The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 1 December 2022 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: One step at a time** *Diligent Resources: Story Briefing*				
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	22
03 Risk					
10.20	3.1	Significant risk register	Review	Medical director	28
10.30	3.2	Board assurance framework 2022-23 *Diligent Resources: PAHT Board Assurance Framework 2022/23*	Review/ Approve	Head of corporate affairs	36
04 Patients					
10.35	4.1	Report from Quality and Safety Committee 25.11.22: • Part I • Part II – Maternity Oversight	Assure	Committee Chairs	To follow
10.45	4.2	Maternity: • Maternity Assurance Report Q2 including SI report • Perinatal Mortality Review Tool Quarterly Report • Maternity SI Report • East Kent report	Assure	Chief nurse/ Director of midwifery	41 51 58 62
11.00	BREAK 1100-1110				
11.10	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Chief nurse	71
11.20	4.4	Learning from deaths (Mortality)	Assure	Medical director	91

05 People					
11.30	5.1	Report from People Committee 28.11.22	Assure	Committee Chair	To follow
11.35	5.2	Equality, Diversity and Inclusion Annual Report	Assure	DoP	95
11.45	5.3	Workforce Race Equality Standards and Workforce Disability Equality Standards	Approve	DoP	107 112
06 Performance/pounds					
11.50	6.1	Report from Performance and Finance Committee 24.11.22	Assure	Chair of Committee	117
11.55	6.2	Finance update	Assure	Director of finance	122
12.05	6.3	Integrated performance report	Discuss	Chief Information Officer	132
07 Strategy/Governance					
12.15	7.1	Report from Strategic Transformation Committee 28.11.22	Assure	Chair of Committee	To follow
12.20	7.2	Report from Senior Management Team Meetings	Assure	Chair of Committee	186
08 Questions from the public					
	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Summary of actions and decisions	-	Chair/All	
	9.2	New risks and issues Identified	Discuss	All	
	9.3	Any other business	Review	All	
	9.4	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
12.30		Close			

Date of next meeting: 2 February 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.

Ground Rules for Meetings:

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

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

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 6 October 2022 from 09:30 to 12:15

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Helen Glenister	Non-Executive Director (NED-HG)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Laura Warren	Associate Director – Communications (AD-C)
Giuseppe Labriola	Director of Midwifery (DoM)
Staff Story (via MS Teams):	
Asiya Ali	Audiologist
John Waters	Head of Audiology
Members of the Public	
(None)	
Apologies:	
Ann Nutt	Chair of Patient Panel
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed all to the meeting. As it was Freedom to Speak Up and Black History Month she asked the Director of People (DoP) to say a few words. In response the DoP informed members that the REACH (race equality and cultural heritage) staff network would be putting on a number of events during the month including providing a safe space in which staff could talk about how their race impacted them. Some events were also being organised as part of the Leadership Academy. Information on both topics was available on AlexNet and she pointed out that colleagues did not need to be black to take part in Black History Month. In response to a further comment from the TC, the DoP confirmed she would talk about Rainbow Badges at the end of the meeting (see minute 9.5).
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 reflection of the meeting held on 04.08.22 with the following amendments:

	Minute 4.6	In response to a question from NED-GW in relation to sharing SIs across the ICS the DoN&M confirmed that the organisation reported into the local LMNS, the Director of **Nursing &** Midwifery would be vice chair of that from the autumn …
	Minute 4.8	This item was presented by the DoN&M who drew members' attention to the overall improvement in fill rates and a**n** ~~**huge**~~ increase in care hours per patient day (CHPPD) compared to three years previously.
1.4 Matters Arising and Action Log		
1.5	There were no matters arising. Action ref: TB1.07.10.21/07 – Risk Management Approach/Appetite In response to a question from the TC, the Medical Director (MD) confirmed that the above had been approved at Senior Management Team (SMT) and the strategy would be presented to Trust Board in November for approval. It was agreed the action could be closed.	
Staff Story: Asiya's Story (via MS Teams)		
1.6	The DoP introduced the item and informed colleagues that Asiya Ali (AA) had been an Audiologist at the Trust up until recently and had a hearing impairment. She had secured a promotion nearer home so had now left the organisation. She would now tell the Board her story (via a video clip and her manager John Waters (JM) would add a section at the end in terms of measures that had been taken to support AA and others in the Trust with hearing issues. The CEO would also add his own perspective as he and AA had previously taken part in a reverse mentoring programme together.	
1.7	AA started off by saying that she was an Audiologist and had worked at St. Margaret's Hospital in Epping. She had worked with both adults and children and had provided services such as hearing assessments, hearing aids and repair assessments. She herself was deaf and wore a hearing aid on one side and had a cochlear implant in the other. She had chosen to have the implant because she had found she was struggling to lip read all the time at work which made her tired and then with COVID and the use of masks lip reading had become impossible until transparent masks had become available. The implant had made a huge difference particularly in terms of speaking to people on the telephone. The implant came with blue tooth which she could stream directly to her hearing aid.	
1.8	*AA responded to a few questions in the video clip:* *Why did you want to become an Audiologist?* AA confirmed that since she had been young she had always been interested in her own audiology. She recalled during an appointment with her consultant one day when she was 19 she had told the consultant that one day she would be in her job! She had been fascinated by technology and the things that could be done to improve people's hearing, particularly with the advances in technology.	
1.9	*How was your speech impacted?* AA confirmed she had started wearing a hearing aid from a young age in conjunction with speech and language therapy. There were some words she found difficult to pronounce and some sounds she couldn't hear, for example she couldn't hear the 'S' sound. She would have to focus on the main word and then try to form a sentence around that which was difficult at times.	
1.10	*How was your education?* AA informed members that she had received a lot of support in secondary school. A Teacher-of -the-Deaf attended lessons with her and there were language assistants on hand too. The teacher had a radio aid and AA had one too which amplified the teacher's voice and there had also been an FM system (radio aids for both student/teacher which amplify the teacher's voice) which she had taken through to university as sitting in a lecture hall of 500 students could be very noisy.	
1.11	*How is your work life?*	

	AA recalled the previous year that things had been hard in terms of trying to hear with her hearing aid. People had had to remove their masks so that she could lip read. She sometimes had an interpreter for patients. Luckily transparent masks had then come into use and subsequently the implant had then reduced the need to lip read. She confessed however that when she became tired towards the end of a day she reverted to lip reading and looking directly at people.
1.12	*Trust Support?* AA commented that deaf people had to make sure they had people's full attention. If people talked behind a deaf person then obviously they couldn't hear them. Face-to-face was best but deaf people could also pick up body language which helped. She would encourage people to speak clearly and slowly and not to shout. Clear masks had been invaluable.
1.13	John Waters, Head of Audiology (JA) then spoke about supporting staff which he confirmed was relatively easy in the Audiology Department because their role was to support patients with the same issues. The team always used good communication tactics, face-to-face wherever possible and didn't shout. The British Academy of Audiology had published guidelines and one service that the team used was the 'Access to Work' service where extra equipment could be obtained e.g. microphones which could be paired with the hearing aid and placed on someone's lapel which was useful when talking to patients and taking their history. Audiology colleagues were lucky in that they worked in sound-proofed booths but he added that remote microphones for colleagues in the ED would be fantastic.
1.14	In terms of reasonable adjustments staff were now using clear masks but extra time was allowed for those taking histories and staff were provided with remote microphones if they wished. The etiquette on virtual meetings was to use the caption function and to ask participants to speak slowly so the captions could keep up.
1.15	The CEO then added that AA had been his mentor in the organisation's Reverse Mentoring programme. The key points for him had been the great job that JW and his team did to support colleagues and patients. His first session with AA had been during COVID and via MS Teams and he recalled AA had kept asking him to speak slowly and to look directly at the screen so that she could lip read. The live caption function on Teams had improved but was still 4-5 words behind so he admitted he had struggled a bit too. In terms of supporting colleagues in other departments the organisation did a good job but there was more it could do. Before AA left she had been working with nursing staff from a patient perspective to ensure everyone knew which patients had hearing loss, particularly those who were not wearing an aid. She had been an inspiration to her team and had brought home the message that there were people out there with hearing loss, but for whom simple adjustments such as speaking slowly and clearly and looking directly at them could make a hugely positive impact.
1.16	The TC opened the item to questions. In response the DoQI reminded colleagues he himself wore a hearing aid and he sympathised with some of the points that AA had raised in terms of the issues with lip reading if colleagues didn't speak clearly or look directly at you. COVID he agreed had been particularly hard in terms of mask wearing and he had had to rely on focussing on people's eyes. He agreed JW had done some great work in his team to support colleagues but there was more that could be done more widely to support colleagues across the organisation and to that end JW was now working in conjunction with the Staff Health & Wellbeing (HWB) team to support others.
1.17	TC commented that an action for her would be to pick up with the Head of Corporate Affairs (HoCA) in terms of making the Board table more square so that colleagues like the DoQI could see everyone's faces.
ACTION **TB1.06.10.22/19**	**Review the layout of the Board room for future meetings.** **Lead: Trust Chair/Head of Corporate Affairs**
1.18	Non-Executive Director George Wood (NED-GW) suggested the story may be useful in terms of sharing with the ICS where there may be different levels of awareness and advancement.
ACTION **TB1.06.10.22/20**	**Consider sharing the Staff Story with the ICS.** **Lead: Trust Chair**

1.19	In response to a question from NED Darshana Bawa (NED-DB) the DoP confirmed that in terms of a patient attending the Audiology department, they would be made aware if their appointment was with a clinician who was hard of hearing – there were four currently in the department.
1.20	In response then to a question from NED Helen Glenister (NED-HG) the DoP confirmed she did not know how many staff in the organisation currently had a hearing impairment. This led to a wider conversation in that the organisation was low in reporting any kind of disability and work had started to encourage staff to declare that. Currently less than 3% of staff had declared a disability which was much lower than had been declared in the Staff Survey.
1.21	As a final point and in relation to the conversation above the DoP emphasised that the introduction of clear masks had not been down to the organisation itself but had been a national issue.
1.22	The TC requested that a 'thank-you' note be sent to AA from the Board.
ACTION TB1.06.10.22/21	**Send a 'thank you' note to Asiya Ali. Lead: Board & Committee Secretary**
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC presented her report and the paper was taken as read. The only item on which to update was that she had undertaken a recent walkabout with NED-GW and Associate NED Anne Wafula-Strike (ANED-AWS) where they had chatted to a patient in Costa Coffee who had been in a wheelchair. The patient had relayed to them the problems of conveyance to hospital by ambulance for those in a wheelchair because ambulances could not carry a wheelchair. The TC stated she had then looked into the issue further and had uncovered an instance where an assistance dog and wheelchair had been left at the side of the road by an ambulance crew. She had therefore written to the Association of Ambulance CEOs asking for their support.
2.2	In response to a question from NED Colin McCready (NED-CM) the TC confirmed the final interviews for the position of CEO of NHS Providers would be held on 04.12.22.
2.3	NED-HG then asked for an update on the IT issues which had occurred during the Trust's Annual General Meeting (AGM) earlier that week. In response the Chief Information Officer (CIO) reported there had been a number of performance issues remotely and issues were most likely down to the hardware which could happen at any time. NED-CM suggested using a webinar instead. The CIO agreed that could be looked into but from a capacity perspective that shouldn't have been an issue on the day.
2.4	As a final point NED Helen Howe (NED-HH) flagged that she had been made aware that week during a Health & Wellbeing meeting that the Citizens' Advice Bureau was now on site and providing webinars to support staff.
2.2 CEO's Report	
2.5	The CEO presented his report and informed members that the position had changed somewhat since submission in so far as the number of COVID positive patients had increased dramatically to 63 as of the previous day, from circa 28 a week earlier. This aligned with the number of infections in the community. The organisation's Infection Prevention & Control (IPC) team was working overtime to look at any potential changes to the rules in terms of supporting patient flow and in terms of ongoing transmissions for colleagues. In terms of the latter a decision had been made to revert to mask-wearing in all clinical areas of the hospital and conversations continued around the potential for increased testing. The position was not unique to the organisation and it was possibly a couple of days behind other local trusts. The position put into context just how pressurised winter may become, coupled with 'flu and the cost of living crisis. The COVID booster (along with 'flu) was now being provided on site for staff.
2.6	In terms of winter, national modelling suggested that as many as an additional 14,000 beds may be needed across the country to support the NHS in safely getting through winter. For PAHT and the local West Essex Health and Care Partnership, that equated to the equivalent

	of approximately 45–50 beds. Teams had been working with colleagues in the wider health and care partnership as well as colleagues internally to reduce duplication and maximise efficiency of processes and decision-making, as well as supporting changes to clinical pathways.
2.7	The paper included an update on recent political developments and changes to roles. Whilst it was early days the focus of the new ministerial team had remained very largely the same as the previous team with a strong initial drive around ensuring the NHS was as fit as possible for winter and supporting the ongoing recovery of services impacted by the COVID-19 pandemic.
2.8	In terms of the ICS and Board developments he continued that Hertfordshire and West Essex (HWE) Integrated Care System (ICS) continued to develop and drive some changes across the wider system. As well as supporting winter planning in the system it was also supporting the development of a range of options for a system-wide elective hub to underpin COVID recovery and to drive the better use of information and data across all agencies.
2.9	In response to a question from NED-GW around COVID, the Director of Nursing & Midwifery (DoN&M) confirmed that if was difficult to confirm whether people were catching COVID in the community or on admission to hospital. Patients were only being tested on admission if they were symptomatic and there was an ongoing discussion as to the benefits of testing all at the front door.
2.10	The CEO then responded to a second question from NED-GW around the levelling up of certain services in the ICS. He confirmed whilst it was not referred to as levelling up, there was a piece of work underway with the Acute Provider Collaboration around fragile services to ensure those could be sustained for the population and also to look at how to support a more speedy recovery of elective services. There had been agreement to look at community service provision across the whole system with consideration to levelling that up (there were different sets of access targets) so the ICS would do some work to look at what outstanding service provision looked like and how to attain that in a phased way over time.
03 RISK/STRATEGY	
3.1 Significant Risk Register (SRR)	
3.1	This update was presented by the MD who highlighted that the overall number of significant risks on the register had increased from 66 to 70. There were no new risks with a risk rating of 20, three new risks with a score 16 and two with a score of 15.
3.2	There were three new risks scoring 16: Two for 'people': critical care staffing and information governance training compliance and one for 'places' regarding the need for a decant facility. There were also two new risks scoring 15, both for 'people': maternity basic life support training compliance and neurology staffing.
3.3	In response to a question from Associate NED Rob Gerlis (ANED-RG) around the potential risk posed by industrial action, the DoP confirmed a paper had been presented at the People Committee and at SMT and it was now a watching brief which would link to the work around winter planning. The Chief Operating Officer (COO) added the new Emergency Preparedness Resilience & Response (EPRR) manager was now in post and working with the People team to set up a number of scenarios/desk-top exercises. In response to a request from the TC, it was agreed the DoP/MD would discuss further in terms of whether that risk should be on the risk register.
ACTION TB1.06.10.22/22	**Consider whether the potential risk around industrial action should be on the risk register.** **Lead: Director of People/Medical Director**
3.4	In response to a further point raised by NED-HG, it was agreed the reference to the CCG in item 3.1.2 would be updated. It was also agreed that the date for completion of the Aseptic Unit would be amended to March 2023.
ACTION TB1.06.10.22/23	**SRR: Revise the reference to CCG.** **Lead: Medical Director**
ACTION TB1.06.10.22/24	**SRR: Revise the target date for completion of the Aseptic Unit.** **Lead: Medical Director**

3.5	In line with the recommendation it was agreed the Board had reviewed the SRR and it was content to approve the new risks. It also recognised the potential risk around industrial action.
3.2 Board Assurance Framework (BAF) 2022/23	
3.6	This update was presented by the HoCA who informed members that the risks had been updated with Executive Leads and reviewed at the relevant Committees during September 2022. Following review at PAF it was recommended that the score for Risk 5.2 (capital) be reduced to 8 which was the target risk score. BAF risk 3.2 (Financial and Clinical Sustainability across health and social care system) was also presented for consideration by the Board (the Board is responsible for reviewing this system risk).
3.7	As Executive Lead for the risk the DoF confirmed given the capital programme was already well balanced and the organisation was likely to achieve its capital resource limit (CRL) his view would be to reduce the risk score.
3.8	In line with the recommendation the Board noted the updates to the risks and approved the reduced score for risk 5.2 (capital).
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
The Director of Midwifery (DoM) to the table for the following two items.	
4.1	Report from QSC.30.09.22 This report was presented by the chair of QSC, NED-HG and the following key points were highlighted: • **Quality PMO Update:** There was good overall progress however there were 2 red-rated items. S5 (e-consent, consent on the day of surgery) and S3/N (Safeguarding Training) where it was considered there was currently insufficient assurance. External peer review panels were not held in August, delaying a number of actions (12) potentially moving from green to blue (embedded) and a scheduled peer review panel on 15.09.22 would aim to address that. • **Reports from Feeder Groups:** QSC had been pleased to note that some immediate actions had already been taken in relation to some concerns raised at the recent AGM around patient difficulties in getting through to the hospital to revise appointments. • **Claims Deep Dive:** QSC had requested some assurance around this and the update had provided assurance that a number of elements would be addressed with a new electronic health record (EHR). • **Ambulance Handover:** The Committee had felt assured about the safety of patients in relation to long waits. It agreed however that the overall patient experience was impacted by those waits. • **Research & Development Annual Report:** QSC had commended the work of the team and the fact that almost 1k patients had been recruited to projects across the system as a whole.
4.2	In response to the above the DoQI added he would also commend the MD and Director of Clinical Quality Governance for starting to explore EDI in relation to patient safety incidents.
4.3	ANED Liz Baker (ANED-LB) queried how patient safety was not compromised by long waits and ambulance handover delays. In response NED-HG confirmed that assurance had been provided by the team on mitigating actions being taken in terms of safety huddles, points of escalation, improvements in the frequency of observations. She acknowledged the position was not ideal but QSC had been assured on the mitigations in place. The COO added that if there were any concerns the consultant in charge would review and bring patients in ahead of time. Treatment could also be commenced in the ambulance if required. The CIO then added that the SPC chart in the IPR evidenced that arrival to triage times had significantly reduced which was linked to the recent implementation of ED NerveCentre and use of the Manchester Triage Tool. NED-HH flagged that QSC had also discussed the fact that delays to ambulance handover meant delays in ambulances getting to new patients which was a wider system risk.

4.4	In response to the above NED-GW asked what could be done to address the issues of delays in ambulance handover. In response the COO informed members that winter planning was underway with the whole system not just individual organisations and there were checks 3 – 4 times daily with the ambulance service. The ambulance service would itself triage patients, just as the acute providers did on arrival.
4.5	In response to the above the TC suggested it might be useful for NEDs (if they desired) to spend a day in the East of England Ambulance call centre, as she had done and where she had learned a lot.
4.6	In summary the TC stated that the Board had welcomed the update, particularly on ambulance handovers and the assurance on claims and she requested that her video to staff (post-Board) include the good news around research and development.
ACTION **TB1.06.10.22/25**	**Trust Chair's video to staff following Board to include the good news story around research and development.** **Lead: Trust Chair**
4.7	Report from QSC2.30.09.22 This report was presented by ANED-RG, as chair of QSC (Part II). He updated that feedback from the Regional Chief Midwife (who was an attendee) had been very complimentary in terms of the establishment of the meeting and in terms of service improvements. The Committee had received assurance on the majority of items and had noted there would be a review of staffing in October in line with the Ockenden recommendations. It had also discussed in detail the issue around care for out-of-area women (which had also been raised by the Board) and the issue would remain on the Committee's action log with a further update requested for October. He thanked Maternity colleagues for providing a briefing for him (as new chair) on the Maternity Incentive Scheme.
4.8	The TC thanked ANED-RG for his update and noted in particular the issue of cross-border care.
4.2 Maternity Incentive Scheme (MIS)	
4.9	This item was introduced by the DoN&M who reminded colleagues of the requirements of MIS to present certain papers to the Trust Board for sign-off and those would now be presented. The Director of Midwifery joined the Board for the maternity agenda items.
4.10	Mid-Year Midwifery Establishment Review This update had been referred to in the Committee's report above. She reminded members there had been an establishment review for Maternity services in February 2022 with investment for maternity support workers and specialist midwives. The DoM would be reviewing the position in terms of specialist nurses over October which would feed into the establishment review in December. She opened the item to questions. The DoM added that the review would also be in conjunction with the recommendations from the East Kent Kirkup report which was about to be released.
4.11	The TC asked for some detail around the plans in place for managing the increased risk for BAME patients associated with not having 'Continuity of Carer' (CoC) targets in place. In response the DoM confirmed that what was most important was understanding the community and having good antenatal care in place. The DoN&M added that whilst CoC targets were no longer the national expectation, the organisation would absolutely continue to pick out its most vulnerable service users and those at highest risk.
4.12	At this point NED-HG informed members that she had attended a Maternity Voices Partnership meeting the previous day and the amount of work underway in terms of connecting with the wider communities was very positive. The DoQI added it also linked to the Harlow levelling up programme of work with Harlow raised as an area of concern so the focus on the locality and engaging with services.
4.13	As a final point the DoM confirmed a consultant midwife had now joined the organisation and her remit would include a focus on public health and midwifery-led care so she would be supporting community midwives and would be looking to target particular areas.
4.14	The Board noted the position in terms of the midwifery establishment review.
4.16	Maternity SI Update

	The DoN&M was pleased to report there had been no serious incidents in Maternity in August. The thematic analysis of incidents in the paper was not showing anything different and she commended the team for the establishment of the Maternity Improvement Board.
4.17	The Board noted the position in terms of Maternity SIs.
4.18	Maternity Digital Strategy The DoM informed members that it was a requirement of NHS Resolution that every provider had a Maternity Digital Strategy in place. The Trust's strategy had been produced in collaboration with the LMNS and the stakeholders listed within. Its main focus was to look at the interoperability between systems and to support staff to provide care. It provided a timeline of the projects being worked on and was presented that day for approval as a requirement of MIS.
4.19	In response to a question from NED-GW, the DoM confirmed that where women had different providers, all providers could see the care records and any associated risk factors. On discharge women/babies would be followed up by their health visitor or GP (both of whom had access to the care record).
4.20	The TC requested a description of the maternity pathway for NEDs.
ACTION **TB1.06.10.22/26**	**Details of the Maternity Pathway to be provided to NEDs.** **Lead: Director of Nursing & Midwifery**
4.21	Following on from the above, the DoN&M confirmed (in relation to possible cases of children at risk that there had been national access to the Spine for a number of years so information sharing was in place. If a patient attended the ED unplanned then the spine would be accessed to see whether or not that patient was at risk.
4.22	At this point NED-HG flagged that safety action two of the MIS (maternity dataset) had been a risk for some time albeit it was looking as if that had now been addressed. She asked how far the digital strategy would address those data issues. In response the DoM confirmed the new EHR would support that and he was able to confirm he had heard the previous day there was now 99% assurance around compliance with safety action two but this would be confirmed and reported to QSC II.
4.23	In response to a question from ANED-LB in terms of handheld patient notes, the DoM was able to confirm that the road-map talked about a two year journey during which the 'red book' (patient notes) would become electronic. There would also be central CTG monitoring.
4.24	In line with the recommendation the Board approved the Maternity Digital Strategy. In doing that it recognised there would be significant benefits for women/babies/families but it also noted the concerns raised points around health inequalities and deprivation.
4.3 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.25	This update was presented by the DoN&M and the key points to note were as follows: • Overall staffing risk rating in month: achievement across the overall fill rate was stable (93.2%), with an RN/M overall fill of 88.3% and a HCSW overall fill of 104.2%. • Maternity staffing: detailed overview of the maternity staffing and key actions in place. • Turnover rates for nursing were stabilising. Recruitment work was ongoing utilising NHSE and ICS best practise with healthy pipelines of both RNs and HCSWs.
4.26	NED-CM asked for further detail on the reference in the paper to redeployment to Nightingale Ward. In response the DoN&M confirmed that this was the decant ward so needed to be staffed. It was not the COVID ward but was internal winter escalation capacity which had been possible due to funding from the ICS.
4.27	NED-HH reflected that the report did not allow the reader to measure or see the variation in acuity of patients and how hard it was for staff on the wards. It was in effect a blunt tool that required some interpretation.
4.28	The TC summarised by stating that the Board noted the report and the overall pressures on both the hospital and its staff.
4.4 Learning from Deaths Update	

