STC was pleased to note that the contract for a new electronic health record had now been signed with anticipated go-live in autumn 2024.
2.9 BAF Risk 1.2 (EHR)	Y	N	N	In line with the recommendation it was agreed the risk score should remain at 16.
3.1 Strategic/System Update including:	Y	Y	N	There had been a good conversation at the ICB Board meeting the previous week around the NHS estate and maximising its use across the public sector to support both patients and staff. In terms of the West Essex Healthcare

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**6 April 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:	**27 March 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
Report from West Essex Health Care Partnership (WEHCP), Stakeholder Update and Hewitt Review				Partnership (WEHCP), there would be a development meeting the following day to work through how organisations would continue to work together in a different way and continue to work with the ICB. Members were also informed there was an EDI Improvement Plan which had been written and linked to six high impact actions aligned with strategic EDI workforce outcomes – this was now awaiting Government publication.
3.3 Stakeholder Update	Y	N	N	The CC updated that she had attended a recent Harlow Growth Board workshop which had looked at all the ways in which different organisations in Harlow could work better together to align and champion the message that Harlow was a great place to live, work and do business.
3.4 BAF Risk 3.2 System Pressures	Y	N	N	In line with the recommendation it was agreed the risk score would remain at 16.
4.1 Well-Led Review Update	Y	N	N	STC agreed with the recommendation that KLOE 3 be closed (RAG rated blue) following review and assurances provided around delivery. It was acknowledged this would lead to the closure of the Well Led KLOEs aligned to STC and they

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:			**6 April 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:			**Strategic Transformation Committee (STC)**	
REPORT FROM:			**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:			**27 March 2023**	
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
(KLOEs assigned to STC)				would therefore be removed from the STC agenda. It was recommended however that a review be undertaken in 12 months' time to ensure sustainability and embedding of practice.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board –6 April 2023 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy
DATE OF MEETINGS: **07.03.23 & 21.03.23**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in March:

07 March 2023:

- Staff Survey Results
- PQP face to face workshop

21 March 2023:

- IPC Associates Team Business Case - **Approved**
- Clinical Strategies Update
- Quality Briefing
- Quality PMO
- CQUIN 2023/24 – **Supported**
- Porter and domestics rosters – **Approved**
- Medical workforce review
- Recovery Dashboard
- IG Update
- Significant Risk Register
- Linen Contract – **Approved**
- AOB:
    - Communications review commissioned, a further updated would be brought to the next meeting
    - Entonox Update - 6 rooms now had Entonox
    - Aseptic Unit planned to go live at the beginning of June
    - PQP Learning Sessions had been arranged for SMT members
    - The importance of SMT communication/visibility with staff.

7.2

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 06 March 2023

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 External Audit – Audit Plan and Progress Update	Yes	Yes	No	The Committee noted the audit plan for 22/23. It was noted a higher level of planned materiality had been reported following a review of the audit approach (2.5%). It was highlighted a successful interim audit had been completed. The value for money risk assessment would be presented to the May Audit Committee.
3.1 Internal Audit Progress Report	Yes	Yes	No	Internal Audit noted progress had been made against the plan. The following reports were finalised and presented to the Audit Committee: • HFMA – Financial Sustainability (advisory only) • UTC report (advisory only) • Board Assurance Framework and Risk Management Arrangements (substantial assurance)
3.2 Internal Audit Plan 2023/24	Yes	No	N/A	The Committee approved the Internal Audit Annual Work Plan for 2023/24.
3.3 Counter Fraud Progress Report	Yes	No	N/A	Good progress was being made in regards to counter fraud plans and activity. The national fraud initiative was underway and the LCFS was in the process of reviewing the matches received.

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 06 March 2023

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.4 Counter Fraud Plan 2023/24	Yes	No	N/A	The Committee approved the Counter Fraud Annual Work Plan for 2023/24.
4.1 Annual review of the Board Assurance Framework and Risk Management System	Yes	Yes	N/A	The Committee received the review of the BAF and Risk Management System. The following was highlighted as next steps: • Development of risk management policy • Further training for staff with a responsibility of risk assessment • Transition from Risk Assure to Datix • Significant Risk Register to change to Corporate Risk Register
4.2 Quality Account Timetable	Yes	No	N/A	The Committee noted the proposed timetable for the production and publication of the Quality Account in line with previous national guidance. It was noted guidance for 2022/23 had not been issued yet.
4.3 Waivers, Losses, Special Payments and Debt Write Offs	Yes	No	N/A	During the period 1 October 2022 to 31 December 2022: • The Value of losses and special payments totalled £56k (8 cases); • 522 debts totalling £269k had been assessed as unrecoverable of which £222k had been provided for. Bad debt provisioning was currently being reviewed ahead of year end.

BOARD OF DIRECTORS: Trust Board (Public) 6 April 2023 **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 06 March 2023

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				• 28 waivers totalled £2,100k of which 4 (£388k) were non-compliant
4.4 Annual Accounts Timetable Update	For Information	No	N/A	The Committee noted the final timetable for the completion of the Trust's 2022/23 Annual Report and Accounts.
4.5 Accounting Polices/Changes in GAM	Yes	No	N/A	The Committee approved the one change to the Trust's accounting policies and noted the impact on the Trust. It was noted there was no divergence from the accounting policies set out in the DHSC Group Accounting Manual (GAM).

BOARD OF DIRECTORS:	**Trust Board 6 April 2023**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**John Keddie – Committee Chair**			
DATE OF COMMITTEE MEETING:	**17 March 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Charity Update	Yes	No	No	The Committee received an update on recent charity activities from the past three months. The following was highlighted: • The recent recruitment campaign for a new head of charity • A local family raised £1,018.60 for the NICU by taking part in the 'Santa in the city' 4km run • Greater Anglia had once again pledged to collect and donate Easter eggs this spring. • Sir Rod Stewart donated £8,176.80 to fund a mobile MRI scanner for one day and for the provision of 20 scans. He attended the unit on Friday 24 February.
2.2 Charity Risk Register Update	Yes	No	No	The risk register was reviewed; no new risks had been added since the last meeting.
2.3 Breast Fund Update	Yes	No	No	The Committee approved the following event; • Snowball December 2023 The additional financial information on the events approved in principle at the previous was received and the following events were approved: • London to Paris Cycle June 2023 • Freedom Trail 2023 • Cuba Cycle 2023 • Patagonia Trek 2023
3.1 Charitable Funds Finance Report	Yes	No	No	The Committee noted the following updates: • Total fund balances at M9 were £1,055k • Donations totalling £193k had been received by the Charity up to 31 December 2022.

BOARD OF DIRECTORS:	**Trust Board 6 April 2023**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**John Keddie – Committee Chair**			
DATE OF COMMITTEE MEETING:	**17 March 2023**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				• Total fundraising income up to 31 December 2022 was £346k. £180k has been incurred up to 31 December 2022 The audit of the charity accounts was discussed following a suggestion from the Trust external auditors to possibly use a smaller firm to conduct the audit as it would be more cost effective. It was agreed this would be discussed offline and at the next Audit Committee if required.