4.29	This update was presented by the MD. She informed members that the organisation's mortality indices remained within 'as expected' and the Trust was well positioned in terms of its regional peer group.
4.30	In terms of the standardised mortality ratio (SMR) outlying groups there were two outlying groups 1) Alcohol-related mental disorders and 2) Cardiac dysrhythmias. The patient notes would be audited to look at coding and quality of care with findings presented to October 2022 Strategic Learning from Deaths Group. The three CUSUM breaches had been reviewed with no concerns and SHMI also remained 'as expected' within 30 days at 99.29.
4.31	The MD continued that some recent learning taken from the outputs of the structured judgement reviews (SRJs) had revealed the visibility of DNACPRs in the community was limited. This learning had been presented to the West Essex End of Life Steering Group with a request for support to address the issue across the ICS.
4.32	She was pleased to confirm that Mortality & Morbidity meetings were now taking place monthly in all divisions and that a Lead Medical Examiner had been appointed (a GP) who was working well with PCN leads on the community death pilot with St. Clare Hospice and to expand GP death scrutiny. As a final point and in relation to a comment made at QSC that month, she acknowledged that the SLfDG had not been quorate that month but had closed some of the risks on the Learning from Deaths risk register. She provided assurance those would be reviewed again at the next meeting assuming that meeting was quorate.
4.33	In response to a concern raised by ANED-RG in relation the issue of DNACPRs, the CEO confirmed it was an ongoing issue, there was a continuing dialogue with ambulance trusts and it was consistently being escalated. It would remain of key focus for the Trust.
4.34	In response to the above NED-HG confirmed she was the chair of the East & North Herts End of Life Group and she would ensure the issue remained a top priority.
4.35	The TC summarised by confirming that the Board noted the paper and would require a future update on the community DNACPR issue.
ACTION **TB1.06.10.22/27**	**Provide the Board with a future update on the community DNACPR concern.** **Lead: Medical Director**
4.5 Questions from the Public	
4.36	There were no questions from the public.
Break 1103-1115	
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	This update was presented by NED-HH. She confirmed the Committee had noted the significant improvement made in regard to the six PAHT2030 culture related KLOEs and had thanked the PMO and team for the hard work to drive the changes and improvements. It had also been assured in terms of the provision of safe nursing and midwifery staffing and that processes were in place for managing and monitoring staffing levels. The Committee had noted the potential risk of accommodation costs and availability due to the acceleration of the international nurse recruitment drive.
5.2	NED-HH continued there had been agreement that the BAF risk score would remain unchanged at 16 but the controls had been updated and it was agreed to include a gap in control around direct engagement.
5.3	As a final point members were informed that PC had been assured on the measures being taken to address statutory and mandatory training compliance and the proposals for non-compliance which had been discussed with SMT. The Committee had noted the Q2 Pulse staff survey results which had shown an increase in score for 6 out of the 9 core engagement questions.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This update was presented by NED-CM who informed colleagues the meeting had been one of two halves. PAF had recognised the improved transparency and visibility of the current

	position and had been assured on the associated controls. Conversely the organisation was not where it wanted to be financially. It was agreed cost drivers and levers would be included in the Finance Report going forward. As mentioned earlier in the meeting, it had been agreed that the risk score for capital would be reduced to 8.
6.2	In terms of CIPs there had been partial assurance but recognition of the large gap to be closed and the requirement for pace.
6.3	There had been some very informative updates on stranded patients, the new hospital and finance modernisation.
6.2 Integrated Performance Report (IPR)	
6.4	This item was introduced by the CIO and the three key headlines were as follows: • **Four hour standard:** This remained in special cause variation however since the implementation of Nervecentre ED there had been a significant drop in the time from arrival to triage, a significant safety indicator. • **Pressure ulcers:** After a spike in June for grades 3 and 4 there had been a return to common cause variation. • **Statutory/Mandatory training and appraisal:** The former was in special cause variation and showing a statistically consistent trend with current performance at 86% against a target of 90%. The latter was still in special cause variation also with performance consistently at or near 80%.
6.5	NED-HG asked, in terms of ED attendances, whether any form of analysis was being undertaken to identify the cohort which should be seen elsewhere. In response the COO confirmed that was underway and she would talk more that afternoon in terms of winter planning and the wider system. As part of the capacity modelling, each piece of the pathway was being drilled into to see where patients were attending from. This would feed into the clinical model at the front door and the wider ICS response to urgent care. The CIO added that colleagues were in the process of developing a new self-service performance report which had been shared with Executive colleagues the previous day which would provide some granularity.
6.6	In response to the above ANED-RG cautioned that the work around ED attendances must include the system as a whole otherwise there would just be knock-on effect. In response the CEO flagged there was a significant change in patient presentation for many reasons and there needed to be assurance across the system that the right care was in the right place. He acknowledged Primary Care was also under pressure and whilst work was underway to analyse ED attendances, it would not be a quick fix in terms of immediately removing a cohort of front door attenders.
6.7	As a final point the DoQI informed members that the system was working on a population health management programme on how the local population accessed services and 400 patients had been identified as a study in terms of how and why they accessed services. It was hoped this would support improvements going forward.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	As chair of STC, the TC introduced this item. She informed members that assurance had been received on all the items discussed and members had agreed that the Committee was maturing well and starting to fulfil a useful role.
7.2	NED-GW highlighted it would be useful for the Board to receive a presentation on all the actions and investment currently in train to address child deprivation so that the priorities for the ICS/ICB were clear. In response the DoS commented that it was fair to say the ICB and local place-based partnerships were still forming. He and the DoQI attended regular meetings to align the system with PAHT strategy. He himself had been involved in the ICB strategy development and that was still work in progress but would be looking at how to develop services in the locality and understand the data. What was missing was a comprehensive data to allow proper decisions to be made on populations and that would now be a big push for partners. There were some good pockets of work underway but investment

	decisions were still in their infancy. The DoQI added that STC received updates on current work-streams but decisions on how to use funding had not yet been agreed. Same day care and cancer screening would be some of the priorities. He could bring an update on that when the work was more developed. He provided assurance however that the Trust was part of that work and the MD was on the attendance list for the Health Inequalities & Prevention meeting.
7.3	The CEO continued that all the PAHT2030 priorities were linked into what was happening in the system and were constantly changing. PAHT2030 was about linking the hospital and the system so 'corporate transformation' and 'transforming our care' were not being undertaken in isolation of place-based conversations.
7.4	In response to the above ANED-LB agreed that the Committee was now starting to fit in with the wider picture and she asked whether there would be an opportunity for a representative from the ICB to come and talk to the Board about the strategies to bring them to life. In response the CEO confirmed the ICB strategy was in effect the Trust's strategy and the Trust was ultimately responsible for delivery the PAHT element of the ICB strategy. The challenge on that should be at STC to decide whether it was too PAHT-centric or too ICS-centric.
7.5	NED-GW reiterated his concern around mental health issues and deprivation and asked who was providing the Board with assurance that these issues were being addressed. In response to the above ANED-RG commented that the issues raised by NED-GW had been identified some time ago as an area of focus for Harlow and his concern was that it was taking some time for it to be devolved.
7.6	In response the CEO informed members there were a whole range of issues being considered and nothing was being 'waited for' in essence. How much was devolved to place from the system was a separate issue but that wasn't preventing the Trust from moving forward. There was huge work underway on inequalities and STC had received a paper on that. He acknowledged the Trust needed to be 100% part of the ICB, to challenge and to do the right thing for its patients but it would never be able to solve issues such as housing or education, it could only drive those issues. The organisation had a responsibility to recognise that the acute element would change as different ways of working and models of care evolved, so it would need to get the balance right, play its role, support improvements and work with the system to develop different pathways, but at the same time being primarily responsible for acute care provision for the local population.
7.7	The CEO continued he was concerned about winter and where the responsibility for patients lay. Everyone wanted to solve all the ills of the local population, not just the acute, but priorities would need to be agreed and when those would be addressed and how. Winter was going to be challenging and COVID numbers were already on the rise. Work would continue with partners in the community but some elements would need to take a different level of priority. His suggestion therefore would be for the Board to have an on-going and open dialogue on its priorities/focus and for members to continue to challenge each other.
7.8	The TC thanked colleagues for the useful discussion above and agreed that she and the CEO would write to Paul Burstow (Independent Chair of Hertfordshire and West Essex ICB) in terms of him attending a future Board session.
ACTION **TB1.06.10.22/28**	**Ask the Chair of Hertfordshire & West Essex ICB to update Board colleagues on ICB plans for investment.** **Lead: Trust Chair/CEO**
7.2 Report from Senior Management Team (SMT)	
7.9	This paper was presented by the CEO for information and was noted. Members had no comments.
7.3 Well Led Review	
7.10	This update was presented by the DoN&M who reminded members that the Board had undertaken a Well-Led self-assessment in July 2022 and had rated itself as good, with elements requiring improvement. There were three ratings which remained assessed as 'requires improvement' (RI) albeit significant progress against those KLOEs had been

	recognised in terms of associated actions and oversight. Those KLOEs were: 3) Is there a culture of high quality, sustainable care? 4) Are there clear responsibilities, roles and systems of accountability to support good governance and management? 6) Is appropriate and accurate information being effectively processed, challenged and acted on?
7.11	In terms of the recommendation in the paper (consider the self-assessment ratings and agree next steps to address/progress the KLOEs rated as RI), the next step would be to correlate the evidence against each of the KLOE ratings, agree the central repository for information with support from PM3 and the QPMO office. The Trust wanted to be 'outstanding' and to that end the divisions were also now undertaking Well-Led reviews to understand their own position.
7.12	In line with the recommendation the Board agreed the self-assessment ratings and next steps to address the KLOEs rated as RI.
7.4 Report from Audit Committee	
7.13	As chair of the Audit Committee, this report was presented by NED-GW. He highlighted that the Committee's terms of reference (ToR) had not been included in the pack for review/approval but there had been no changes from the previous version.
7.14	He flagged that the MD had brought up the question of training for members and he was pleased to advise that KPMG would be running a session on 29.11.22 and that invite was extended to all Board members.
7.15	As a final point he confirmed there had been good progress on counter-fraud, and there were no issues in terms of losses and waivers.
7.16	The TC summarised by stating that the Board noted the report and approved the Committee's revised ToR, which had not changed from the previous version.
7.5 Report from the Corporate Trustee	
7.17	This item was presented by ANED-JK as chair of the Charitable Funds Committee (CFC). He updated that the Committee had received an update on recent charity activities from the past three months, including the spring appeal, tap to donate machines and the upcoming London Marathon and the 2022 Royal Parks Half Marathon, both taking place that month. The spring door drop appeal had raised £5,309.50 which had represented a net loss to the charity, however good qualitative data about the donor base had been gained.
7.18	In terms of risk, CFC had noted two new risks relating to the awareness of all fundraising by staff for the Trust and the Head of Charity role. The draft Charitable Funds Annual Report & Accounts had been presented in draft.
7.19	In response to a question from NED-GW it was confirmed that the Trust would continue that year with providing presents for inpatients on Christmas day. In response to a second question ANED-JK confirmed that the Charitable Funds strategy was in draft, he hoped to bring that to December Board for approval and within that would be a 'top ten' wish list for the charity.
7.20	The TC thanked ANED-JK for his update.
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 TC commented that from discussions that day it was clear the hospital remained under pressure and would be under additional pressure in coming months. NED-GW asked about staff morale given both the pressures at work coupled with cost of living pressures. In response the DoP confirmed that staff health and wellbeing was at the top of the agenda and staff were being encouraged to put forward ideas to the Trust to improve the position for people. The results of the quarterly People Survey had just been received and there were

	some green shoots but the key would be to keep the dialogue going with staff, albeit the organisation was limited in terms of what it could do.
9.3	NED-HH added there had lots of ICS engagement around staff health and wellbeing in the form of webinars, the outputs of which she had been reporting back to the Health & Wellbeing Department. She very much welcomed the recent news that the Citizens' Advice Bureau would now be on site to support staff. In response to a question from ANED-AWS she confirmed that the HWB team were looking into a general 'health check' for staff which may prompt a wider discussion around their wellbeing where they may previously not have felt able to ask for help.
9.4	As a final point the DoN&M highlighted the need for continued Board visibility on the shop floor particularly with the coming winter and added pressures for staff.
9.3 Any Other Business (AOB)	
9.5	The DoP informed members that Rainbow badges had been launched during *This is Us* week back in June. She had some available that day along with accompanying literature/declaration form.
9.6	In response to a final question from ANED-AWS, the Associate Director of Communications confirmed there was a Carers' Support team currently in place at the Trust.
9.4 Reflections on Meeting	
9.7	Reflections were that patients had been at the forefront of discussions that day. Members had welcomed the return to face-to-face meetings, and the room layout would be reviewed for the next meeting in terms of making it easier for everyone to hear.

Signed as a correct record of the meeting:	
Date:	01.12.22
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 01.12.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.10.22/19	Board Room Layout	Review the layout of the Board room for future meetings.	TC HoCA	TB1.01.12.22	Actioned.	Closed
TB1.06.10.22/20	Staff Story	Consider sharing the Staff Story with the ICS.	TC	TB1.01.12.22	Pending until next meeting with the ICS Chair.	Open
TB1.06.10.22/21	Staff Story	Send a 'thank you' note to Asiya Ali.	B&CS	TB1.01.12.22	Actioned.	Closed
TB1.06.10.22/22	Industrial Action	Consider whether the potential risk around industrial action should be on the risk register.	DoP MD	TB1.01.12.22	This is referenced in BAF Risk 2.3 and is being added to the People Team Corporate Risk Register.	Proposed for closure
TB1.06.10.22/23	Significant Risk Register	Revise the reference to CCG.	MD	TB1.01.12.22	Actioned.	Closed
TB1.06.10.22/24	Significant Risk Register	Revise the target date for completion of the Aseptic Unit.	MD	TB1.01.12.22	Actioned.	Closed

ACTION LOG: Trust Board (Public) 01.12.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.10.22/25	Chair's Video to Staff (following Board)	Trust Chair's video to staff following Board to include the good news story around research and development.	TC	TB1.01.12.22	Actioned.	Closed
TB1.06.10.22/26	Maternity Pathway	Details of the Maternity Pathway to be provided for NEDs.	DoN&M	TB1.01.12.22	Circulated 23.11.22.	Closed
TB1.06.10.22/27	Community DNACPR	Provide the Board with a future update on the community DNACPR concern.	MD	TB1.01.12.22	Verbal update to be provided at TB1.01.12.22.	Open
TB1.06.10.22/28	ICB Update to Board	Ask the Chair of Hertfordshire & West Essex ICB to update Board colleagues on ICB plans for investment.	TC CEO	TB1.01.12.22	Date being arranged for February 2023.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors - 1 December 2022

Agenda item:	2.1								
Presented by:	Hattie Llewelyn-Davies								
Prepared by:	Hattie Llewelyn-Davies								
Date prepared:	24th November 2022								
Subject / title:	Chair's Report, December 2022								
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**		
Key issues:	To inform the Board and other colleagues about my work; to increase knowledge of the role; to evidence accountability for what I do								
Recommendation:	The Board is asked to discuss the report, give feedback and note it.								

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

Previously considered by:	Not applicable
Risk / links with the BAF:	No risks identified.
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below.
Appendices:	None

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

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

The work on succession planning continues, we have asked all NEDs to complete a skills matrix to guide us in future recruitment processes. We have begun to review the role of the Maternity and Neonatal Safety Champion, since despite being enormously valuable in keeping our parents and their babies' safe and ensuring a quality service, the role is very time consuming and we need to know that it is a good use of NED time.

We have organised a development day in the New year facilitated by Helen Nellis, an experienced strategy expert in the NHS to take forward the recommendations of the Well Led Review and our expertise to lead the organisation.

3.0 External Work:

I attended the annual NHS Providers Conference with several member of the Executive Team in Liverpool earlier this month. We heard a number of valuable insights on ways of working and also heard important speeches from the Secretary of State, the Shadow Secretary and the CEO of NHSE.

I was honoured to be part of the team who appointed a new CEO of NHS Providers a month ago. We are extremely honoured to have appointed Sir Julian Hartley to the role. Julian has a passion for the NHS and has worked in it all his life. He will be a skilled and determined champion for us.

NHSE have set up a new service to offer mentoring for new chairs by experienced chairs. I am delighted to have been paired up already with a new chair and look forward to supporting her on her journey. I have no doubt that I will also learn as much from her as the other way around.

We were pleased to host a visit from Lord Victor Adebowole, chair of the NHS Confederation, who came to understand at first hand the pressures of running an acute hospital at the moment.

4.0 Staff Welfare and Resilience:

One of the issues most concerning to the Board at present is the impact of the issues relation to the cost of living on our people and our local population. We are developing new services to support our people all the time. I would welcome any ideas from staff about additional things we might do.

The Non Executives continue to do regular visits, both as individuals and teams to areas of the hospital. If any areas for improvement are identified on these visits they are fed back to the relevant teams and managed through the Trust's governance processes.

The most recent visit was to our Pathology Services where we saw an incredibly busy department with great morale and a determination to resolve any issues that presented themselves. It was an inspiring visit for us.

We have visited the following areas of the hospital since December 2021:

21/11/22	Pathology
27/10/22	Lister Ward
05/09/22	Harvey Ward
28/07/22	Williams Day
24/06/22	Pharmacy
12/05/22	Mortuary
06/04/22	Maternity
07/03/22	Eye Unit
21/02/22	Children's ED and Dolphin Ward
10/12/21	Urgent care pathway

5.0 The System:

One of the priorities that the Board agreed for me during my first year in post was to continue to play a strong role in wider system and developing the role of the Integrated Care System. This remains a priority and we have been developing our knowledge of local services as part of this with things like the tour of Harlow that the NEDs recently undertook. I have also recently visited some of our colleagues in Essex to learn more about the issues in that part of our service area.

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

Author: Hattie Llewelyn-Davies. Trust Chair.
Date: 24 November 2022

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 1 December 2022

Agenda item:	2.2
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	23 November 2022
Subject / title:	CEO Update

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - COVID-19, recovery and Urgent and Emergency Care - Winter - Political developments nationally - ICS wide pathology procurement - GMC enhanced monitoring - Industrial Action risk - Other key headlines / developments for noting
Recommendation:	The Trust Board is asked to note the CEO report and the progress made on key items.

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

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

Chief Executive's Report
Trust Board: Part I – 1 December 2022

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

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

1.1 COVID-19 Recovery

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

We are making strong progress in recovering all of our services with our planned activity in many areas now greater than pre-pandemic levels. Our cancer waiting times are amongst the best in the East of England region, as our numbers of patients waiting in excess of 52 and 78 weeks for their intervention. Our elective recovery is slightly below pre-pandemic levels at the moment with approximately 95% of value weighted activity compared with 2019 levels.

More detail is available in the Integrated Performance Report.

1.2 COVID-19 booster and flu vaccinations

The national autumn COVID-19 booster vaccination programme started on 1 September for the most vulnerable and NHS workers have been able to access the booster through local vaccination and the national programme since the end of September. We continue to encourage as many colleagues as possible to take up the booster.

Our local flu vaccination programme has been running for a couple of months and all colleagues are encouraged to seriously consider having the vaccination.

There is an expectation of the potential for another spike in new COVID-19 infections in mid-January and taking the learning from the southern hemisphere and the west coast of the USA, and expectation of higher levels of flu infections this winter compared to previous years.

1.3 Urgent and Emergency Care

We continue to see high and sustained demand for our urgent and emergency care (UEC) services. The current challenges in primary care locally, and the challenges that we have as a system with accessing suitable community and social care capacity is putting considerable strain on our Emergency Department and our ability to have as effective and strong flow of patients in to, through and out of the hospital as we would like. This is also causing pressure and backlogs for ambulance waits. Performance against the national standards can also be seen in the Integrated Performance Report.

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

We have made strong and sustained improvements against the conditions on our licence through the Section 31 notice for UEC and by the time of the Board meeting it is likely that we will have written formally to CQC colleagues to ask for the notice to be removed.

(2) Winter

As outlined in my paper to the Board in October, all the expectations remain that the NHS will have a winter like we have never seen before in terms of pressures and demands due to:

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

National modelling suggests that additional inpatient bed capacity will be needed to support the NHS in safely getting through winter. For HWE ICS the equivalent of 140 additional beds are estimated to be required and through a range of schemes we are on track to provide this by the end of December.

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

We ran a series of winter events on 10 November with support from place-based, system and national colleagues to maximise learning from others and to support a series of marginal gains and improvements across all elements of the UEC pathway to maximise the quality of care we will provide to patients. All sessions were well attended by clinical and non-clinical colleagues across the Trust and wider place-based partnership and key actions that local teams are leading on include:

- Enhanced model of triage in ED and increased streaming
- Further enhanced use of the Urgent Treatment Centre for appropriate patients
- Reduced ED management of patients and reduced inpatient admissions through greater use of SDEC
- More timely specialty decision making in ED
- Enhanced frailty assessment
- Improved timely daily decision making on inpatient wards to support timely discharge
- Implementation of a continuous flow model from ED to AAU to IP wards
- Expanded use of virtual ward capacity in conjunction with community services colleagues
- Enhanced discussions and decisions for patients no longer meeting the criteria to reside

There are a number of wider place and system developments across the health and care system in addition including:

- Use of the HARIS model to support the appropriate reduction in ambulance conveyances
- Expanded number of care packages
- Greater community and social care availability

(3) Political developments nationally

At the last Trust Board meeting I outlined a number of changes in key political roles affecting the country and the NHS. Since this time there have been a significant number of additional changes to key roles.

Rishi Sunak has been appointed as the country's Prime Minister, with Jeremy Hunt, former SoS for Health and Social Care appointed as the Chancellor of the Exchequer.

One of the first appointments made to cabinet under the new PM was Stephen Barclay being appointed back into the role he held for two months over the summer as the SoS for health and social care.

Since this time, there have been two changes to the health and care ministers. Current DHSC ministers are:

- Helen Whately – Minister of State (social care)
- Will Quince – Minister of State (health and secondary care)
- Maria Caulfield - Parliamentary Under Secretary of State (mental health and women's health)
- Neil O'Brien – Parliamentary Under Secretary of State (primary care and public health)
- Nick Markham – Parliamentary Under Secretary of State (minister for the Lords)

The focus of the new ministerial team has remained very largely the same as the previous team with a strong initial drive around ensuring the NHS is as fit as possible for winter and supporting the ongoing recovery of services impacted on by the COVID-19 pandemic.

The Chancellor gave his autumn statement on 17 November which saw the announcement of an additional £3.3bn being given to the NHS in each of the next two financial years. The statement also announced additional funding into social care of £2.3bn next year and £4.8bn the following year. Expectations of how this funding will be spent and the commitments from NHS and social care in return will be clarified in the national planning guidance, due at the end of December, but will include reductions in ambulance waits, improvements in ED performance, improvements in access to primary care, continued improvements in productivity and expanded elective recovery and continued improvements in the efficient use of resources. Capital investment looks as though it will remain broadly the same as planned for the next two years, with a decision on the total capital envelope for the New Hospital Programme due before Christmas.

In addition, former labour health secretary, Patricia Hewitt, has been asked to review the role of and powers of Integrated Care Systems across the country, with an expectation of ICSs being given greater levels of autonomy. She will report in to the SoS and we will feed local PAHT and West Essex Health and Care Partnership views into the Hewitt Review.

(4) ICS wide pathology procurement

All acute organisations across the ICS have been working for a number of years to develop an integrated, networked pathology service for primary and secondary care in line with the Lord Carter recommendations from 2017.

The Outline Business Cases recommended a preferred option for a joint procurement for an outsourced pathology service in 2020, which has now concluded, with a Full Business Case (FBC) developed.

The FBC is:

- aligned with the Lord Carter recommendation for a networked service
- moves the services to place / system based rather than provider-based care
- supports closer integration of providers
- enables a greater ability for all pathology services locally to adapt to new and emerging technologies and
- improves sustainability of services and staffing in hard pressed professions.

It is planned that the FBC will go through the formal governance structures of the three acute providers and the Integrated Care Board over the next 6 weeks for discussion and approval. Should the FBC be approved by all contracting authorities, a contract with the third-party provider will be signed in early 2023 and the services transferred during the calendar year.

(5) General Medical Council Enhanced Monitoring

I received a letter from the Medical Director and Director of Education and Standards at the General Medical Council (GMC) on 11 October notifying me that the GMC are placing PAHT into their enhanced monitoring process.

This is a result of GMC and local Health Education England (HEE) colleagues having some concerns that for some of our doctors in training in some of our specialties, that we are not meeting some of the GMC's requirements for training.

We have had a number of discussions with HEE, GMC, CQC and NHSE colleagues as well as a large number of discussions with our doctors in training and their education supervisors about how to address the GMC's concerns and have a clear programme of work to support this, supported by the PMO. We are meeting regularly with HEE colleagues to discuss progress and the support required from them and other agencies and we have enhanced the local governance to support this work. Regular updates and progress will be presented to the Board via the Workforce Committee.

(6) Industrial Action risk

As Board members will be aware, a number of unions have either balloted their members or are in the process of balloting their members over industrial action as part of their ongoing disputes with the government over remuneration and pay awards for NHS colleagues.

At the time of writing this paper on the Royal College of Nursing (RCN) ballot had been concluded and results made known. The RCN ran a disaggregated ballot, meaning that each individual provider needed to meet the two relevant thresholds for individual local strike action to take place of:

- 50% of eligible colleagues to vote
- Total of 40% of all eligible colleagues to vote 'yes' to strike action

For RCN members at PAHT:

- 41.6% of eligible colleagues voted
- 94.3% of whom voted 'yes' to strike action
- Total of 39.2% of all eligible colleagues voted 'yes' to strike action

As a result, there will not be any strike action from RCN colleagues at PAHT as neither of the two required thresholds were met.

We are supportive of all colleagues, whichever way they voted, and will continue to work in partnership with local and regional union representatives to minimise the risk to patients of any potential industrial action from any of the other unions currently balloting their members. The largest number of union members at PAHT is with Unison.

(7) Other key headlines / developments for noting

Other key items of note for the Trust Board include:

- Hattie and myself welcomed Lord Victor Adebowale to PAHT on 21 November. Victor is Chair of the NHS Confederation and former Chief Executive of Turning Point. It was an opportunity

for us to talk about current local, place and system pressures; how we see health and care developing in Harlow and West Essex into the future; the importance of system wide working and the need for the new hospital for Harlow.

- Sarah-Jane Marsh, CEO of Birmingham Women's and Children's Hospital has been appointed as the NHSE national director for urgent and emergency care and deputy COO, replacing Dame Pauline Philip in the UEC role. We look forward to working with Sarah-Jane, as we have with Pauline, to support UEC locally.

- Andrew Bramidge has been appointed as the new permanent CEO of Harlow Council. Andrew has worked in the council for 9 years, most recently as the Director of Strategic Growth and Regeneration. We look forward to working with Andrew and his team together with the Leader of the Council and other key councillors to support the regeneration of Harlow and reduction of health inequalities across the local communities.

- The Review Body on Doctors' and Dentists' Remuneration visited PAHT on 11 November as part of its process for making recommendations to the government on remuneration for these staff groups. It was an opportunity for a range of Executive Director colleagues and doctors of all grades and professions to give their views to the Review Body and potentially influence national remuneration thinking and values over future years.

- Therese Coffey announced in September 2022 that the government required all NHS Trusts to offer pension recycling by 2023 to minimise the risk of loss of senior clinicians from the NHS. This has been confirmed as still being a requirement and a recommendation will be made to the Trust's Remuneration Committee this afternoon.

Author: **Lance McCarthy, Chief Executive**
Date: **23 November 2022**

The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 1 DECEMBER 2022

3.1

Agenda item:	3.1							
Presented by:	Fay Gilder – Medical Director							
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance							
Date prepared:	22 November 2022							
Subject / title:	Significant Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents the significant risk register (SRR) for all our services. The significant risk register (SRR) is a snapshot of risks across the Trust and was taken from registers on 26.10. 2022. This paper includes all items scoring 15 and above. The overall number of significant risks on the register has increased from 70 to 75 (table 1 and section 2). The main themes for the 12 risks scoring 20 on the SRR are: • Five risks for our places: two existing risks for refurbishment of the maternity unit and the pharmacy aseptic unit. • Three new risks for our places: electrical infrastructure to cope with increasing demands, uninterrupted power supply for critical areas of the trust and secure access to main kitchen • Four are our performance risks - two ED access standards, one regarding referrals to treatment standards and one for cancer-waiting times standard, unchanged since the last paper. • Two for our patients: electronic storage of maternal CTG reports and system wide midwifery care with East Hertfordshire, unchanged since September 2022. • One for our people - consultant cover in obstetrics, unchanged. • Actions taken and mitigations in place for each of these risks are detailed in section three. One new risk scoring 16 since 2 September 2022 are: • Staffing for the catering service with actions detailed section 4. Four new risks scoring 15 are: detailed in section 5 • Haematology staffing impacting the service • 24/7 endoscopy service required for JAG accreditation • two stage consent for surgery • medical gas training required for porters							
Recommendation:	Trust board is asked to review the contents of the significant risk register							

The Princess Alexandra Hospital NHS Trust

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:	Risk Management group on 9 November 2022 Senior Management Team on 15 November 2022
	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks and those that they require assistance with to RMG on a monthly basis.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation. This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	Nil

1.0 Introduction

This paper details the significant risk register (SRR) across the Trust; the registers were taken from the web-based Risk Assure system on 26.10.22 and updated since the risk management group meeting. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

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

2.0 Context

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

There are 75 (70 on previous paper) significant risks on the risk register, an increase of 6 from the paper discussed in Septembers Senior Management Team and October 2022 Trust Board. The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Cancer & Clinical Support	5 (5)	7 (10)	1 (1)	(0)	**13 (16)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	2 (2)	4 (3)	3 (0)	(0)	**9 (5)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Governance	1 (0)	0 (0)	0 (0)	0 (0)	**1 (0)**
IM&T	1 (1)	2 (2)	0(0)	0 (0)	**3 (3)**
Integrated Hospital Discharge Team	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Learning from deaths	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Workforce - training	1 (1)	0 (0)	0(0)	0(0)	**1 (1)**
FAWs Child Health	2 (2)	4 (3)	0 (0)	0 (0)	**6 (5)**
FAWs Women's Health	4 (4)	4 (4)	4 (4)	0 (0)	**12 (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	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Surgery	3 (1)	1 (1)	0 (0)	0 (0)	**4 (2)**
Urgent & Emergency Care	3 (3)	5 (4)	0 (0)	0 (0)	**8 (7)**
Totals	**27 (25)**	**36 (36)**	**12 (9)**	**0 (0)**	**75 (70)**

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

3.0 Summary of risks scoring 20 and above

There are 12 risks with a score of 20. A summary of these risks and mitigations is below, information taken from divisional risk registers:

3.1 Our Patients

Family and Women's

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

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care to support any investigation and enable the provision of evidence should there be a need in the future. Currently produced on paper which fades rapidly. (Risk reference: 20202/06/01 raised in June 2020).
  Action: All notes where a serious incident has occurred are photocopied and stored. ATI has been completed
  Mitigations: Notes evidence is stored should a claim arise.

System working for women living in East Hertfordshire

- Women that wish to deliver at PAHT and who live in East Herts will have their midwifery antenatal and post-natal care delivered by East Herts midwives. Both trusts do not undertake the same foetal growth monitoring and their records are kept separate. This reduces compliance with continuity of carer (Risk reference: 2022/01/01 raised 21 January 2022).
  Action: PAHT midwifery staff are working with the governance team at East Hertfordshire to regularly review any issues and monitor incidents.
  Mitigation: Risk discussed at Trust board and across the Local Midwifery Network Service. Trust monitors any incidents that occur due to cross border working. October review shows no recent incident

3.2 Our People

3.2.1 Family and Women's teams -

- **Consultant cover in obstetrics**
  Consultant cover improved and achieves 87 hours per week with extra ward rounds in place as recommended in the Ockenden report. Risk that senior medical cover cannot be available should it be required immediately. There is a high potential for obstetric consultants needing to be called into the trust. The national requirement of 98 hours consultant cover is required for units with 4,000-5,000 deliveries per annum. (Risk reference: 2020/10/01 December 2020).
  Action: All consultant job plans have been reviewed and changes made to job descriptions. Four consultant posts are out to advert.
  Mitigations: Low threshold for consultants needing to return to site within 30 minutes. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations.

3.3 Our Performance

3.3.1 ED performance

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

- Compliance with the statutory standard for the Emergency department (ED) (Risk reference: 001/2017 raised April 2014)

- Achieving the standard of patients being in ED for less than 12 hours (Risk reference: 002/2016 raised July 2016)
  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 performance against internal professional standards. East of England escalation process in place to reduce ambulance offload delays.

3.3.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62-day standard (Risk reference: 005/2016 on register since July 2016)
  Actions: Tumour site recovery action plans are monitored with robust tracking to support backlog clearance trajectory. Develop and see approval of refreshed recover plan to reduce the number of long waiting patients on the patient target list. This includes improving tracking data quality and skill mix of cancer team and theatre capacity discussions. Speciality level recovery plan in place monitored daily, and reviewed at tumour site weekly meeting.
  Mitigations: Revised patient target list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway. Revision of the recovery trajectory set for 22/23.

3.3.3 Referral to treatment constitutional standards

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored and tracked by operational teams (Risk reference 006/2017 raised February 2017)
  Action: 52 week breach focus in paediatric urology due to lack of suitably qualified medical staff. Plan in place to have two visiting consultants from Addenbrooke's to review long wait patients and treat as appropriate. Address longer term service provision in discussion with Addenbrooke's and East & North Herts. 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 STP partners to manage paediatric urology and plan to address longer term service provision underway with Addenbrooke's and E&N 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 Maternity Unit

- The maternity unit requires refurbishment which has been highlighted through external visits as part of the Ockenden assurance assessment, reviews within the maternity incentive scheme and from feedback received from service users (Risk reference: 2022/04/01 raised February f2022).

Action: Development plan is being created to share with the maternity leads and options appraisal has been shared with SMT.
Mitigations: Estates and facilities are contacted where individual faults are found to complete necessary repairs

3.4.2 Pharmacy

- Aseptic unit to produce chemotherapy
  The Trust requires a new aseptic unit to comply with routine screening and lack of capacity to obtain chemotherapy from outside the trust. (Risk reference: Pharm/2014/06 on risk register since December 2014, score increased from 16 to 20 in July 2022)
  Action: Funding has been approved for the new unit by Trust board in August 2022 with a planned date for completion of new aseptic unit by 31/3/23.
  Mitigation: All quality systems ae now in use with staff training up to date on the processes to use within the aseptic unit and a standard operating procedure (SOP) is in place. Business continuity plans in place to manage potential short term breakdown of the unit and dedicated staff currently manage the work in this unit

3.4.3 Estates and Facilities

- **NEW: Electrical infrastructure**
  The current electrical infrastructure does not have the ability to cope with new developments on site that will be required to meet regulatory compliance. (Risk reference: EFM-ELEC-2022 raised June 2022 with scores adjusted after review at estates board meeting)
  Action: Business case completed for capital funding for installation of a new HV station with associated switchgear and housing to be purchased
  Mitigation: Regular generator tests and maintenance on plant with test results not showing any failure.

- **NEW: Power supply**
  To have an isolated power supply (IPS) and an uninterrupted power supply (UPS) to the Emergency department, Theatres and Intensive care unit. This will ensure that if an incident of generator failure occurs, that critical equipment can be maintained. This is a regulatory requirement to provide systems of resilience and protection to essential equipment used in these areas. (Risk reference: EFM-IPS-2022 raised June 2022 with scores adjusted with scores adjusted after review at estates board meeting)
  Action: Request for capital funding for suitable installation of IPS/UPS that has adequate backup to allow the trust to test their business continuity plans, to provide assurance that in event of generator failure critical systems can be maintained.
  Mitigation: Regular maintenance and testing of generator and testing results.

- **NEW: Secure Main Kitchen doors**
  Main kitchen requires secure one-way access doors
  Health and safety risk posed as doors are not secure and the kitchens can be accessed (Risk reference: EFM-CATDOOR-2002 raised June 2022, with scores adjusted as requires upgrade works)
  Action: Business case to be completed for Kantec intercom system
  Mitigation: Regular checks that the doors are secure

3.5 Our Pounds: Nil

4.0 One new risks with a score of 16 has been raised since 2 September 2022

4.1 Our People

4.1.1 NEW: Catering service

Insufficient staffing levels within the catering service and risk to provision of meals for patients (Risk reference SFM-Chef-20.4.2022 raised in March 2022, the score adjusted after review at estates board meeting)

Action: Booking staff via NHSP and agency to cover vacancies. Out to advert for staff

Mitigation: Review of rotas and staffing levels on daily basis. When necessary put out a reduced menu in restaurant

5.0 Four new risks with a score of 15 have been raised since 2 September 22

5.1 Our Patients

5.1.2 NEW: Haematology service that is effective, responsive and safe

There is a risk of sustainability in this service after October 2022 due to staffing issues with two consultant vacancies, one nurse specialist vacancy and a historical lack of service development to grow with increasing patient demands (Risk reference Haem/2022/01 raised in June 2022 with score adjusted in October due to changes in staffing)

Action: work ongoing to improve the culture huddle for team cohesiveness, peer review of service by external body, ongoing recruitment for consultants and review of structure within the division to create an operational focus on cancer and haematology.

Mitigation: Advanced nurse practitioner supporting the nurse specialist role and locum consultant in post.

5.1.3 Surgery

- **NEW: Consent**

  Embed a two stage consent process before undertaking a procedure and intervention (Risk reference: S&CC002/2022 approved by division in September 2022)

  Action: Audit for e-consent go live on 28/11/22 and will commence for trauma & orthopaedics, obstetrics & gynaecology. This will be monitored through divisional reporting.

  Mitigation: Theatre checklist is amended and staff will confirm consent has taken place as part of checking patient into the department.

- **NEW: Endoscopy service to obtain JAG accreditation**

  Trust is unable to provide 24 hour / seven days a week gastro-intestinal (GI) bleeding rota (Risk reference: ENDO001/2022 raised September 2022) and so lost JAG accreditation

  Action: Division developing a business case for a 24 hour/7 day a week GI bleed rota, expecting to present this to SMT in early December 2022. Trust has completed a JAG accreditation action plan

Mitigation: Loss of the JAG accreditation does not impact the clinical effectiveness of the endoscopy unit for the patients it currently treats. The JAG accreditation action plan is working towards being ready to obtain accreditation in six months.

5.1.3 Our Places

NEW: Safe handling of medical gas cylinders by porters

New staff are not trained by accredited medical gas trainer and some staff out of date for their three yearly refresher. This is statutory requirement for staff dealing with medical gas (Risk reference EFM-GAS-2022 raised in June 2022 and score with scores adjusted after review at estates board meeting)

Action: training with accredited medical gas trainer to be arranged for all portering staff

Mitigation: Only trained staff allowed to move medical gases and training records are in place.

6.0 Recommendation

Trust Board is asked to review the contents of the significant risk register.

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

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 December 2022

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2022/23
Purpose:	**Approval** ☐ **Decision** ☐ **Information** ☐ **Assurance** ☐
Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during November 2022. Updates are reflected in red font. Following discussions at Board in October 2022 it is proposed to add a new risk to the Trust's BAF. The risk relates to resilience during Winter and is described as: *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.* The risk has been scored at 12 (4x3) under the patient safety domain. The Chief Operating is the executive lead for the risk. The risk is attached as Appendix C. Risk 3.2 has been updated, the risk description revised to reflect the impact of system pressures on PAHT and the score is 16. It is recommended that this risk is reviewed at Strategic Transformation Committee going forward. The risk is attached as Appendix D. 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 new risk (BAF risk 4.1 winter resilience) and the revised risk description for risk 3.2 system pressures. - Note the updates to the remaining risks.
Trust strategic objectives:	**Patients** x; **People** x; **Performance** x; **Places** x; **Pounds** x
Previously considered by:	STC, QSC, PC and PAF in November 2022. The Winter resilience risk was discussed at EMT.
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 4.1 Winter resilience Appendix D – BAF risk 3.2 System pressures

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

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			↔	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			↔	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			↔	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			↔	10	COO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.3 PC	Workforce: Inability to recruit, retain and engage our people	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			↔	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			↔	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			↔	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 New risk	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			New risk	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			↔	12	COO
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.										
5.1 PAF	Finance – revenue: Risk that the Trust will fail to meet the financial plan due to the following factors: An indicative annual budget for 22/23 has been established.	12	12	12	12	12			↔	8	DoF

Board Assurance Framework Summary 2022.23

	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.										

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**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.1		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.	**Causes:** Overwhelming seasonal demand for the Trust's services Ageing and frail population Lack of capacity across health and social care system Increased demand and pressure on primary care Workforce challenges within EEASST Increase in mental health presentations and patients requiring support Covid waves or other infection increases	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Regular monitoring via 3 x daily site status meetings ii) ICS escalation meetings (step up when required) to compare relative risk and agree support across the system iii) Daily winter management meetings within the Trust iv) Winter capacity planning meetings - 3x a week to deliver additional capacity v) Weekly Urgent Care Board in place vi) Weekly place based operational meeting vii) Local Delivery Board in place with system partners. UEC ICS Board in place with COO representation viii) Presentation to Hertfordshire Oversight Scrutiny Committee & Essex Oversight Scrutiny Committee	i) Operational meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings vi) System Operational Group vii) Urgent Care Board viii) Elective Care Group & System Access Board	i) Monthly PRM reports ii) Monthly IPR reported to PAF/QSC and Board iii) Winter updates to PAF and Board	**4x3=12**	i) Staffing (Trust wide) and site capacity ii) System capacity and demand pressures Actions: i) Ongoing recruitment and retention plan ii) System winter action plan and additional capacity iii) Preparation of community capacity when additional funding is released by Essex County Council iv) Creation of an elective surgery surge plan to ensure elective capacity is maintained at times of significant emergency pressure.	None noted.	New risk	**N/A**	**4x3=12** **April 2023**
			Effects: Poor patient experience and safety risks Poor staff experience and low morale impacting on recruitment and retention Unstable patient flow Delayed ambulance handovers increasing safety risks Increase in patients not meeting criteria to reside Increased agency costs											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2022-23**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**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	**Causes:** i) High levels of demand in Primary care and Mental health Services ii) Inability for all parts of system to meet demand impacting on PAHT services iii) Unmet demand post Covid iv) Resource constraints in primary care v) Long term sustainability of primary care and mental health services vi) Pressures on social care to meet needs of population vii) Community service and social care package and bed availability	**4 X4= 16**	DoS Strategic Transformation Committee	i) Acute collaboration developing to focus on hard pressed specialties and access to elective surgery ii) Capital investment across the system to support elective activity and CDCs iii) WE HCP Board and increasingly joined up and aligned projects across place iv) HWE ICS oversight v) Local Delivery Board and ICS UEC meetings to support UEC actions and innovations and winter monies	Discussions at a range of meetings including: i) STC meetings ii) Trust Board meetings iii) Urgent care programme board iv) PRMs v) Divisional board meetings vi) QSC vii) PAF meetings viii) Local Delivery Board and ICS UEC meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO/COO reports to Board (alternate months) and ICS updates iii) Winter planning updates to Trust Board (October, November and December 2022)	**4 X 4= 16**	i) Primary care under-resourced ii) Workforce plan to be developed to meet demand iii) Uncertainty around Capital allocation in the long term	Lack of clear and well developed place and system plans to fully address the causes and effects	23/11/2022	**Risk description changed and risk score to remain at 16.**	**4x3=12 March 2024**
			Effects: i) Increased demand for emergency services at PAHT with consequent increase in ambulance waits and concerns regarding patient safety in emergency department ii) Increased number of patients not meeting criteria to reside iii) Double running of capacity to meet Covid demand (red ED and IP ward capacity) iv) Patients receiving care in less than optimal settings as a result of lack of flow within and outside of the hospital v) Increased pressure on staff vi) Increased expenditure to meet demand for services											

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

Agenda item:	4.2
Presented by:	Giuseppe Labriola – Director of Midwifery
Prepared by:	Erin Harrison – Head of Maternity Governance and Assurance
Date prepared:	11.10.2022
Subject / title:	Maternity Assurance Report – Quarterly review Jul-Sept 2022 (Q2)

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

Key issues:	The Maternity Incentive Scheme (MIS) Year 4 details the requirement for quarterly reporting to Board including details on number of serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance. Maternity recruitment is ongoing with healthy pipelines of midwives and support workers joining the organisation. Full compliance with the maternity incentive scheme continues to be a concern for the organisation however, good progress is being made with the maternity improvement board providing oversight. An assurance visit was completed in September by the ICB and Regional team highlighting positive improvements in the maternity service.
Recommendation:	The Board is asked to note the contents of this report.

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

Previously considered by:	To be considered at Divisional Board 26.10.22 Quality & Safety Committee (Part II) – 28.10.22
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was published in October 2021
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose/issue

This paper is to provide assurance to the Board.

2.0 Background

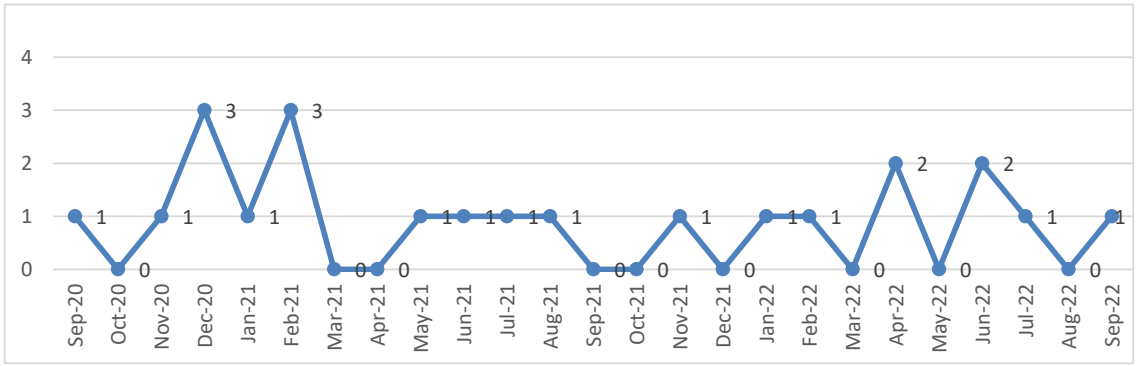
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) to continue to support the delivery of safer maternity care.
The maternity incentive scheme applies to all acute Trusts that deliver maternity services. As in previous years, members will contribute an additional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

3.0 Analysis

Serious Incidents

Maternity currently have 6 SI's under investigation, 0 of which is being investigated by HSIB, the detail can be found in Table 2. Table 1 details the trend of declared SI's within the last 24 months to September 2022.

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



There were 2 new serious incidents declared in Quarter 2 of 2022/23. The detail can be found in table 2.

Table 2. Serious Incidents declared and submitted for July-September 2022 (Q2)

	Serious Investigations	
	Number Declared for Q2 2022/23	**2**
	Number Submitted for Q2 2022/23	**2**
	Number Past CCG Deadline as of September 2022 (Not including HSIB/Approved Extensions)	**0**
	Total Open SIs for Maternity to date (including HSIB)	**6**
	New Serious Investigations declared	

Ref	Date Reported on STEIS and STEIS Code	Summary	Learning Points
Paweb ######	**July 2022** 2022/####	Baby boy born following induction of labour for a medical reason. Baby was discharged home on day 1 with a prescription for folic acid. On day 12 they were discharged from community care. On day 17 the mother reported concerns and was immediately advised to attend the emergency department. Baby was admitted for supportive care and a blood transfusion.	• Communication surrounding paediatric plan • Communication between the midwifery team and the family • Case booked for perinatal mortality and morbidity review
Paweb ######	**September 2022** 2022/#####	Concern with wired and wireless telemetry Cardiotocograph (CTG), wireless telemetry found to pick up electronic monitoring from another patient, for a short period of time and the wireless telemetry was stopped.	• Escalated to Medicines and Healthcare products regulatory agency (MHRA) and Manufacturer to review • Prompt escalation of incident by midwife • Wireless telemetry recording suspended • Escalated to national maternity team
All open serious incidents			
Paweb ###### **Awaiting SIAP**	**April 2022** 2022/####	A woman attended with gynaecology complications and following medical investigations, a small surgical object was found in the womb. Surgery was required to remove the object.	• Round table held with Trust and notes/images received. • Investigation ongoing.
Paweb ######	**June 2022** 2022/####	Woman attended in early pre-term labour in the 26th week of pregnancy. The baby was born quickly and required resuscitation but sadly died.	• In cases of preterm birth resuscitaire needs to be used via piped gases. • Neonatal Consultant to be called at earliest opportunity
Paweb ######	**June 2022** 2022/####	A woman attended the emergency department in the early second trimester of her pregnancy, less than 23 weeks. The mother collapsed and her baby was born with signs of life. The baby initially responded well to resuscitation, and was transferred to the neonatal intensive care unit (NICU). Unfortunately, the baby could not be transferred via the Paediatric and Neonatal Decision Support and Retrieval Service (PANDR), due to complications. The baby sadly died.	• Case to be used for Perinatal Mortality and Morbidity Meeting • Review of gestation and pathways of communication between the emergency department (ED) and Maternity
Paweb ######	**February 2022**	A woman in her third trimester with history of reduced fetal movements and Covid	• Cross border working with reviewing results –

With ICB	2022/####	was diagnosed with a blood coagulation disorder and very sadly her baby was stillborn. Post-mortem consistent with covid placentitis. The case involved cross border agencies.	discussions ongoing with ENHT • Communication barriers due to language barrier

Clinical Incidents

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

There has been a 7% decrease in the amount of open incidents at the end of Q2. All moderate harm incidents have had a review and all relevant concerns have been escalated through the Trust Governance processes, all relate to post-partum haemorrhages.

Table 3. Current Clinical incidents open and closed

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter	262 (94% low or no harm)
Number of Incidents Moderate Harm or Above	16
DoCs Outstanding	None
Number of Open Incidents	126 (8 moderate harm or above)
Number of Incidents Submitted for last financial year April 2021 – March 2022	1262
Percentage of Open Incidents	36%

Table 4. Legal Cases Received over Q2 (July-September 2022)

Legal Cases			
	New	**Closed**	**NHSR (Early Notification Scheme)**
Jul 2022	1	1	0
Aug 2022	3	2	1
Sep 2022	0	1	0

Perinatal Mortality Review Tool Summary

PMRT is a way to standardise perinatal reviews across NHS maternity and neonatal units.The tool ensures a high quality review and that parents are involved in the process. PAHT perform a review of cases on a monthly basis which is undertaken as a multidisciplinary panel including midwives, obstetricians, neonatologists and external experts. Reports will be published and shared with the family and placed in the medical notes.

Table 5 shows the current open cases for PAHT. All cases are within the reportable time frames for MIS Yr 4.

Table 5. Perinatal Mortality Review Tool Open Cases

Perinatal Mortality Review Tool Summary

13 open cases for PAHT
3 open with other Trusts
All open cases for PAHT have dates booked for review, the oldest case dates back to 02/12/2021 and the final report is currently being written. This report is also linked with a serious incident within the Trust.

MBRRACE-UK Real Time Data Modelling for past 6 months

The MBRRACE-UK reporting system. The system is used to report all cases of maternal death, late fetal losses, stillbirths and neonatal deaths. Table 6 shows reported cases over the last 6 months.

Table 6. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months
20 reported deaths to MBRRACE which included: 7 Antepartum stillbirths 0 Intrapartum stillbirth 1 Neonatal death 12 late miscarriage Ethnicity:

White British	10
Any other white	3
Black or Black British African	2
White Irish	1
Any other Ethnicity	2
Not Known	1
Any other Asian Ethnicity	1

External Reviews and External Scrutiny

Table 7. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*
PAHT currently have 0 cases that are under investigation by HSIB as per Table 1. Below shows the status of all reported cases to HSIB.

Cases to date	
Total referrals	15
Referrals/cases rejected	7
Total investigations to date	8
Total investigations completed	8
Current active cases	0
Exception reporting	0

On the 26th September the Regional Midwifery team undertook an assurance visit surrounding the Ockenden recommendations.
Positive practices:

- Midwifery staffing vacancy has a clear plan and trajectory to fill vacancies

- Continue medical staff recruitment to enable an increase for antenatal clinic and day assessment unit availability, improved service user waits and allocation to Triage
- PROMPT and fetal surveillance training compliance for midwives, and medical staff is good and there is a trajectory to achieve compliance for anaesthetic staff
- Preceptee packages, workshops and support
- Specific Home Birth study day
- GC 1000 research project in community
- Implementation of the research journal club
- The stop smoking service
- Postnatal contraceptive implant service
- Completion of outstanding action plans
- Equipment had annual safety checks
- Notice boards were informative and up to date
- Guideline renewal has clear processes and the majority are up to date
- Staff are receiving exit interviews to inform retention initiatives
- Supportive professional midwifery advocates, pastoral support booklet
- Introducing e-consent
- Opportunities for staff development, career clinics with the director of midwifery
- Support programme for the international recruits
- Support for maternity support worker's training
- Recovery training
- Improvement in the Bereavement room plans to sound proof
- Feedback posters from the safety champions
- Huddles and handovers are now embedded
- Culture work to improve behaviours is ongoing
- Triage area has a side room for initial triage
- COSHH substances stored securely
- Areas were clean
- Introduction of pink LocSIP boards
- Improvement with labour ward coordinators being supernumerary
- Good adherence to the uniform policy
- Going for BFI Gold standard

Areas to continue improvement:

- Ensure Triage is implemented as planned
- Allocate medical staff to Triage for every shift and a regular audit cycle for Triage, to maintain compliance with BSOTS Terms & Conditions
- Inform all staff of the plans for the cultural work
- Develop a sign up to civility framework/charter
- Review PA's for Obstetric leadership roles to align with the NHS England self-assessment tool
- Review the Obstetric workforce presence and availability due to the impact of addressing Gynaecology waits
- Support the development of community hubs
- Review scanning availability
- Development and implementation of the TC pathway and facilitate care for babies <34wks
- Improving the environment whilst awaiting the new build
- Strengthening the induction of labour processes

Quick fixes:

- Infection prevention and control issues in theatres
- Develop the plan to spend the ringfenced money from NHS Resolution CNST

- Development of nominated and engaged physicians to support the maternal medicine network pathways
- Recruit to antenatal screening vacancy
- Decide if the disabled toilet in antenatal clinic is fit for purpose

No inquests undertaken for maternity care.

Staffing

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

<table>
<tr><th colspan="4">Staffing</th></tr>
<tr><td colspan="4">Staff feedback from frontline champions and walk-abouts:

Staff have escalated concerns surrounding the shortage of midwifery staffing and IT issues on Labour Ward.

Staffing is not a concern unique to PAHT with maternity services across the country experiencing similar problems; and services identifying steps to address issues around staffing, leadership and resourcing.

A recruitment day was undertaken in Q1 with new midwives joining the workforce throughout Q2 and more to join in Q3.

There is ongoing recruitment internationally with 3 international midwives obtaining their NMC Pins.

IT issues have been escalated formally through both the Division and the Safety Champions. There is ongoing consultations with the IT team to remedy the situation.</td></tr>
<tr><td>Consultant Obstetric Cover on the Labour Ward</td><td colspan="3">87 hours cover (RCOG recommendation is 98 hours)</td></tr>
<tr><td>Junior Doctor Rota Gaps</td><td colspan="3">No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)</td></tr>
<tr><td>Midwifery and Neonatal Staffing</td><td colspan="3"><table><tr><th></th><th>Jun</th><th>Jul</th><th>Aug</th></tr><tr><td>Overall Sickness (<3.7%)</td><td>4.73%</td><td>5.55%</td><td>5.22%</td></tr><tr><td>Short Term Sick</td><td>2.38%</td><td>2.04%</td><td>2.56%</td></tr><tr><td>Long Term Sick</td><td>2.35%</td><td>2.66%</td><td>3.51%</td></tr><tr><td>Turnover (voluntary) (<12%)</td><td>17.98%</td><td>17.79%</td><td>17.82%</td></tr></table></td></tr>
<tr><td colspan="2">Proportion of midwives responding with ‘Agree or Strongly Agree’ on whether they would recommend their trust as a place to work or receive treatment (Reported annually)</td><td colspan="2">Proportion of speciality trainees responding with ‘excellent or good’ on how they would rate the quality of clinical supervision out of hours (Reported annually)</td></tr>
<tr><td colspan="2">Workshops have been booked with the Senior Leadership Team to discuss results and implement changes. Monthly feedback sessions in place via multiple sources</td><td colspan="2">Awaiting Staff Survey</td></tr>
</table>

Training Compliance

With the pandemic a decision was made to suspend all training to support safe staffing. PROMPT, Neonatal Life Support and Fetal Monitoring study days have continued to be compliant with Maternity Incentive Scheme Year 4. From July 2022 the Fetal Monitoring Study day went back to face to face training.

Table 9. Training Compliance

	Jul-22	Aug-22	Sep-22
SFH	92%	89%	95%
PROMPT	91%	91%	88%
NLS	98%	98%	97%
Appraisals	68%	69%	67.37%
BLS	71%	75%	72%
FAWS	82%	86%	88%

MIS Progress

Year 4 was launched in August 2021 with the required minimal evidential standards updated and distributed in May 2022. The 10 Safety Actions have not changed since last year's scheme however there has been inclusion of further evidence required. Once all evidence has been collated the Board will be required to sign off the scheme which will be in February 2022.

Table 10. MIS Progress Yr 4

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

In terms of Safety Action 2 current reporting reflects 9/11 scores achieved which at this time achieves the standard. There are regular meeting in place with the Digital Team to try to resolve this and has been escalated through the Divisional Board with Executive oversight.

.

Ockenden

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

The IEA are:

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

7. Informed consent

The final report was released in March 2022, the service is currently in the process of reviewing the 15 new Immediate and Essential Safety Actions. This will be monitored via the revised maternity improvement board – with a focus monthly on regulatory requirements.

Table 11. Immediate and Essential Safety Actions outcome

IEA Progress			
IEA 1	94%	IEA 5	93%
IEA 2	100%	IEA 6	77%
IEA 3	75%	IEA 7	57%
IEA 4	100%	WF	100%

Saving Babies Lives Care Bundle v2 (SBLCBV2)

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

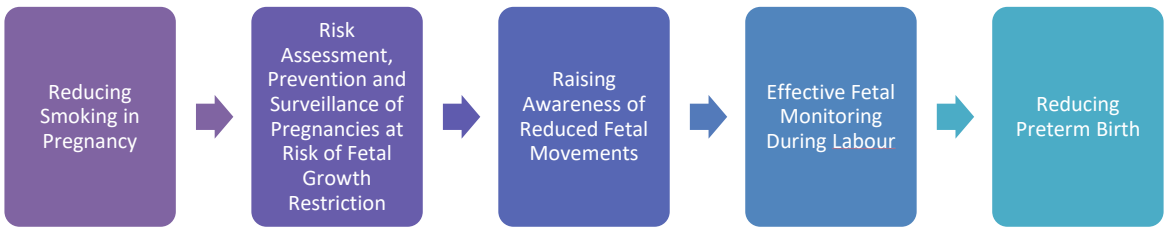


Table 12. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Compliant with all elements. No areas of concern identified.

Complaints/PALS

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

Complaints	Pals	Compliments
July – 0 August – 2 September - 1	July – 0 August – 1 September - 5	July – 1 August – 0 September – 7
Themes		
All complaints received over Q2 related to direct care provided and communication. Pals themes were surrounding communication and delay.		
Service User Feedback		

"I just wanted the time to write and say how wonderful my maternity experience has been from start to finish.

Tara in the lotus team at St.Margaret's was absolutely incredible she made me feel safe and reassured at every stage, she was calm and welcoming and went above and beyond for me as it was my second baby and I had a bad time with my first who was born at the beginning of the pandemic.

I'd also like to mention the amazing elective theatre staff and the anaesthetist Dr.Ban they were just so reassuring and made the whole experience magical again.

I don't think I can actually put into words how thankful I am, but the staff mentioned above are absolutely incredible."

4.0 Oversight

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

5.0 Recommendation

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

Author: Erin Harrison – Head of Maternity Governance and Assurance
Date: 11.10.2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

4.2

Agenda item:	4.2							
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Kate Boxall, Bereavement Midwife							
Date prepared:	14/10/2022							
Subject:	Perinatal Mortality Review Tool (PRMT) Quarter 1 2022							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This is the fourth year that NHS Resolution are operating the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The data provided in this report relates to the third year's scheme. Under the Clinical Negligence Scheme, Trusts are required to meet all ten maternity safety actions. Safety Action One relates to the use of the National Perinatal Mortality Review Tool to review perinatal deaths. This report provides information on all deaths of babies at The Princess Alexandra Hospital NHS Trust (PAHT) in Quarter 1 April/ May/June 2022 and the review process, findings and actions plans arising from the reviews. At PAHT we have a monthly PMRT meeting and all cases that meet the criteria are reviewed. Despite the limitations caused by the pandemic, the meetings continue on a monthly basis where able to do so. Currently the health group are on track to achieve the safety standard one for year four.							
Recommendation:	To provide assurance to the Board that maternity services are meeting the standards required from Safety Action One of the Maternity Incentive scheme.							

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

Previously considered by:	To be discussed at Divisional Board 26.10.22 and QSC.28.10.22.
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme – Year 4

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

2.0 Background

The required standards for meeting Safety Action One have been updated in May 2022:

a) All perinatal deaths eligible to be notified to MBRRACE UK from 6th May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by the Trust.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, from 6th May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. How are we detailing in the analysis below that we have met this section?

c) For at least 95% of all deaths of babies who died in the Trust from 6th May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by Trust staff and the baby died either at home or in the Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

d) Quarterly reports will have been submitted to the Trust Board from 6th May 2022 onward that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

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

Deaths eligible for notification from 1st January 2018 onwards are:
• Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred. • Stillbirths – the baby is delivered from 24+0 weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life. • Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. • Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth. • Post-neonatal deaths – We are no longer collecting information for post-neonatal deaths because of the difficulty in ensuring complete data collection from the wide variety of places of death for these cases.

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

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

3.0 Analysis

Since the commencement of the Maternity Incentive Scheme on 9th March 2018 there have been ninety four (94) cases reported (Stillbirths/Neonatal Deaths) that adhere to the PMRT criteria

Year	Number of cases reported
2018	17
2019	17
2020	19
2021	24

There were four deaths, notified to MBRRACE during April-June 2022 quarter 1.

Report ID	Review completed
8####	01/08/2022
8####	12/10/2022
8####	12/10/2022
8####	To be completed 09/01/22

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

Case one 8####

A Stillbirth at 33+4/40 gestation, Booked low risk, attended maternal and fetal assessment unit (MFAU) with history of reduced fetal movements, intrauterine death confirmed by ultrasound scan. Spontaneous vaginal birth of male infant, cord wrapped around neck and under both arms. Parents declined a Post Mortem, PMRT completed.

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

Issues and Actions

Issue:	Action	Implementation plan / comment	Responsible person	Target completion date
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	Training/discussions with community.	Previously actioned. Healthy Lifestyles Midwife in post.	Outpatient Matron Healthy lifestyles midwife	31/08/2022
Symphysis fundal height measurements were not performed at correct times/intervals	Training with all staff, community teams, emphasising importance at each visit.	Community Team Meeting	Outpatient matron Community Team Leaders	31/08/2022
Referrals for scans and/or further investigations were not undertaken when required	Documented on Cosmic at each antenatal appointment.	To cross reference both notes and Cosmic system.	Outpatient Matron Community Team Leaders	31/08/2022

Case two – 8####

A Neonatal Death at 22+1 gestation. The mother is White/Caucasian. Booked high risk due to anxiety and depression, confirmed placenta praevia at 20/40 ultrasound scan. Attended Emergency Department with history of vaginal bleeding. Emergency caesarean section (EMCS) and hysteroscopy in main theatres. Male infant born with signs of life, resuscitation attempted, baby lived for 55 minutes. Decision made to stop resuscitation with Consultant present. Declined post mortem. PMRT completed – being reviewed as a serious incident. Seen in sensitive clinic/postnatal consultant appointment

Grading	
Grading of care of the mother and baby up to the point of birth of the baby	The review group identified care issues which they considered would have made no difference to the outcome for the baby
Grading of care of the baby from birth up to the death of baby	The review group identified care issues which they considered may have made a difference to the outcome for the baby
Grading of care of the mother following the death of her baby	The review group identified care issues which they considered may have made a difference to the outcome for the mother

Issues and Actions				
Issue:	Action	Implementation plan	Responsible person	Target completion date
This mother had placenta accreta during her pregnancy and there was a delay in the diagnosis	Not relevant to the outcome and no action is needed. No history to suggest placenta accreta.	None required	N/A	N/A
Chromosone analysis of the baby was not carried out despite it being requested	Training to be provided to all staff regarding the use of formalin and histology/cytogenetics	Training – actioned immediately	Bereavement Midwife	30/06/2022

Case three – 8####

A Stillbirth at 34+5 weeks gestation, the mother's ethnicity is Black African. Booked intermediate care as previous hypertension and Group B Streptococcus in first pregnancy. Attended Labour Ward with back and side pain. No fetal heart when auscultated on Cardiotocograph (CTG), confirmed by Ultrasound (USS). Spontaneous vaginal birth of female infant. Declined post mortem. Seen in Sensitive Clinic/Postnatal Consultant appointment. PMRT completed.

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

Issues and Actions				
Issue	Action	Implementation/ plan/comment	Responsible person	Target completion date
This mother booked late.	Early access to care to ensure correct pathways are identified.	LMNS post to promote early access to maternity services.	Neonatal Patient Safety and Quality lead Nurse (LMNS)	31/10/2022
This mother's progress in labour was not monitored on a partogram	Sharing the learning with the trust. Discussion with labour ward team to review. Previously actioned	Daily handover reminder, fresh care review check, Dr's ward round- to check	All labour ward co-ordinators.– LW Manager LW Matron	31/10/2022

Case four – 8####

A Stillbirth at 30+3 gestation (Romanian). Booked high risk due to obstetric history and low lying placenta. 2 admissions to MFAU for reduced fetal movements. Attended USS at 30+3 for placental location when cardiac activity absent.
Emergency Caesarean Birth - Category 3 performed, umbilical cord x 3 tight around baby's neck, male infant. Declined post mortem, PMRT grading awaited as MDT delayed.

Grading	
PMRT to take place Grading and any actions will be confirmed then	

4.0 Recommendation

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

Author: Kate Boxall, Bereavement Midwife
Date: 14/10/2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

Agenda item:	4.2
Presented by:	Giuseppe Labriola, Director of Midwifery
Prepared by:	Erin Harrison, Head of Maternity Governance and Assurance
Date prepared:	31st October 2022
Subject / title:	Overview of Serious Incidents within maternity services

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

Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SIs) reports and a summary of the key issues are shared with Trust boards. There were 0 new maternity incidents declared since the last report There were 0 maternity incident closed since the last report Maternity services currently have 6 SIs under investigation (0 HSIB).
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents.

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

Previously considered by:	QSC (Part II).25.11.22
Risk / links with the BAF:	BAF 1.1 (Clinical Outcomes)
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:	n/a

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

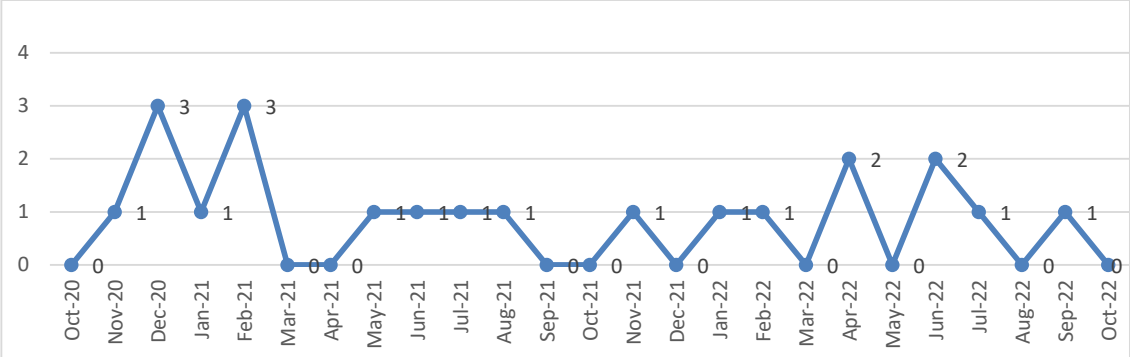
2.0 Background

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

3.0 Analysis

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

Table 1. Comparison of SIs reported for Maternity in last 24 months (to October 2022)



There were 0 new serious incidents declared in October 2022.

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

Serious Investigations		
Number Declared for October 2022		**0**
Number Submitted for October 2022		**0**
Number Past CCG Deadline as of October 2022 (Not including HSIB/Approved Extensions)		**0**
New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Closed Serious Investigations		

4.0 Themes

Table 3 details the top themes identified in maternity SIs within the last 24 months to October 2022

Table 3. Top Themes

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

5.0 Oversight

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

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

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

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

The Princess Alexandra Hospital NHS Trust

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 Harrison – Head of Maternity Governance and Assurance
Date: 31st October 2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

4.2

Agenda item:	4.2
Presented by:	Giuseppe Labriola, Director of Midwifery
Prepared by:	Giuseppe Labriola, Director of Midwifery
Date prepared:	8th November 2022
Subject / title:	Maternity and neonatal services in East Kent – the report of the independent investigation

Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper provides the Trust Board with an overview of the recommendations from 'Reading the Signals – Maternity and neonatal services in East Kent – the report of the Independent Investigation' The review was completed by a team led by Dr Bill Kirkup and was published in October 2022.							
Recommendation:	Board members are asked to reflect on the report and share their insights to inform our next steps. To note and comment on our plans to reflect as an organisation on the report and translate that learning into our existing improvement and transformation plans and governance arrangements							

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

Previously considered by:	To be considered at Divisional Board 16.11.22 and QSC (part II) 28.10.22
Risk / links with the BAF:	This report links with: BAF 1.1, BAF 2.3, BAF 3.1 and BAF 3.2
Legislation, regulatory, equality, diversity and dignity implications:	This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	1. Summary slides, key actions and recommendations

1.0 Background

The independent investigation team led by Dr Bill Kirkup, into East Kent Hospitals University NHS Foundation Trust, published a report setting out its findings and key areas where action is needed to improve patient safety in maternity and neonatal services on 19th October 2022

Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk)

The investigation was formally commissioned by the Secretary of State in February 2020. Its aim was to assess the systems and processes used by the Trust to monitor compliance and improve quality within the maternity and neonatal care pathway, evaluate their approach to risk management and implementing lessons learnt, and to assess the governance arrangements that oversee the delivery of these services.

2.0 Context

This is another devastating report into avoidable harm in healthcare, Dr Bill Kirkup stated that having examined these services between 2009 - 2020 the investigation found:

"Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor".

The report highlights several underlying issues which contributed to the cases of avoidable harm it considered, many of which we see featured in other public inquiries into unsafe care:

- Failures of team working
- Failures in professionalism
- Failures of compassion
- Failures to listen
- Failures after safety incidents
- Failures in the Trust's response, including at Trust Board level

Another recurring theme highlighted by this report is the failure at a regulatory level to identify these problems, and once identified, to take action to address them. The report states:

"We have found that the Trust was faced with a bewildering array of regulatory and supervisory bodies, but the system as a whole failed to identify the shortcomings early enough and clearly enough to ensure that real improvement followed. "

The report identifies four key areas where action is needed to improve patient safety, with accompanying recommendations:

- Monitoring safe performance – finding signals among noise
- Standards of clinical behaviour – technical care is not enough
- Flawed team working – pulling in different directions
- Organisational behaviour – looking good while doing badly

There are 5 recommendations in this report, one of which relates to East Kent's acceptance of the report finding. The remaining 4 are below and available in further detail within Appendix 1.

True transformation of maternity services can only happen by demonstrating compassion, listening to women and families and responding to their needs and individual experiences. The report details a need to establish a transparent and trusted system that can monitor performance, investigate incidents and promptly identify and improve services.

NHS England have asked all Trust Boards to review the findings of this Report at their next public Board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

4.0 Recommendation and next steps

Through our existing maternity governance forums, we are reflecting on the report. We will then translate this reflection and learning into our existing programmes of improvement and transformation so that recommendations from this Report are actioned and embedded systematically and in a sustainable way

We will present and discuss our detailed learning from this report at Quality and Safety Committee in advance of a presentation to the Trust Board at its next public board meeting.

We welcome the single delivery plan for maternity and neonatal care that NHS England plan to publish in 2023. This plan will bring together action required following this report, the report

into maternity services at The Shrewsbury and Telford NHS Foundation Trust, The NHS Long -Term Plan and Maternity Transformation Programme deliverables.

Board members are asked to reflect on the report and share their insights to inform our next steps. To note and comment on our plans to reflect as an organisation on the report and translate that learning into our existing improvement and transformation plans and governance arrangements

Author: Giuseppe Labriola, Director of Midwifery
Date: 8th November 2022

Reading the signals

Maternity and neonatal services in East Kent – the report of the independent investigation

Giuseppe Labriola

Director of Midwifery

Kirkup report briefing

- Dr Bill Kirkup was asked to review Maternity Services at East Kent Hospitals University NHS Foundation Trust by the Secretary of State
- Had care been given to the nationally recognised standards **the outcome would have been different** in more than 97 (48%) of the 202 cases assessed and 45 (69%) of the 65 baby deaths.
- There were at least 8 opportunities where problems could have been acknowledged and tackled differently
- The harm was not restricted to physical damage but the disturbing effects of repeated lack of compassion and kindness
- The report is structured into the following findings: what happened to women and babies, failures of teamworking, failures of professionalism, failures of compassion, failures to listen, failures after safety incidents, failure in the Trust's response (including at Trust Board level), the actions of regulators, missed opportunities and where accountability lies

Key action 1: Monitoring safety performance: finding signals amongst the noise	**What was found** • No reliable early warning system/ mechanism in place to monitor safety in real time, • identify relevant signals in relation to perinatal outcomes • No meaningful, reliable, risk adjusted, timely outcome measures • Often maternity outcome data concealed the truth amongst generic groups, league table and spurious rankings
	The Future • Identification of early warning signs where action can be taken before problems and behaviours become embedded • Regulators can identify units that are outliers and investigate appropriately • All parties can have a conversation based on relevant shared information • Measures utilised are meaningful, risk adjustable, available and timely and presented in a way that is relevant **Recommendation 1: The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.**
Key action 2: Standards of clinical behaviour – technical care is not enough	**What was found** • A failure to listen directly to women affected patient safety • Equal need for staff to behave professionally and show empathy • Openness and honesty at all times was not evident - institutional defensiveness, blame shifting and punishment was inherent • Women's voices were not given the regard required • Stubborn and entrenched poor behaviour across all clinical groups was normalised and tolerated however should be managed in a timely and similar way • The influence of senior role models impacted on all staff • When issues were highlighted they were dismissed, challenged or ignored
	The Future • Compassionate care should be re-established and reemphasised • Every interaction should be based on kindness and respect, achieved via the attitudes and behaviours of clinicians themselves • Professional behaviour and compassionate care should be embedded into training and CPD Importance of listening to women must be re-established and mastered as part of clinical practice • Staff should acknowledge and accept the authority of those in clinical leadership roles (which are essential for the effective and safe functioning of the service) and they must have time and skills to carry them out • Reasonable and proportionate sanctions are required for employers and regulators to address poor behaviours **Recommendation 2: Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.** **Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance**

Key action 3: Flawed teamworking – pulling in different directions	**What was found** • Dysfunctional team working • Poor relationships between and within professional groups - teams did not share a common purpose • Toxic and stressful working environments • Arguments occurring in front of women and families • Failure of trust and respect • Different staff groups seen as defenders and inflictors of medicalised care • Clinicians in training felt isolated, exposed and vulnerable - worked unsupervised in complex situations beyond their experience
	The Future • Find a stronger basis for teamworking in maternity and neonatal services based on an integrated service and workforce with common goals and a shared understanding of the individual and unique contribution of each team member in achieving them (there should be no different objectives for an professional group) • Teams who train together work better together over and above the use of emergency drill training (form undergraduate training onwards) • Re-evaluation of the changed patterns of working and training for junior doctors (unintended consequences of fragmentation of work and support given **Recommendation 3: Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.** **Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development**
Key action 4: Organisational behaviour – looking good while doing badly	**What was found** • Reputation management was prioritised to the detriment of being open and straightforward with families, with regulators and with others • Concerns were dismissed and complaints were managed rather than seen as a source of feedback and learning • There was too much effort spent on seeking to challenge and undermine scrutiny from external reports • Pattern of hiring and firing of the senior teams (frequent short term appointments may be counterproductive) • Ethos of 'heroic leadership' followed by high levels of criticism
	The Future • The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment • Need for the introduction of legislation to oblige public bodies and officials to make all of their dealings, will families and with official bodies, honest and open (previously outlined in a public authority bill) • When families experience harm the response must be based on compassion and kindness as well as openness and honesty • Organisations have a lasting duty of care • Review of the regulatory approach to failing organisations by NHSE would identify alternatives to heroic leadership model including the provision of support of trusts in difficulty and incentives for organisations to ask for help rather than conceal the problems • The identification of problems should not be seen as a sign of individual or collective failure but as a sign of readiness to learn **Recommendation 4: The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.** **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards** **NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership**

Kirkup report briefing

PAHT next steps:

- Series of discussion workshops with staff
- Support with taking the report to their Board
- Maternity leadership team will signpost or mobilise support for staff
- Webinar with MVP and PAHT staff to maintain the confidence of local families in maternity services – local communications on safe services
- NHS England will develop a refreshed national delivery plan in the Winter with PAHT engaged in the process
- Wider implications for services beyond Maternity & neonatal – especially given reflections on governance, learning from incidents, culture, complaints, listening to patients & families and Freedom to Speak Up. To have as a discussion topic at SMT
- Reflections, implications and new ways of working for service being considered by the leadership team

Trust Board (Public) – 1 December 2022

Agenda item:	4.3							
Presented by:	Sharon McNally – Director of Nursing, Midwifery & AHPs							
Prepared by:	Sarah Webb – Deputy Chief Nurse, Giuseppe Labriola, Director of Midwifery							
Date prepared:	17.11.2022							
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels for October 2022 and an update to Nursing and Midwifery Workforce Position – Hard Truths Report							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	Part A: Overall staffing risk rating in month: Amber with a stabilisation being seen with the RN/M fill rate (87.6%). The fill rate of HCSW has decreased by 3.6% to 102.5 %. Nightingale ward opened as winter escalation in month adding additional demand and impacting on staff redeployment data as staff have been moved to support new team. Day fill rates remain lower than night fill. Additional staff including ward managers, matrons and specialist nurses are available during days to support safe staffing. Part B: Maternity staffing. There continues to be challenges across the maternity staffing, and the compliance with the Birthrate Plus acuity application continues to be a focus to enable accurate reporting. Of note, a number of midwifes and support workers have joined the ream, which will have a positive impact over the coming months							
Recommendation:	The committee is asked to note the information within this report.							

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

Previously considered by:	PC.28.11.22
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18

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

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

1.0 BACKGROUND

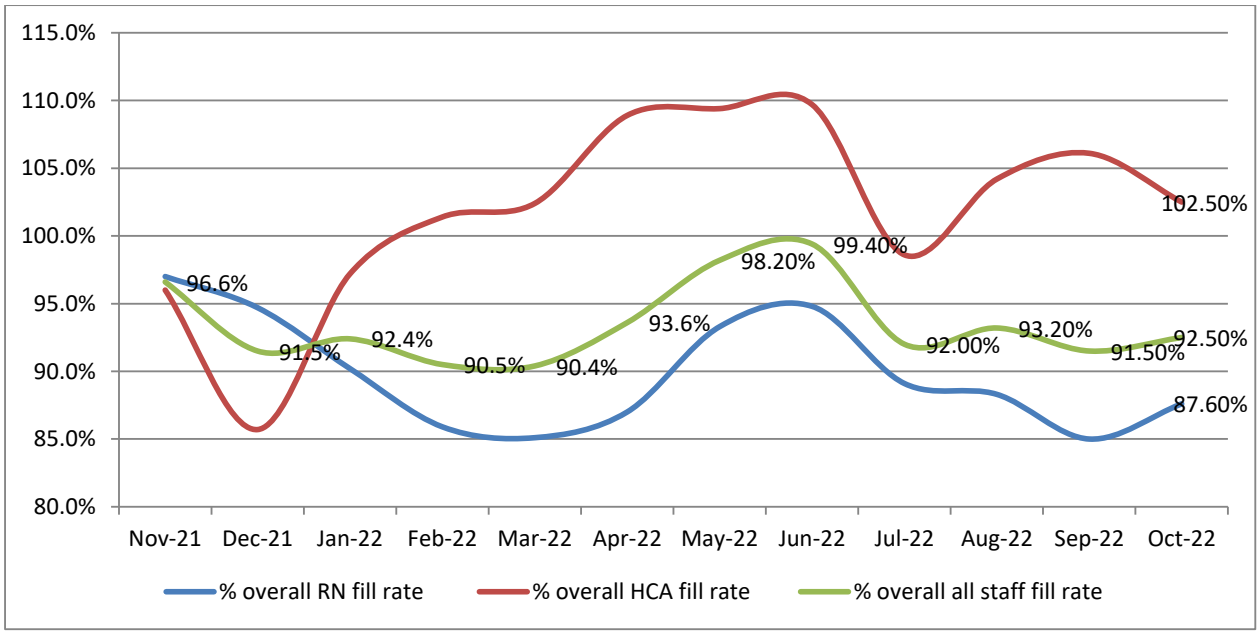
The report is collated in line with The National Quality Board recommendations (June 2016).

2.0 ANALYSIS

2.1 Fill rates for areas submitted to UNIFY:

Overall fill rates for October were 92.5%. RN fill rate increasing by 2.6% to 87.6% and care staff fill rates decreased by 3.6% to 102.5%.

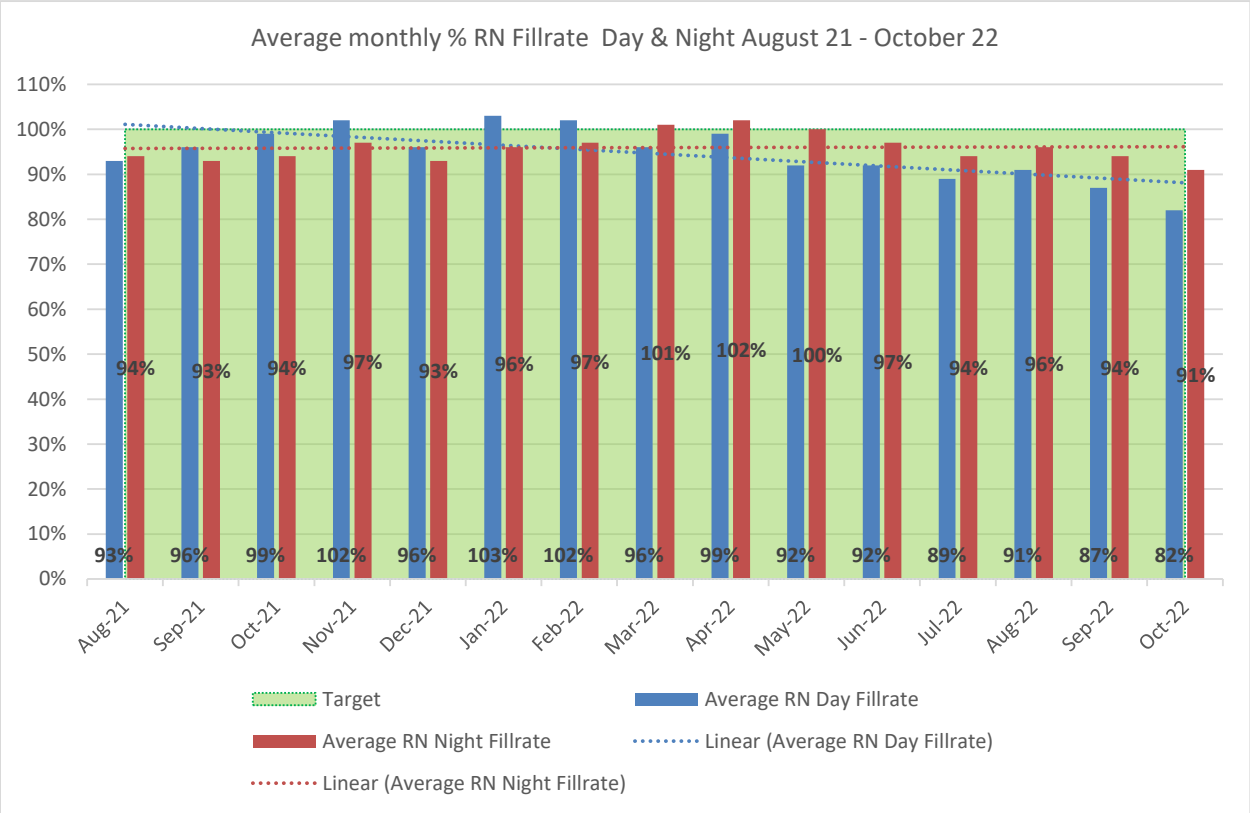
Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average September 2022	83.8%	103%	86.5%	109.9%	85%	106.1%	91.5%
In Patient Ward average October 2022	86.4%	95.2%	89.2%	111.2%	87.6%	102.5%	92.3%
Variance September 2022 – October 2022	↑2.6%	↓7.8%	↑2.7%	↑1.3%	↑2.6%	↓3.6%	↑1.8%



2.2 Fill rates for areas not covered by UNIFY:

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
August 2022	90.8%	74.7%	96.3%	77.5%
Sept 2022	87.3%	72.8%	93.6%	73.1%
October 2022	81.9%	77.2%	90.9%	75.7%

Staffing within ED remains subject to a CQC Section 31 notice. There is bi weekly executive oversight of the nursing (and medical) retrospective and prospective fill rates prior to monthly submission of the data to the CQC. The following graph shows the trend in fill rate since August 2021 when the improvement notice was served.



2.3 Fill rates by ward:

Tye Green Ward reported average fill rates below 75% for RN against the standard planned template during October. While the overall fill rate was 79%, the RN fill was 67.3% with the HCA 97.7%. This is the second consecutive month overall fill rates have been below 75%. Details on impact on care can be found in Appendix 2a

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

Date	Ward name	% RN overall fill	% overall ward fill
October 22	Tye Green Ward	67.0%	79.0%
	Lister	74.3%	86.6%
	Tye Green	70.6%	83.3%
September 22	ITU & HDU	68.6%	67.4%
August 22	Locke	70.3%	87.4%

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

(Appendix 2c) The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) decreased to 217 (↓43) against September. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

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

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded had increased in month to 74 (↑22), AAU raised 14, with A&E 12, Tye Green 9 and Kingsmoor raising 7 Datix reports in relation to staffing levels. ***(Appendix 2e).***

2.5 Care Hours per Patient Day* (CHPPD):

October CHPPD is 6.7. **Appendix 3a** shows the Trust comparative CHHPD data via the Model Hospital portal based on August 2022 data

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

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

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

October 2022									
	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts	Change in fill from previous month
RN	3834	2187	57.0%	582	15.2%	72.2%	1065	27.8%	↓7.9%
HCA	1981	1622	82.7%	0	0%	82.7%	339	17.3%	↓3.3%
RMN	359	21	5.8%	295	82.2%	88.0%	43	12%	↓0.9%

In October, there was an increase in registered nursing demand ↑348 shifts compared to September; there was a reduction in fill rate from 80.1% in September to 72.2% in October

To support patients requiring enhanced care there has been increased demand for RMNs. These shifts are created by Matron or above level to add a level of assurance regarding the need. The Trust is appointing an RMN lead nurse who will work in conjunction with the Lead Nurse for Falls & Enhanced Care and the Interim Safe Staffing Lead to ensure that the requirement is validated and the patients' needs can only be meet by a RMN.
In October there was an increase in RMN demand ↑27 shifts requested compared to September; there was a reduction in fill rate from 88.9% in September compared to 88.0% in October. ***(RMN shift data Appendix 4)***

2.7 Redeployment of staff:

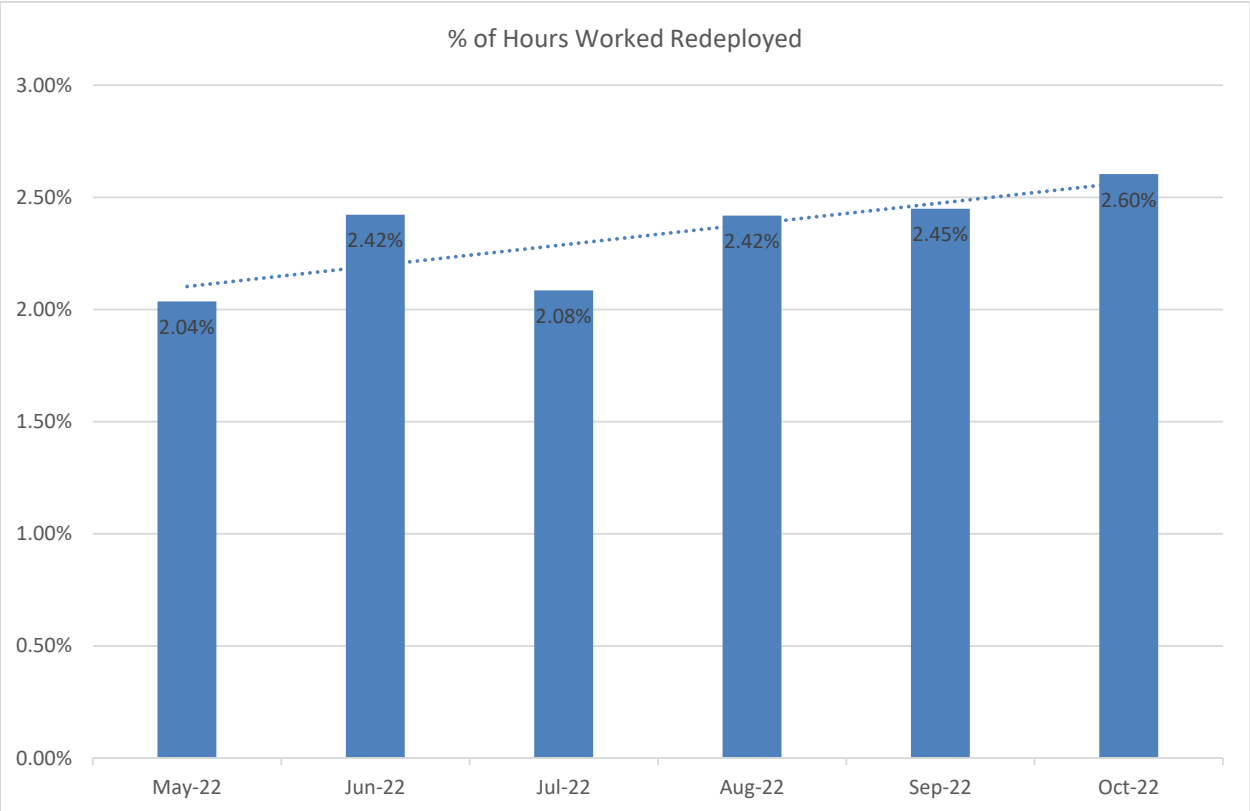
The table below shows how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The data does not capture the moves of bank or agency staff; (including multi post holders). Also excluded are the Maternity Wards and the Enhanced Care Team.

The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare systems. While essential

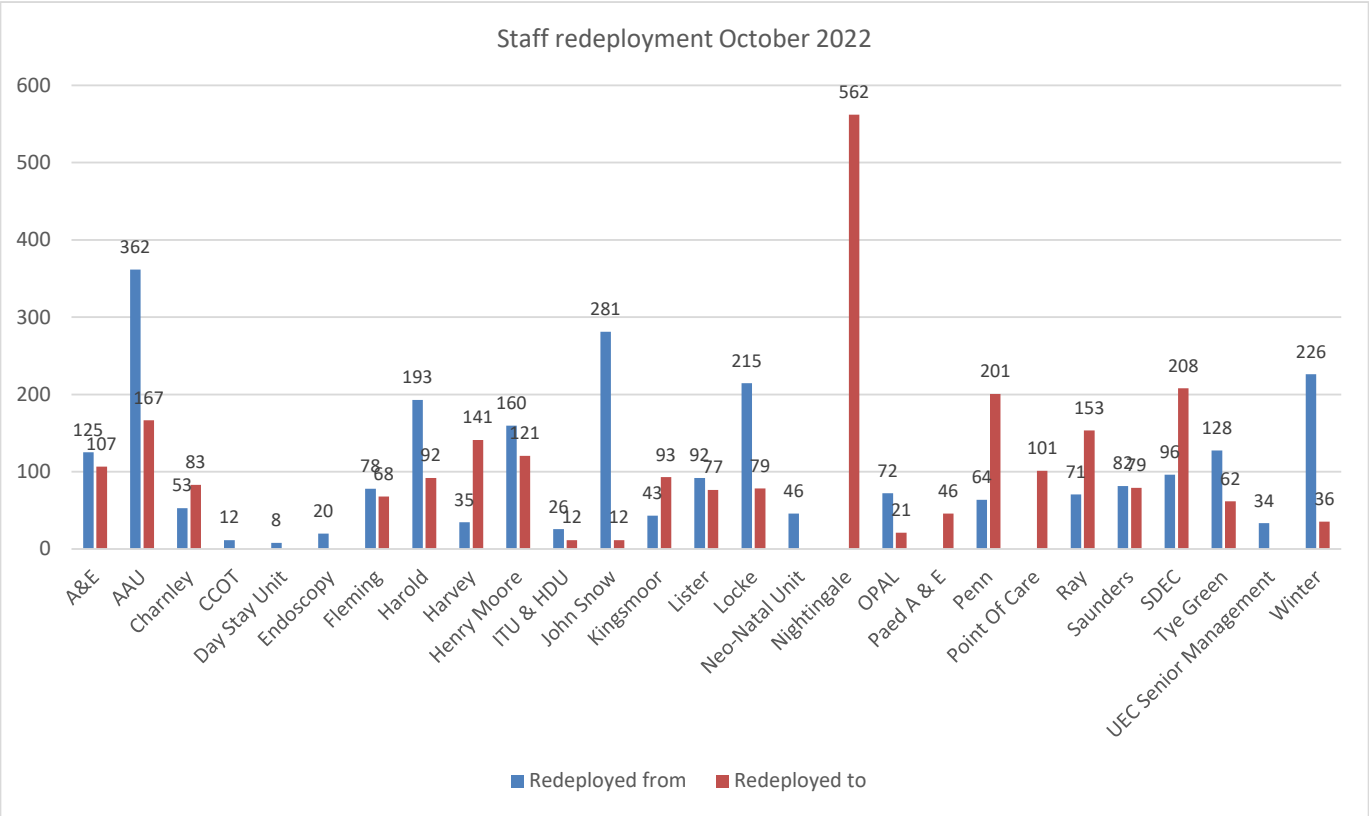
to ensure the safe staffing across the Trust moving substantive staff can impact with poor staff satisfaction and retention rates and therefore is monitored closely to minimise the impact on staff.

The senior nursing leadership teamwork closely with ward managers and teams to ensure there is understanding of the rationale for moves and to ensure there are positive conversations.
The data shows the number of hours of staff worked, the hours redeployed and the percentage of hours worked redeployed to support safe staffing.
The graph shows the trend over the past 6 months, which shows an increase in October which was driven by the opening of Nightingale as an escalation ward.

Date	Total Hours Worked	Total Hours Worked Bank / Agency	Total Hours Worked Excluding Bank & Agency	Total Hours Redeployed	Total Hours Not Redeployed	% of Hours Worked Redeployed
May-22	136878	35846	101032	2057	98975	2.04%
Jun-22	119226	34626	84600	2049	82551	2.42%
Jul-22	164004	2694	161310	3363	157947	2.08%
Aug-22	131738	29531	102207	2472	99735	2.42%
Sep-22	127962	32578	95384	2336	93048	2.45%
Oct-22	130530	39124	91406	2380	89026	2.60%



The following graph shows the hours moved from ward to ward during October 2022. The highest exporter of staff continues to be AAU.



NB Moves of staff into Nightingale as the ward opened as winter escalation ward at the beginning of the month. Substantive staff have been redeployed for the duration of winter to support continuity of care but the rota moves will be reflected in October.

Part B Midwifery Staffing

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

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

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

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

A number of newly qualified midwives have joined the service and have been at varying stages of their orientation. During this period, they are rostered on the e-rostering system as supernumerary or as pre-registration (Band 4) therefore there will be an element of increased fill rates for midwives and support workers due to this supportive time.

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

	Fill Rates LW Registered Midwife (RM)		Fill rates LW Maternity Care Assistants (MCA)		Fill Rates Birth Centre RM		Fill rates Birth Centre MCA	
	Day	Night	Day	Night	Day	Night	Day	Night
October	100%	75%	88.2%	78.8%	125.1%	95.1%	90.7%	93.5%

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

	Fill Rates AN ward RM		Fill rates AN ward MCA		Fill Rates PN ward RM		Fill rates PN ward MCA	
	Day	Night	Day	Night	Day	Night	Day	Night
October	107.5%	63%	92.3%	100%	108.5%	74.8%	125.4%	111.1%

Intrapartum acuity:

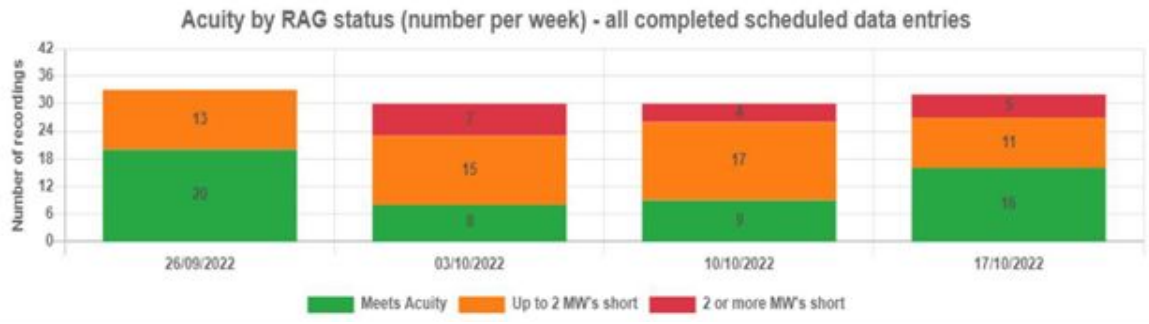
The maternity service implemented the use of the Birthrate Plus intrapartum acuity tool in 2021. The data is inputted into the system every 4 hours by the Labour Ward Co-ordinator and measures the acuity and the number of midwives on shift to determine an acuity score. Birthrate Plus defines acuity as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

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

During the reporting period of October, the Labour Ward did not achieve an 85% confidence factor in the month – 74.4% compliance of the tool was achieved. 42% of recordings were made where staffing met acuity. The majority of negative acuity is amber with up to 2 midwives short with a much smaller percentage of occasions being red which equates to 2 or more midwives short.

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

Table 3. Intrapartum Acuity



Red flags:

In total there were 14 red flags recorded during this reporting period. The majority of these related to delays in the induction of labour process (n=1, 7%) and the co-ordinator not able to maintain supernumerary status (n=8, 62%). All delays for induction of labour and the inability for the co-ordinator to be supernumerary will be incident reported via the DATIX system and thoroughly reviewed.

Action: There is a working group in progress reviewing the process of Induction of Labour. This includes improving the flow of activity through the unit and to minimise delays in transfer.

1:1 care in established labour:

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

Supernumerary status of the coordinator :

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 9 occasions (64%) during the reporting period.

Action: As part of the investigations into the loss of supernumerary status by the co-ordinator, the individual senior midwives have been supported to understand the recognition and actions required to address the red flags. It has been confirmed that the co-ordinator was supernumerary over these 9 episodes. Further amendments to the Birthrate Plus application are required and further training for midwives will be organised.

Specialist Midwives:

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

During this reporting period there were 331 management actions taken. The majority of these related to redeploying staff internally (n=77, 23%), additional staff sourced from bank/agency (n=49, 15%), staff unable to take breaks (n = 14, 4%) and escalation to the manager on call (n=32, 10%). On (n=25, 8%) occasions the on call continuity of carer midwives were in the maternity unit to support and the birth centre closed (n=88, 27%). On (n=5, 2%) specialist midwives were working clinically.

Action: The Triage Service is planned for a go live date on the 28th November which will transform the flow and activity on the Labour Ward. Roster review meetings with Matrons and the staffing co -ordinator

have been planned 2 weeks prior to roster approvals to resolve rota gaps. A new “break shift” has been created with a midwife allocated for formal break relief daily – this role will be evaluated for effectiveness. Multidisciplinary recruitment meeting arranged to plan quarterly recruitment events. Eighteen Newly qualified midwives have now completed their orientation. Two further international midwives join the Trust this month (November). Five more newly qualified midwives join in January 2023. Two registered nurses are beginning the process of starting the midwifery short course. One international nurse joins the service this month also. These new additions to the team will also support a reduction in red flags.

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

October	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Labour Ward	14	0	9 (adjusted to 0)	331	42%	13%	45%	125/168	74.4%

Maternity inpatient wards:

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

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

October	Red flags	Extra Care breakdown	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Antenatal Ward	15	8% exceptional care needs 92% safeguarding	6	30%	0%	18%	33/84	39.29%
Postnatal Ward	1	31% extra care babies, 7% exceptional care needs 8% Safeguarding	2	29%	6%	8%	49/84	58.33%

Antenatal Ward - During this reporting period there were 6 management actions taken. The majority of these related to redeploying staff internally (n=1, 17%) and specialists/managers working (n=3, 50%). In total there were 15 red flags recorded during this reporting period. The majority of these related to delays in time critical activity (n=13, 87%) and delay in admission and beginning of induction process (n=2, 13%).

Postnatal Ward – During this reporting period there were 2 management actions taken which were escalate to manager on call (n=2, 100%). In total there was 1 red flag reported. This related to delay in in time critical activity (n=1, 100%)

Action: The Induction of labour workstream for the maternity improvement board continues to progress various elements as previously shared: daily review of those waiting for transfer to labour ward, digital booking, alignment with the Local Maternity and Neonatal System Induction of Labour (IOL) pathways and review of assessment for IOL using a Bishop Score system. Where red flags are raised with delays these are highlighted at the Safety Huddle, which occurs daily. Additionally, in response, risks to ensure that women and their babies are safe and the necessary actions are taken by the team, to address issues where needed. All antenatal women are seen on the daily ward round and by the senior leadership team to address concerns with delays should women and partners be concerned. The IOL workstream moving forward will have the addition of either the Maternity Transformation lead or the Head of Midwifery. Birth Rate plus training for the ward managers is planned, to improve confidence factors, this is now critical and will be escalated along with local communications to raise the profile and compliance of the data, via safety huddles and handovers. Four nursery nurses have been successfully recruited this month and four volunteers are completing their training to support infant feeding, on the postnatal ward.

B: Workforce:

4.0 Nursing Recruitment Pipeline:

Registered Nurse pipeline for 2022/23.

Current vacancy rate is 12.3% for Band 5 and 7.2% overall. Recruitment for international nurses is ongoing, with a recruitment event in India planned for November. It is anticipated that we will require 150 international nurses over the next year to reduce the vacancy rate to less than 3% considering turnover and projected local recruitment. NHSI funding is available to support recruitment costs. Turnover has increased slightly again in month at 16.46%

There are currently 29 Registered Degree Nurse Apprentices at varying stages of their training.

Healthcare Support Worker pipeline

HCSW vacancy rate in October was 9.2%. Recruitment activity continues to be successful with open recruitment events run by the Divisions regularly.

Turnover has increased in month to 27%. Work continues to reduce including collaborative work with ICB and regional partners with the aim to drive down the vacancies and increase the stability of our support workers.

.

5 RECOMMENDATION

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

Author: Sarah Webb: Deputy Chief Nurse / Giuseppe Labriola: Director of Midwifery
Date 17.11.2022

Appendix 1

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

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

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	76.1%	107.7%	81.5%	96.8%	78.8%	102.2%	80.6%
Saunders Unit	79.9%	102.1%	88.3%	122.4%	83.5%	109.8%	92.9%
Nightingale	75.6%	120.0%	106.7%	200.7%	87.4%	158.6%	107.6%
Penn Ward	85.6%	102.5%	83.9%	138.7%	84.9%	116.2%	96.1%
Henry Moore Ward	98.8%	123.7%	98.4%	135.8%	98.6%	129.2%	109.0%
Harvey Ward	77.2%	101.0%	93.6%	110.4%	83.9%	105.5%	91.7%
John Snow Ward	106.2%	41.5%	103.4%	74.2%	104.8%	51.8%	81.9%
Charnley Ward	84.4%	99.3%	84.5%	117.7%	84.5%	108.1%	91.2%
AAU	117.8%	101.5%	101.1%	115.4%	109.5%	108.2%	109.1%
Harold Ward	78.2%	60.2%	88.5%	101.2%	82.7%	76.9%	80.4%
Kingsmoor General	79.3%	110.1%	91.9%	104.6%	84.7%	107.5%	93.8%
Lister Ward	76.7%	105.7%	86.4%	119.7%	80.8%	112.4%	93.4%
Locke Ward	82.3%	98.3%	101.6%	93.6%	90.5%	96.0%	92.7%
Ray Ward	85.3%	86.8%	92.8%	132.0%	88.5%	108.4%	94.6%
Tye Green Ward	60.8%	91.1%	75.1%	107.4%	67.0%	97.7%	79.0%
OPAL	77.0%	219.2%	104.8%	114.3%	87.6%	151.3%	111.1%
Winter Ward	83.8%	82.3%	94.1%	111.6%	88.2%	96.3%	91.4%
Fleming Ward	80.4%	101.7%	109.2%	119.0%	91.9%	109.9%	97.3%
Neo-Natal Unit	94.2%	109.3%	90.3%	109.7%	92.3%	109.5%	95.1%
Dolphin Ward	93.5%	44.9%	103.4%	72.8%	97.9%	54.2%	87.0%
Total	72.2%	94.4%	91.6%	113.5%	80.1%	103%	87.0%

Appendix 2a: Ward staffing exception reports

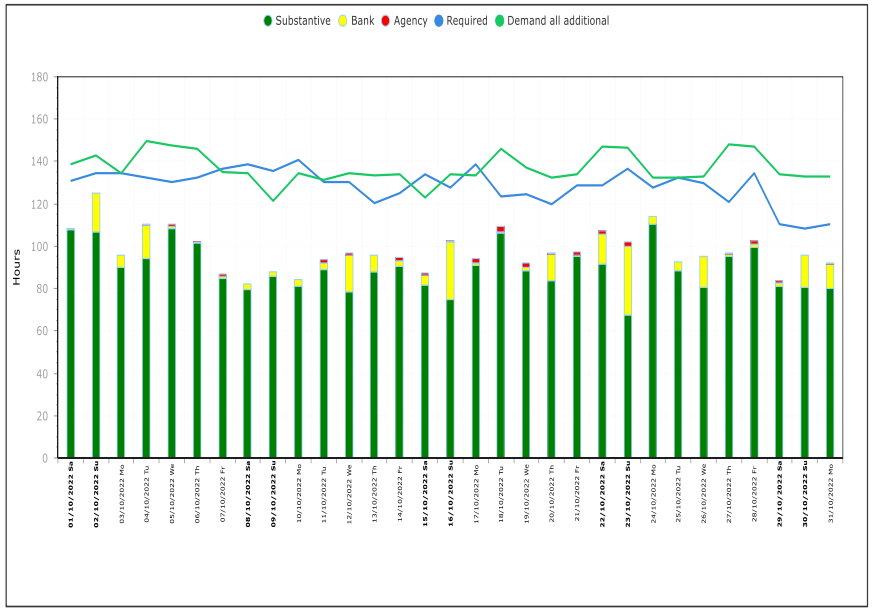
Reported where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. Please note further review of data sets will enable a more robust and detailed analysis going forward (October data)

Report from the Associate Director of Nursing for the HCG

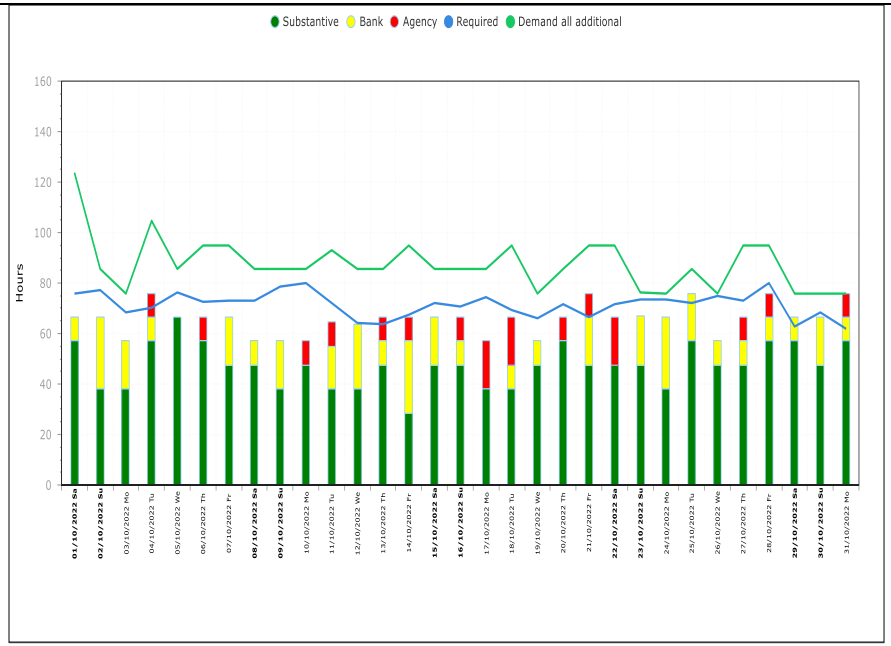
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Tye Green	Tye Green had a high rate of sickness in October at 7.1% attributable to short term Covid-19 related sickness 2 Band 6 promoted to Ward Manager post on other wards in medicine. 2 Band 5 on Maternity Leave	• The award had an increase in the number of falls but no increase in level of harm • No increase in reported pressure ulcers • No increase in incidents raised due to staffing below ward template • 100% NEWs2 Compliance	• Ward Manager working clinically where there are staffing short falls. • Safer Staffing review 3 times daily and redeployment of some staff not captured on Safecare (Outpatients and Practice Development team). • Tye Green- 1 new starter RN in October 22 • Active recruitment into Band 6 vacancies • Management of sickness according to Trust Policy • Immediate escalation of patient safety concerns from ward team and re-review of division wide staffing. Ward safety huddles to assign staff to meet patient needs

Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	6	10	8	0	tbc	0	2

Required vs Actual Day



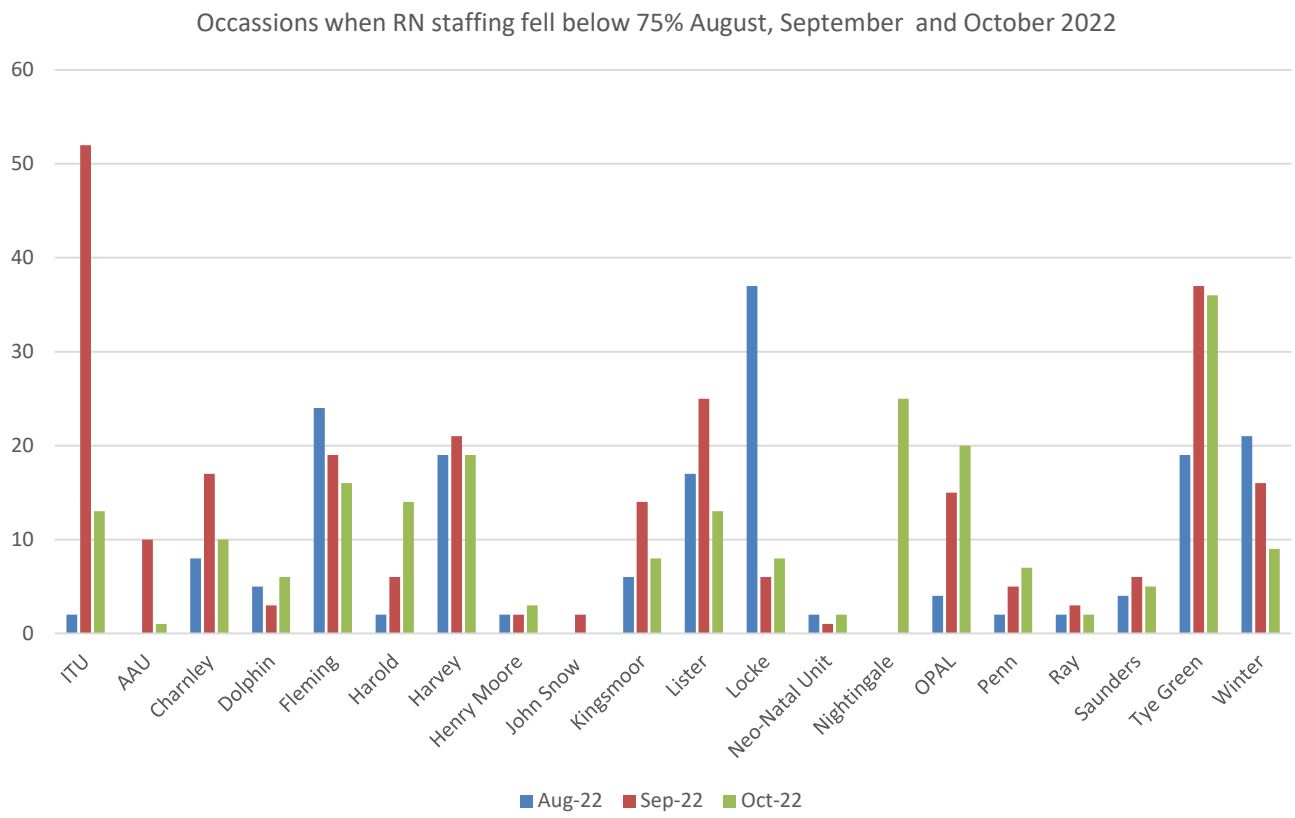
Required vs Actual Night



Appendix 2b: Red flag data

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

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



Appendix 2c: Nursing Red Flags (NICE)

The National Institute for Health and Care Excellence (NICE) guideline Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)1 recommends red flags relating to adult inpatient wards.

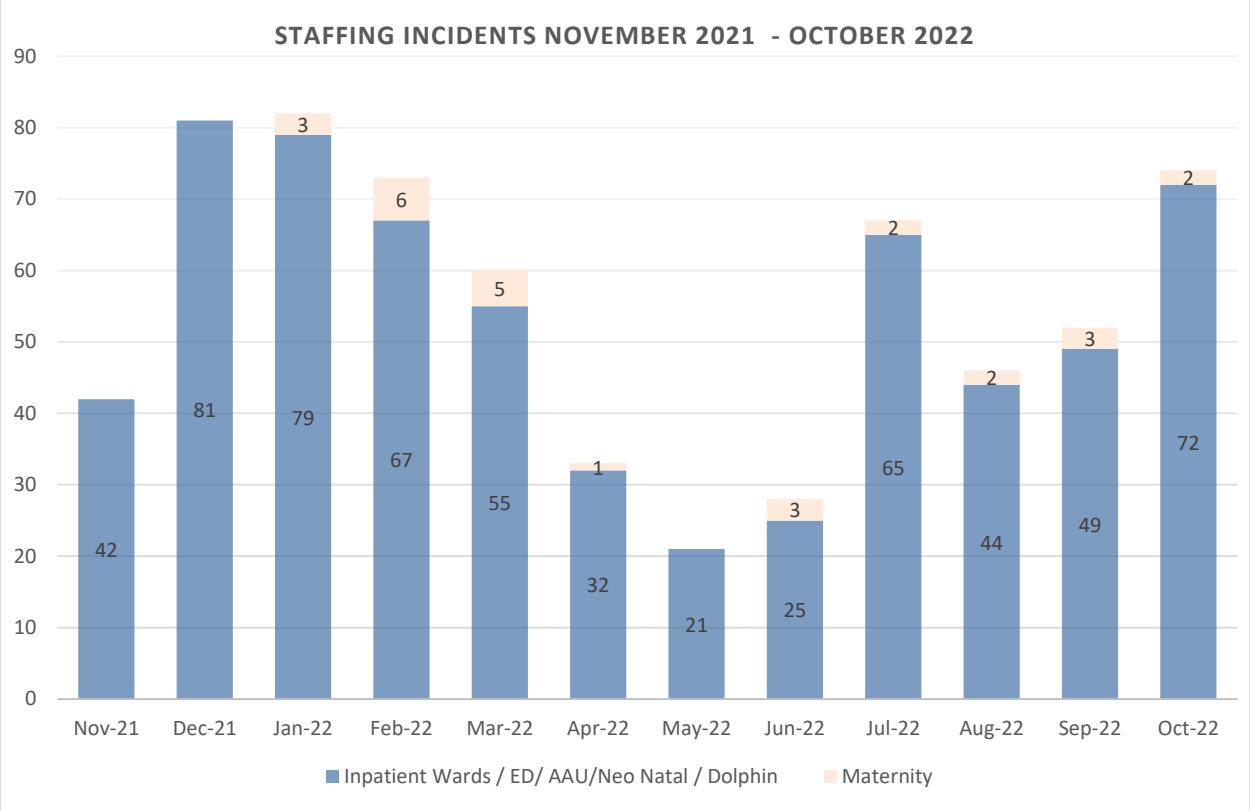
Recommendations for the registered nurses on wards who are in charge of shifts are:

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

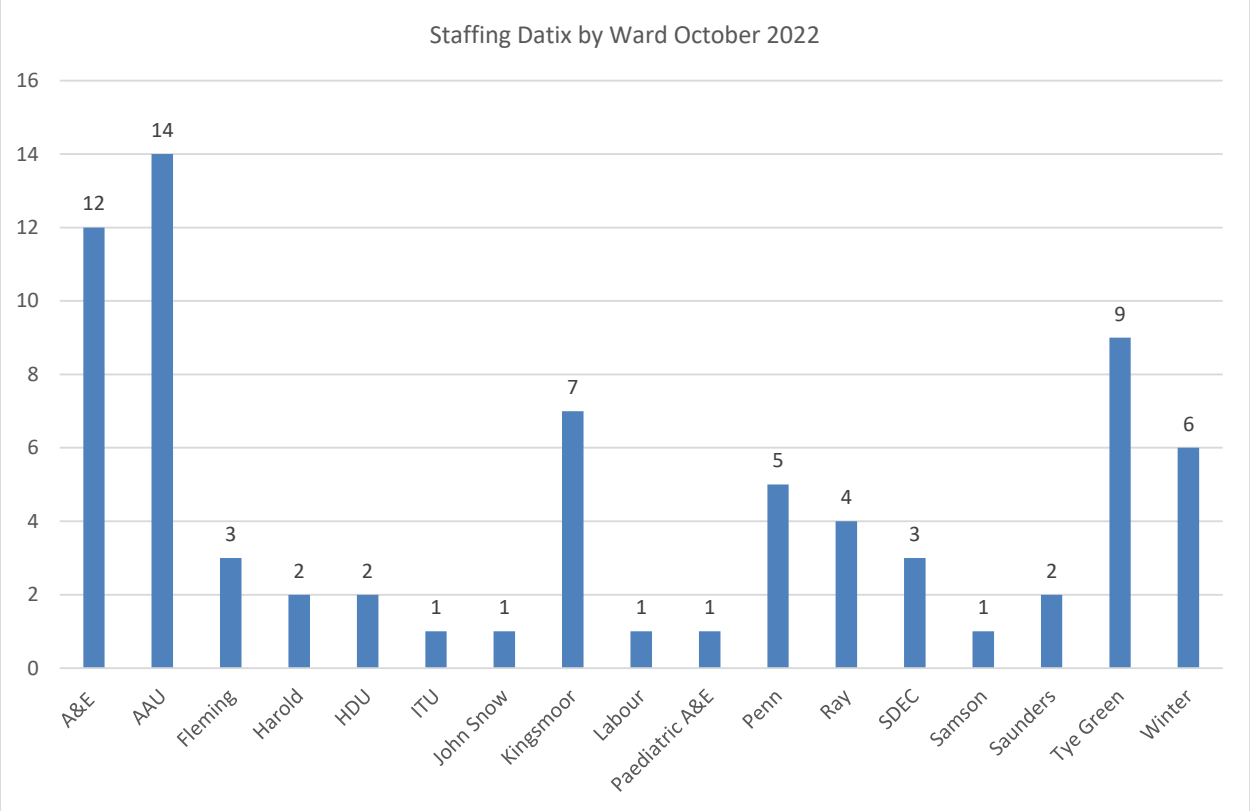
Nursing red flags

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

Appendix 2d: Staffing Incidents Trend Data



Appendix 2e: Staffing Incidents by Ward October 2022



Appendix 3 Care Hours per Patient Day (CHPPD):

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

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

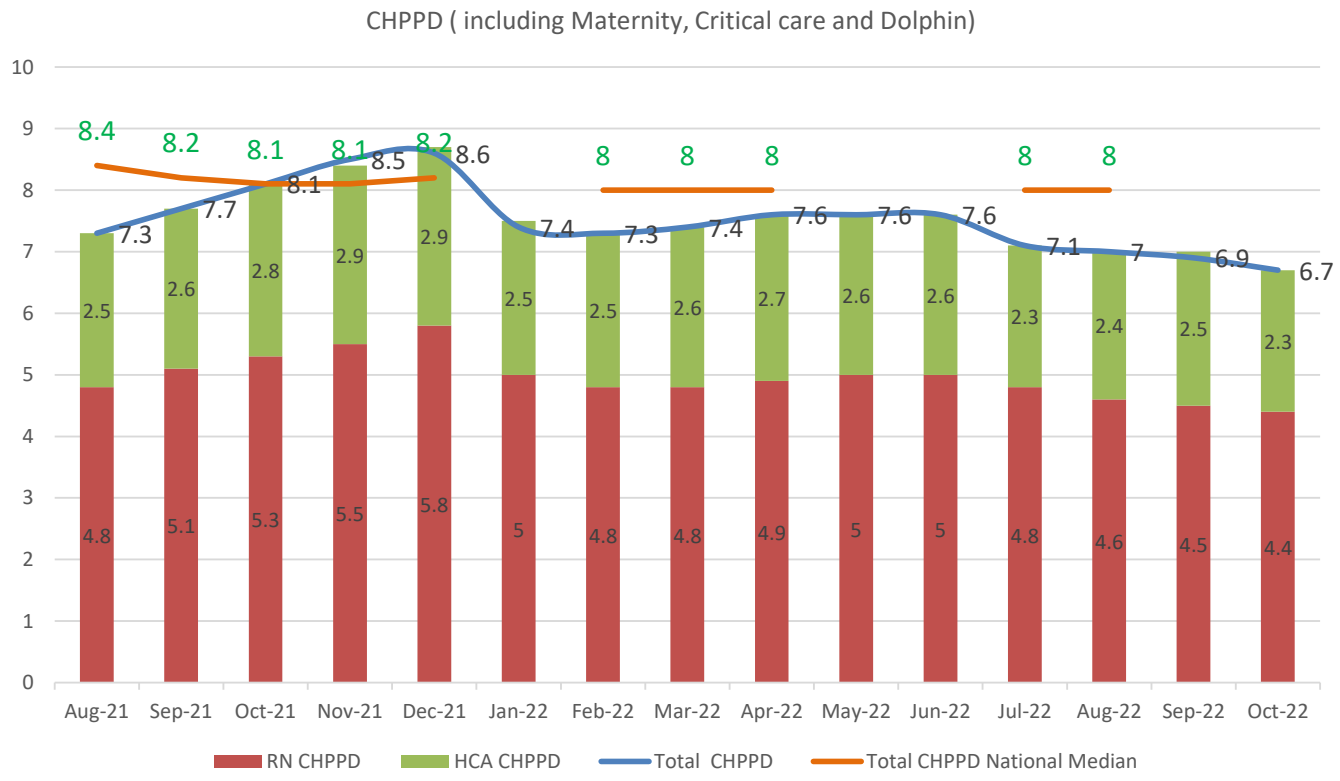
Care Hours per Patient Day* (CHPPD) is calculated every month by adding together the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants.

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

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

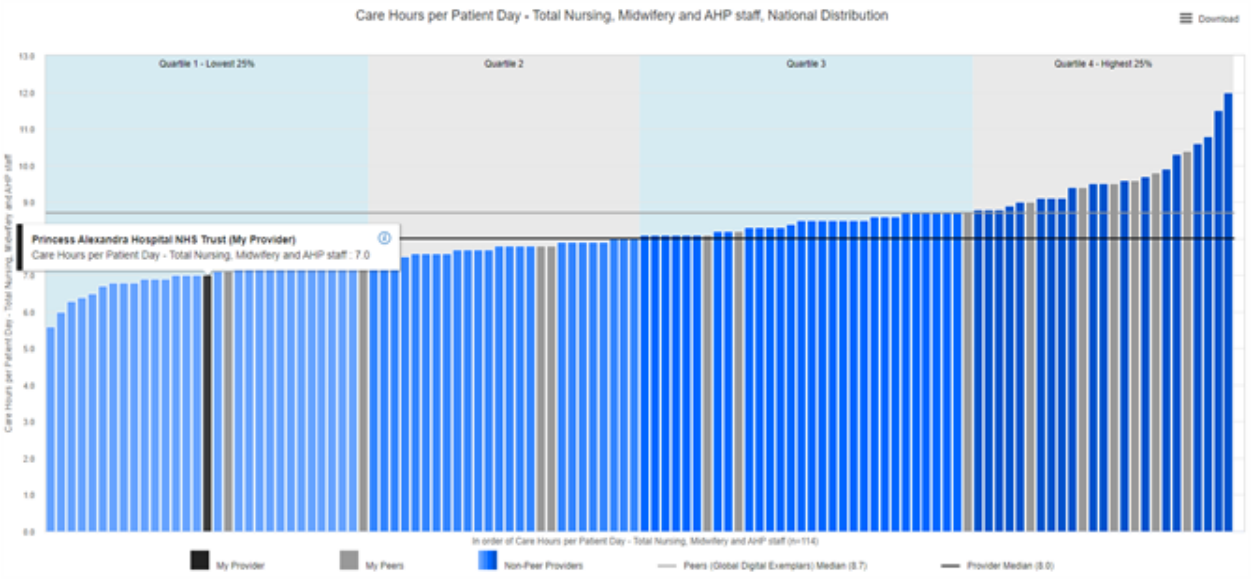
The accuracy of this report is dependant of the rosters being up to date and accurate bed occupancy numbers.

Appendix 3a: Shows Trust total , Registered and Unregistered CHPPD against National Median.
(National Median from Model Hospital)



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

	August 2022 data	National Median (August 2022)	Variance against national median
CHPPD Total	7.0	8.0	-1
CHPPD RN	4.6	4.8	-0.2
CHPPD HCSW	2.4	3.1	-0.7



Appendix 3b

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

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total (including Maternity)	**4.4**	**2.3**	**6.7**

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Ward Total	**4.2**	**2.3**	**6.5**
ITU & HDU	26.3	2.8	29.2
Saunders Unit	3.1	2.3	5.5
Nightingale Ward	3.8	2.7	6.5
Penn Ward	3.2	2.4	5.7
Henry Moore Ward	3.9	2.6	6.5
Harvey Ward	3.4	2.5	5.9
John Snow Ward	4.7	1.8	6.5
Charnley Ward	3.6	1.9	5.5
AAU	5.6	1.9	5.5
Harold Ward	3.4	2.0	5.4
Kingsmoor General	3.0	2.5	5.5
Lister Ward	3.1	2.9	6.0

Locke Ward	3.6	2.5	6.1
Ray Ward	3.3	1.8	5.1
Tye Green Ward	2.8	2.7	5.5
OPAL	3.1	3.1	6.2
Winter Ward	3.4	2.4	5.8
Fleming Ward	3.8	2.0	5.8
Neo-Natal Unit	9.5	2.2	11.7
Dolphin Ward	7.5	1.4	8.8

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Maternity Ward Total	**5.7**	**2.4**	**8.1**
Labour Ward	9.6	2.6	12.1
Birthing Unit	19.5	8.1	27.6
Samson Ward	2.2	1.9	4.1
Chamberlen Ward	6.0	2.2	8.2

Appendix 4: Temporary Staffing Demand & Fill Rate

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

RN temporary staffing demand and fill rates: ***(October 2022 data supplied by NHSP 1.11.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2022	3054	2168	71%	486	15.9%	86.9%	400	13.1%
June 2022	3327	2274	68.3%	487	14.6%	83%	566	17%
July 2022	3760	2391	63.6%	575	15.3%	79	794	21.1%
August 2022	3571	2224	62.3%	544	15.0%	77.5%	803	22.5
September 2022	3486	2250	64.5%	544	15.6%	80.1%	692	19.9%
October 2022	**3834**	**2187**	**57.0%**	**582**	**15.2%**	**72.2%**	**1065**	**27.8%**
October 2021	2982	1862	62.4%	456	15.3%	77.7%	664	22.3%

HCA temporary staffing demand and fill rates: ***(October 2022 data supplied by NHSP 1.11.2022)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2022	1648	1470	89.2%	0	0%	89.2%	178	10.8%
June 2022	1751	1496	85.4%	0	0%	85.4%	255	14.6%
July 2022	1911	1587	83%	0	0%	83%	324	17%
August 2022	1911	1579	82.6%	0	0%	82.6%	332	17.4%
September 2022	1875	1612	86%	0	0%	86%	263	14%
October 2022	**1981**	**1622**	**82.7%**	**0**	**0%**	**82.7%**	**339**	**17.3%**
October 2021	1804	1359	75.3%	11	0.6%	75.9%	434	24.1%

RMN temporary staffing demand and fill rates: ***(October 2022 data supplied by NHSP 1.11.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2022	336	48	9.8%	255	75.9%	85.7%	48	14.3
June 2022	291	32	11.0%	223	76.6%	87.6%	36	12.4%
July 2022	402	34	8.5%	289	71.9%	80.3%	79	19.7%
August 2022	379	32	8.4%	291	76.8%	85.2%	56	14.8%
September 2022	332	27	8.1%	268	80.7%	88.9%	37	11.1%
October 2022	**359**	**21**	**5.8%**	**295**	**82.2%**	**88.0%**	**43**	**12%**
October 2021	246	22	8.9%	180	73.2%	82.1%	44	17.9%

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

4.4

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

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

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

The Princess Alexandra Hospital NHS Trust

4.4

1.0 Purpose/issue

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

2.0 Background

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

3.0 Current Telstra/ NHS Data Headlines

Unable to report due to incomplete coding for May 2022

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

Unable to report due to incomplete coding for May 2022

3.2 Hospital Standard Mortality Rate (HSMR) – Monthly

Unable to report due to incomplete coding for May 2022

3.3 Summary Hospital-level Mortality Indicator (SHMI)

SHMI for the period May-21 to Apr-22 is 99.82 and within expected range. There is one alerting group using confidence interval methodology: cardiac dysrhythmias. There is also one SHMI group (using control limits) which is performing better than expected: fluid and electrolyte disorders. This is of note as it was higher-than-expected just over a year ago.

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

Unable to report due to incomplete coding for May 2022

3.5 Standardised Mortality Ratio (SMR)

Unable to report due to incomplete coding for May 2022

3.6 Standardised Mortality Ratio (SMR) outlying groups

There is one new outlying group:

- Lymphadenitis.

Telstra have reported that there are no concerns with this outlying group. In the last twelve months there were 105 superspells + 1 death. The one death has already been reviewed, as the diagnosis group has been a reported (CUSUM) alert and was noted to be an error with coding which was amended.

4.0 Mortality Programme Updates

4.1 Fractured Neck of Femour

There was a delay in the recent #NoF Pathway meeting and therefore an update will be provided to the December 2022 SLFDG.

4.2 Specialist Palliative & EOLC

Progress:

- Changes to SPCT structure- new Education Lead, new Team Lead.
- Change to Clinical psychology service lead from Heather Munroe to Danielle Bream from Jan 2023 onwards (impact neutral).
- EOL support role across all wards & ED (general EOLC).
- Request for EOLC e learning modules as 3 yearly mandatory training.

Next Steps:

- Agree ways of working together with newly appointed SPCT/EOLC Team Lead & stakeholders.
- Increase PPD recording access on NC across Trust.
- EOLC discharge facilitator role to be trialled within the current team make up.

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 107 deaths in October 2022.

39 cases referred for SJR's.

There are 54 outstanding SJRs (over 6 weeks of the patients' death.)

This has been escalated to the Divisional Director for Medicine, Urgent Care and Surgery, for a plan of action, which will be discussed at the December 2022 SLFDG.

5.2 Key Learning to be addressed

5.2.1 Learning from SJR's:

Themes include opportunities for improvement in the end of life pathways and delays in elements of the #NOF pathway.

5.2.3 Second Review Panel Cases

There were no cases presented to the second review panel.

6.0 Medical Examiner (ME) Headlines

During October 2022 there were 107 deaths, 100% scrutinised between 10 Medical Examiners.

18 cases were referred to the Coroner.

Community Deaths:

The community death pilot with St Claire Hospice is ongoing.
GP death scrutiny is in the process of being expanded with meetings pending with 2 PCNs and 1 GP Practice.

New Developments:

The ME team are planning to engage in discussions with Consultants and junior Drs to facilitate enhanced communication which will allow the scrutiny and certification process to be more efficient for all involved.

Grand Round - Medical Certification of Causes of Death (MCCD) - Sharing the Learning was presented on 09/11/2022 by Lead MEO and Lead Nurse for Mortality and Quality

Webinar: Medical Examiner scrutiny of community deaths (HWE ICS) was undertaken on 15/11/2022

6.1 National Medical Certificate of Cause of Death (MCCDs)

National MCCDs issued within 72 hours: (National Target)

88.75% of MCCDs were completed within 72 hours due to delays in doctors' availability to complete the MCCD.

7.0 Risks

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

- There is a risk that the trust will not be able to facilitate learning from deaths if the mortality data is not available and accurate.

8.0 Recommendation

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

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

5.2

Agenda item:	5.2
Presented by:	Ogechi Emeadi, Director of people
Prepared by:	Nathaniel Williams, People information manager, Padraig Brady, Head of strategic people partnering
Date prepared:	November 2022
Subject:	Equality & Inclusion Annual Report 2021- 2022

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 assurance to the Board on the Trust's progress in relation to Equality & Inclusion under the Equality Act 2010 The report also summarise the Trust's compliance with the following Mandatory framework: • Workforce Race Equality Standards • Workforce Disability Equality Standards
Recommendation:	The Board is asked to: • Note and approve the contents of this report • Endorse further progress on the Trust's Equality, Inclusion Action Plan; • Consider how best we can continue to demonstrate support and leadership for improving E&I related events

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:	People Committee.28.11.22.
Risk / links with the BAF:	Robust performance in relation to equality, diversity and inclusion helps mitigate against risks of service/policy gaps that put protected groups at a disadvantage.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Equality Act 2010 Public Sector Equality Duty CQC Well Led Framework EDS3
Appendices:	Appendix 1 Workforce and Recruitment data Appendix 2 Patient Demographics for the report period Appendix 3 Employee Relations Cases

1.0 Purpose

To provide assurance to the board on the compliance of our statutory obligations under the Equality Act 2010 protecting the equality, diversity and inclusion of staff and patients. Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by the Act.

Advance equality of opportunity between people who share a protected characteristic and those who do not.

Foster good relations between people who share a protected characteristic and those who do not.

The Equality Act requires public sector bodies to publish relevant information to demonstrate their compliance with the PSED

2.0 TRUST CONTEXT

Our strategic objectives are focused around our patients, people, places, performance and pounds, as follows:

- **Our Patients** – we will continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures
- **Our People** – we will support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results
- **Our Places** – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop a business case for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable 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 achieve our agreed financial targets and control totals

Underpinning these objectives is the following Trust values that have been adopted to develop a “behaviour charter” providing a standard for our own and others behaviour, highlighting the importance of valuing differences.

Patient at heart

Everyday excellence

Creative collaboration

3.0 SUMMARY OF PROGRESS AGAINST THE EQUALITY AND INCLUSION ACTIONS

Since the last reporting period the following positive progress has been made:

- ED&I champions on all interview panel at band 8a and above
- Inclusive recruitment training rolled out across the trust. 155 recruiting managers trained to date. From January 2023 at least 1 interview panel member must have attended this training
- Appointment of a dedicated EDI lead role in January 2022.
- Collaborative working with an external specialist EDI organisation to assist in positively developing the trust's staff networks
- Recognition of the establishment of a formal Staff forum – Disability and Wellness Network (DAWN)
- Re-establishment of the Trust LGBT+ staff network
- Rebranding of the staff network to be called REACH (the Race Equality & Cultural Heritage); appointment of a new staff network chair and re-appointment of vice Chair

4.0 Workforce race equality standard (WRES) and workforce disability equality standard (WDES)

The WRES and WDES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – the Equality Act 2010. Reviewing the data helps the Trust to adopt a 'learning organisation' approach and produce action plans to build a culture of continuous improvement. These actions will assist in helping to bring about a workplace that is free from discrimination.

This year's action plans for WRES and WDES will identify areas for improvement but also areas where we feel we are performing well, and ensure we continue to evidence this.

4.1.1 WRES is self-assessed against 9 indicators, four of which relate specifically to workforce data, four are based on data from the national NHS staff Survey questions (not required for this reporting period) and the final indicator considers BME representation on the Trust board. The report is based on the reporting period April 2021 – March 2022.

4.1.2 WDES is assessed against 10 evidence-based metrics three of which relate specifically to workforce data, six are based on data from the national NHS staff Survey questions (Not required this reporting period) and the final one considers disabled and non-disabled representation on the Trust board. The report is based on the reporting period April 2021– March 2022.

Key findings include:

- The percentage of BME Staff employed within the Trust has increased from 33% to 37% compared to last year. The number of BME staff at VSM remain at two headcount from last year
- The likelihood of BME staff entering the formal disciplinary process is 0.60 times more likely than White staff (compared to 1.15 in 2021). Any score less than 1 is seen as a positive indicator.
- BME representation at board level has increased over the last 3 years from 12% to 18% and 21% in 2022
- 2.25% of our total workforce have identified as disabled, an increase on the previous reporting period
- There has been an increase of staff identifying as disabled in the Bands 8a through to VSM compared to the previous year

In conjunction with the EDI Steering group, the current data relating to WRES and WDES has been reviewed and the following action plans for 2022/2023 have been agreed by the group:

3.2.1 WDES Action Plan

Reference	Actions	Responsibility	Timescale
1	ED&I representation on all interview panels. (currently in place for 8a and above)	People Team/ Division	By June 2023
2	Promote positive action to address representation at the board membership when board vacancies arise	Recruitment Team	Review in June 2023
3	To work with an external partner in developing the DAWN staff network to increase their membership, participation and visibility within the Trust, as part of an overall EDI staff engagement strategy	Trust Board and relevant stakeholder representation	Review in March 2023
4	Develop and implement an action plan to evidence that the Trust meets the requirements to increase it's Disability Confident accreditation from Level 1 to Level 2	EDI Steering Group / Trust Board	March 2023
5	Annual agenda to deliver awareness events that are positively promoting disability in the workplace.	EDI Steering Group	Review quarterly
6	Increase the trust offer to support work placements/ experience for people with learning disabilities	Recruitment/ L&OD	By March 2023
7	A rolling campaign during the year to educate and encourage staff to provide declaration information	People Team/Division	Review quarterly

3.2.2 WRES Action Plan

Reference	Actions	Lead	Timescale
1	To work with an external partner in developing the REACH staff network to increase their membership, participation and visibility within the Trust, as part of an overall EDI staff engagement strategy	REACH Staff Network	**Review March 2023**
2	Review the process for accessing CPD funded courses to ensure it is accessible to all staff; ensuring the process for distribution and allocation of funded CPD courses is managed consistently and by a diverse decision-making panel	L&OD Team/ EDI Steering Group	**March 2023**

3	Annual agenda to deliver awareness events that are promoting REACH staff network objectives, in addition to Black History month	EDI Steering Group	**Review quarterly**
4	To review the recruitment data relating to shortlisting and appointments to review the impact of introducing of EDI champions and inclusive recruitment training	EDI Steering Group	**Review quarterly**

5.0 OUR COMMITMENT TO PARTNERSHIP WORKING

5.1 EDISG (Equality, diversity and inclusion steering group)

The equality, diversity and inclusion steering group meets on a monthly basis. The purpose of the steering group is to ensure compliance with equality legislation, to promote awareness of EDI issues and to supporting the integration of diversity initiatives into the workforce. The steering group regularly reports progress to the workforce committee, as a sub-committee of the board, to ensure visibility and scrutiny of all interventions.

The trust intranet has a dedicated page for equality and inclusion and this is in the process of being updated with photos of our champions and equality and monitoring information as part of the development of the trust's new extranet.

5.2 Partnerships and networking

The Trust actively participates in the ICS-wide EDI and BAME chairs network. Strong relationships have been developed with the other participants in the ICS and PAHT is working collaboratively on a number of diversity initiatives including recruitment, coaching and leadership development, unconscious bias training and anti-racism awareness.

5.3 Freedom to Speak Up Lead Guardians (FTSUG)

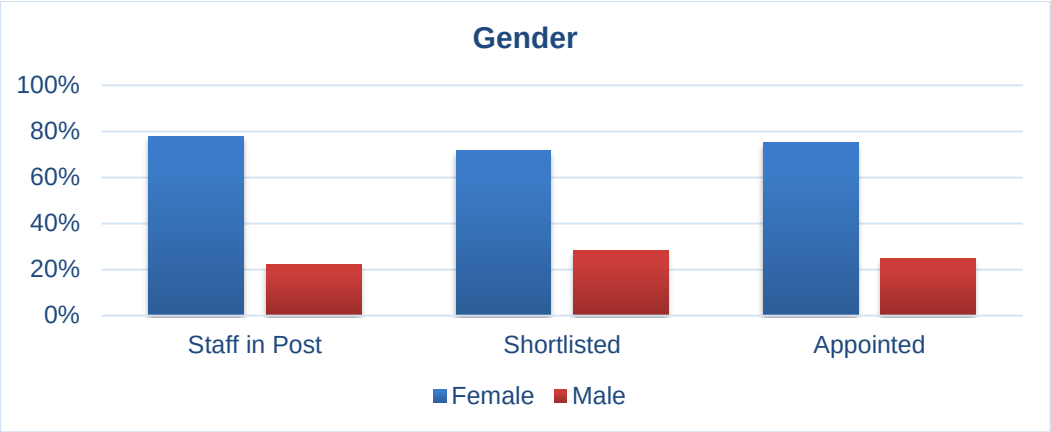
FTSUGs (who are also members of EDISG) have a role in monitoring bullying and harassment within the trust and developing strategies and interventions to address any issues identified. The trust continues to strengthen it's commitment to this important work and has 7 FTSU guardians including a FTSU lead.

The Princess Alexandra Hospital NHS Trust

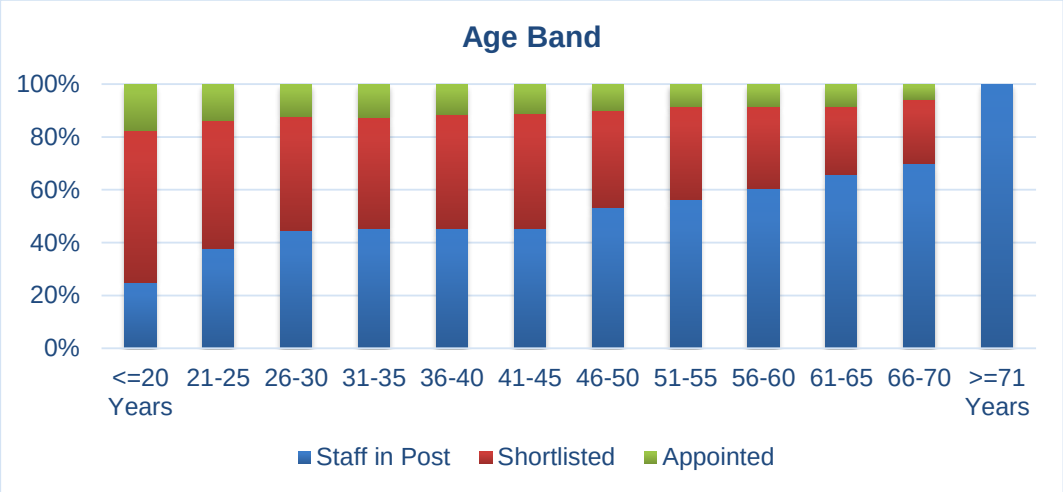
Data in this report is as at March 2022

Appendix 1 Workforce and Recruitment data

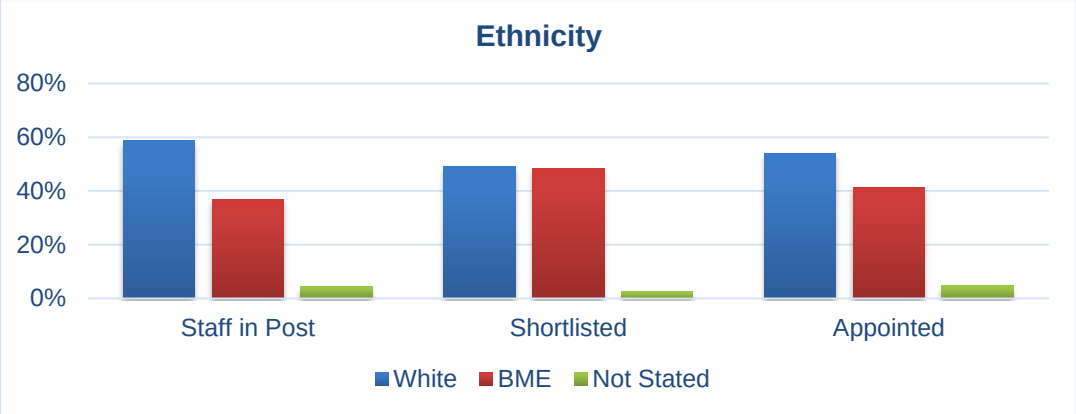
Gender



Age Band



Ethnicity



modern • integrated • outstanding

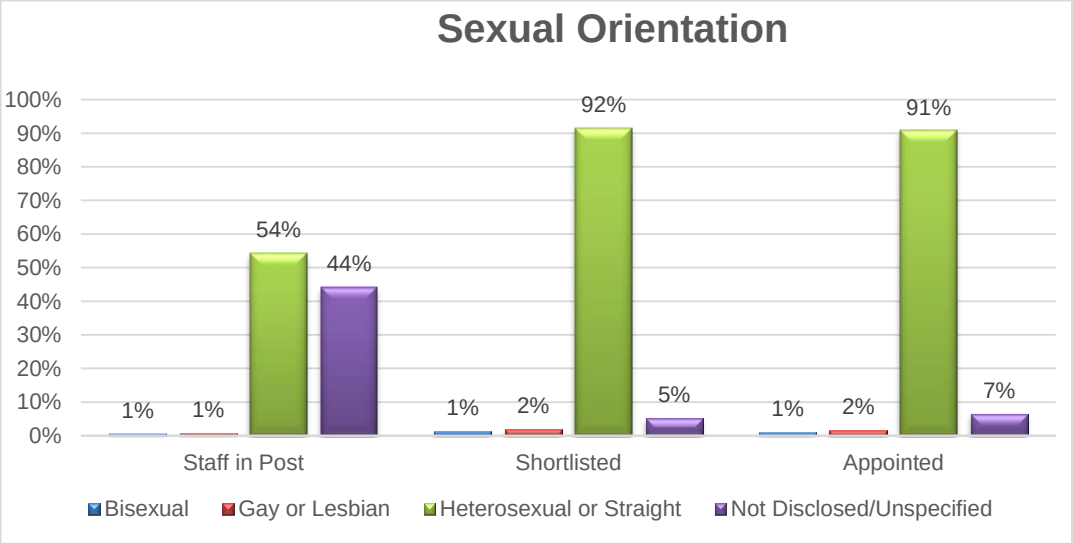
patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

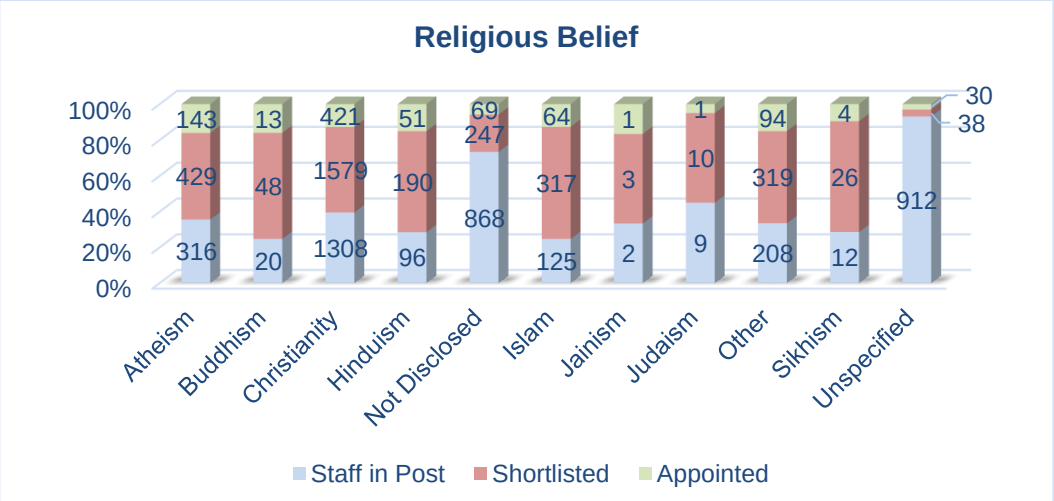
5.2

Disability

Sexual Orientation



Religious Belief



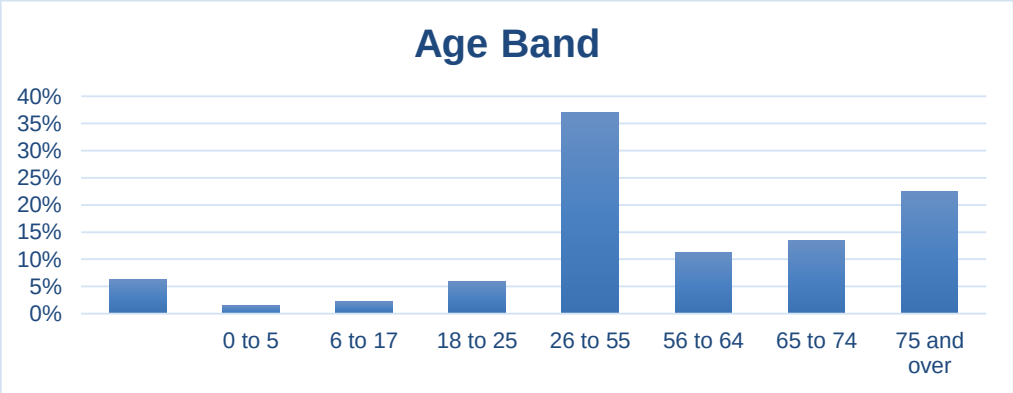
modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

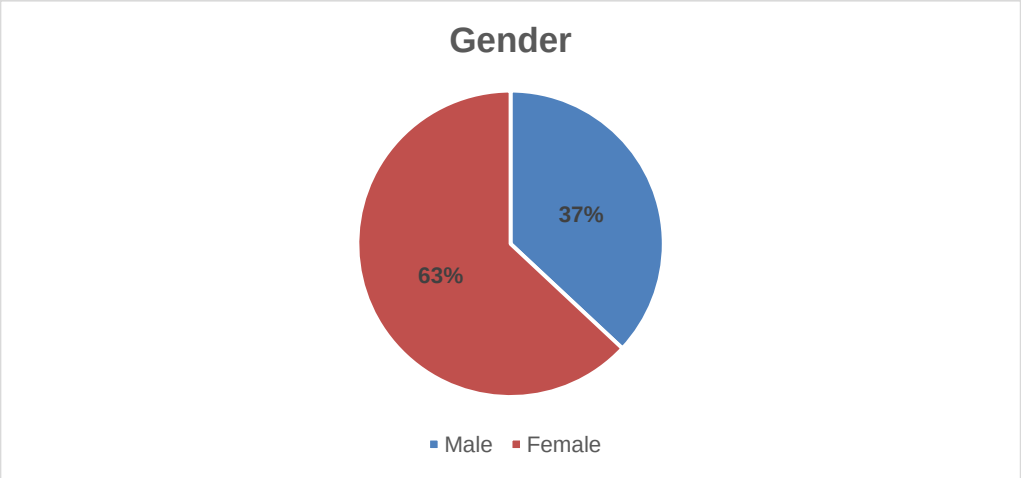
The Princess Alexandra Hospital NHS Trust

Appendix 2 Inpatient Demographics for the report period

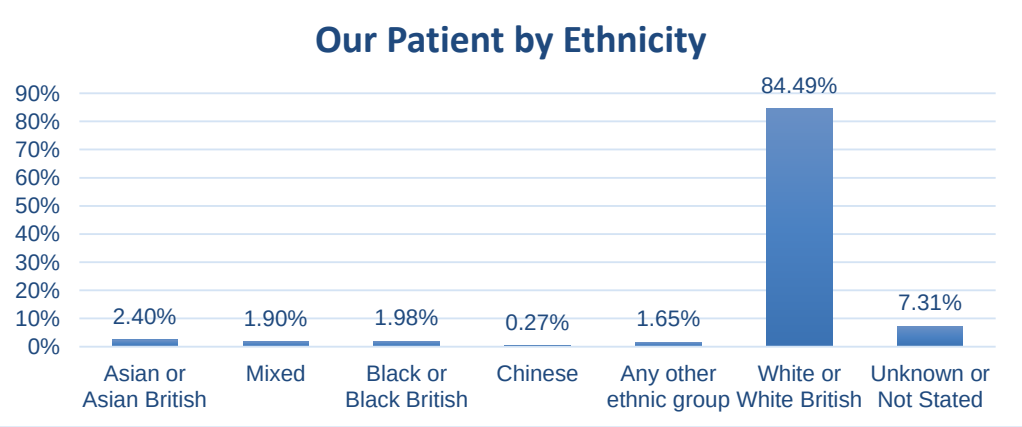
Our Patient by Age



Our Patient by Gender



Our Patient by Ethnicity



Appendix 3 Employee Relations Cases

ER Cases 1st April 2021 – 31st March 2022

The following data analyses the total number of staffs entering a formal employee relations process from April 2021 to March 2022 broken down by ethnicity, gender, disability and age group. More staff entered a conduct process in the year followed by grievance than any other case type.

All ER case type

Case Type	Closed	Live	Grand Total	% of Total Cases
Conduct	27	2	29	40.28%
ET	3	3	6	8.33%
Grievance	17	1	18	25.0%
Performance	9	1	10	13.89%
Probation	9		9	12.50%
Grand Total	**65**	**7**	**72**	**100%**

All ER case type by Ethnicity

Ethnicity	Closed	Live	Grand Total	% of Trust Employees	% of Total Cases
White	43	5	48	58.48%	66.66%
BME	19	2	21	36.95%	29.17%
Not Stated	3		3	4.47%	4.17%
Grand Total	**65**	**7**	**72**	**100%**	**100%**

All ER case type by Disability

Disability	Closed	Live	Grand Total	% of Trust Employees	% of Total Cases
Disabled	4	2	6	1.65%	8.34%
Not Declared	30	3	33	45.29%	45.83%
Not Disabled	31	2	33	53.06%	45.83%
Grand Total	**65**	**7**	**72**	**100%**	**100%**

NB: Support is provided to all staff entering into a formal ER process, including staff identifying with a disability. Measures such as OH support, health assessmens, reasonable adjustments are explored with staff. The overall % of staff identifying as disabled will be impacted by any staff who have "Not Declared" but would be identified as having a disability.

All ER case type by Gender

Gender	Closed	Live	Grand Total	% of Trust Employees	% of Total Cases
Female	43	4	47	77.68%	65.28%
Male	22	3	25	22.32%	34.72%
Grand Total	**65**	**7**	**72**	**100%**	**100%**

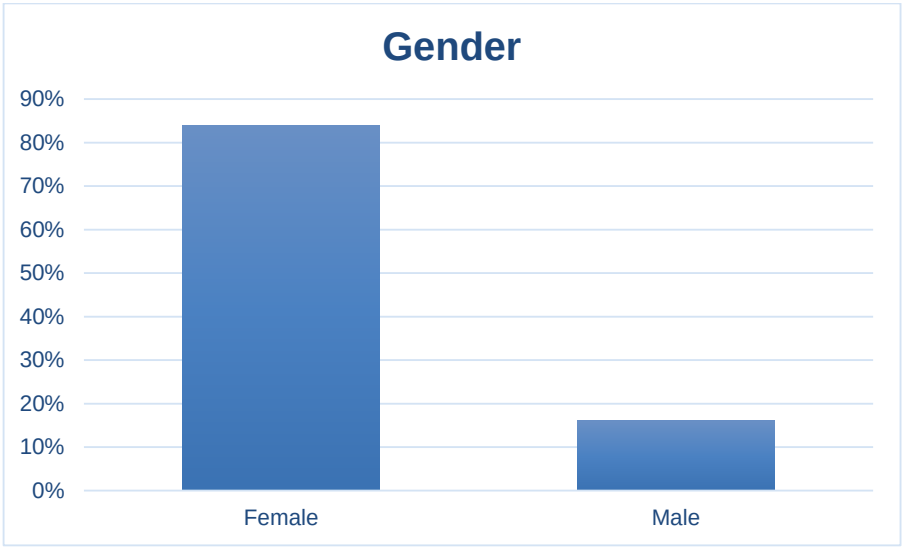
All ER case type by Age Range

Age Range	Closed	Live	Grand Total	% of Trust Employees	% of Total Cases
<=20 Years	2		2	0.52%	2.78%
21-25	6		6	5.88%	8.33%
26-30	6		6	14.89%	8.33%
31-35	12	1	13	16.65%	18.06%
36-40	6	3	9	12.21%	12.50%
41-45	6		6	10.61%	8.33%
46-50	9		9	11.23%	12.50%
51-55	7	1	8	10.86%	11.11%
56-60	3	1	4	9.73%	5.56%
61-65	5	1	6	5.52%	8.33%
66-70	2		2	1.57%	2.78%
>=71 Years	1		1	0.34%	1.39%
Grand Total	**65**	**7**	**72**	**100%**	**100%**

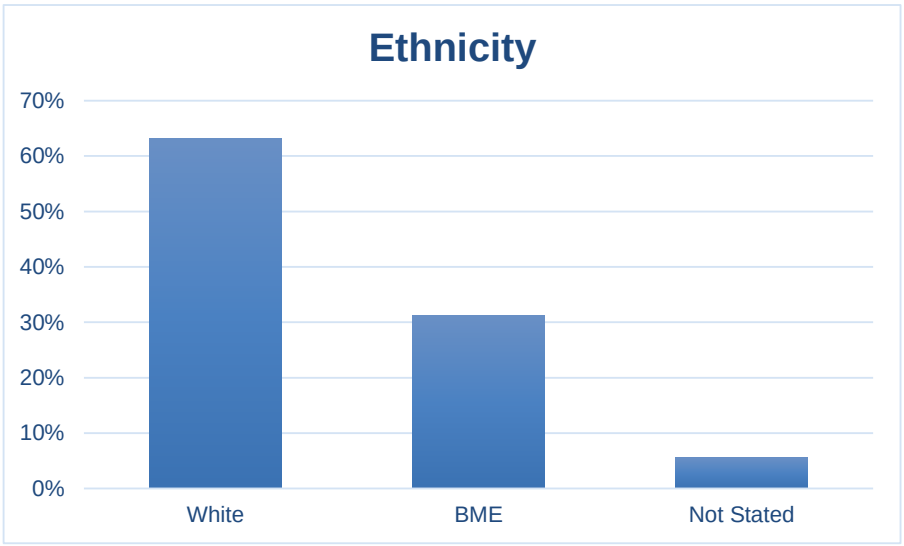
Appendix 4 Non-Mandatory Training & CPD

The analysis shows a snapshot of staff that has undertaken Non-Mandatory Training and CPD in 2021/22

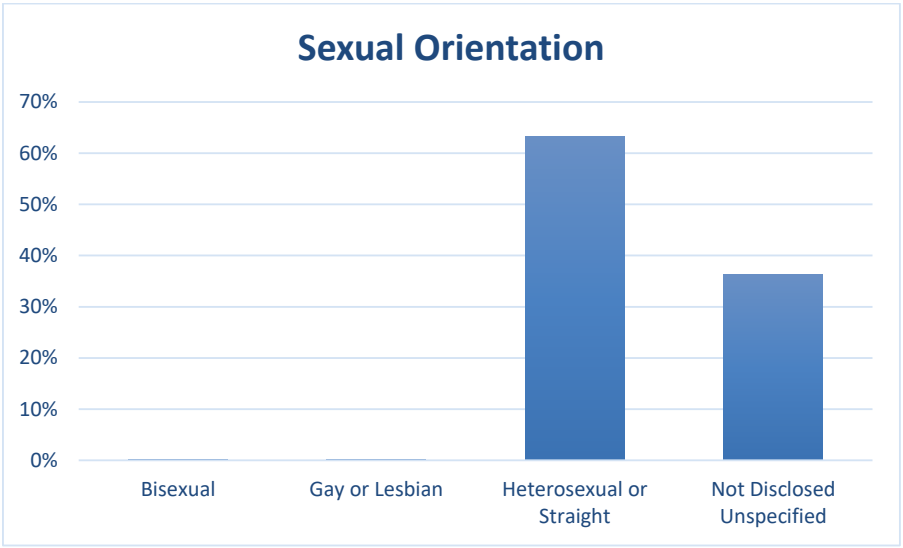
Non-Mandatory Training & CPD by Gender



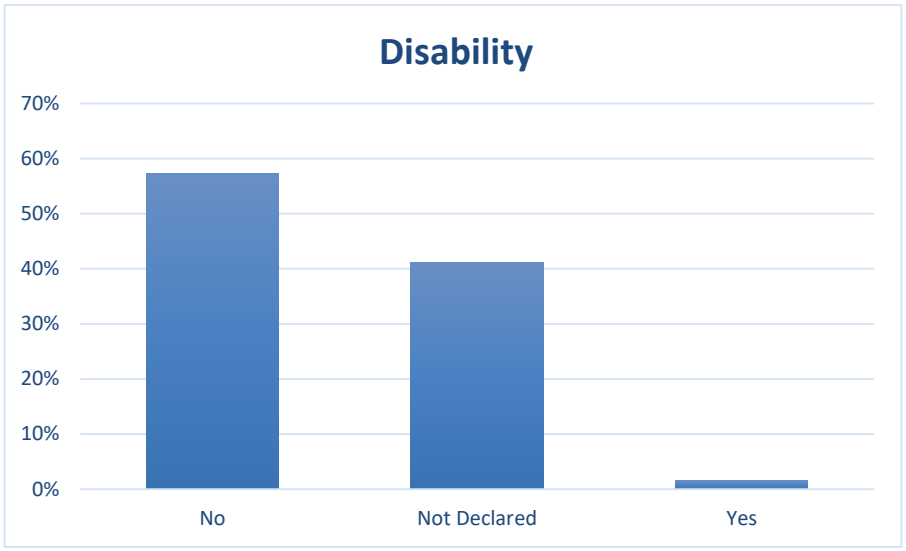
Non-Mandatory Training & CPD by Ethnicity



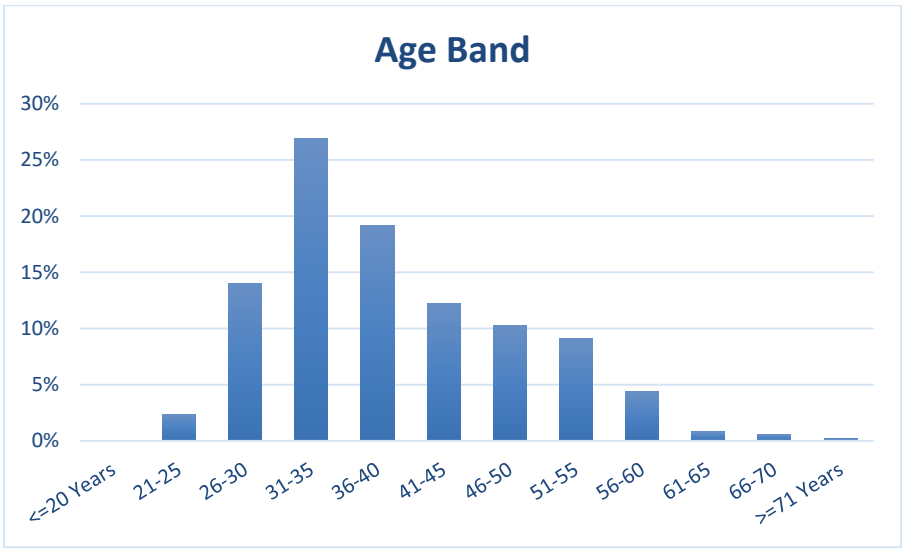
Non-Mandatory Training & CPD by Sexual Orientation



Non-Mandatory Training & CPD by Disability



Non-Mandatory training & CPD by Age Band



Author: Padraig Brady, Head of Strategic People Partnering, Nathaniel Williams, People Information Manager

Date: 24 November 2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

5.3

Agenda item:	5.3
Presented by:	Ogechi Emeadi, Director of People
Prepared by:	Padraig Brady – Head of People Business Partnering, Nathaniel Williams – People information manager
Date prepared:	9 November 2022
Subject:	Workforce Race Equality Standard (WRES) 2022

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	• The Trust has appointed a dedicated lead for Equality, Diversity & Inclusion. • There has been an increase in the number of BME staff recruited into senior roles. • The likelihood of BME staff entering into a formal disciplinary process has reduced to 0.6. Any score less than 1 is seen as a positive indicator The likelihood of white staff being appointed from shortlisting across all posts has decreased slightly compared to last year (this data excludes ongoing international recruitment)
Recommendation:	To present the Board with key findings of the Trust's Workforce Race Equality Standard (WRES) report and subsequent action plan for approval

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 PC.28.11.22
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 WRES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010.
Appendices:	Appendix 1 WRES Key Findings Appendix 2 WRES Data

The Princess Alexandra Hospital NHS Trust

5.3

1.0 Purpose

To provide oversight of the Trust Workforce Race Equality Standard report (WRES) for Trust wide publication.

This paper presents the revised recommendation for 2021-2022, which builds on from action and key objectives of the Race Equality & Cultural Heritage staff network (REACH).

The data covers the period from Apr20 – Mar21 and Apr21 – Mar22 respectively.

Context

The Workforce Race Equality Standard (WRES) was introduced in 2015 as part of the NHS standard contract to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. This is vital as the evidence shows that a motivated, inclusive and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisation.

The WRES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010.

WRES is self-assessed against 9 indicators - four of which relate specifically to workforce data, four are based on data from the national NHS staff Survey questions and the final one considers BME representation on the Trust board.

The data is to enable the Trust to adopt a 'learning organisation' approach and produce an action plan to build a culture of continuous improvement. This will form essential steps in helping to bring about a workplace that is free from discrimination

Appendix 1

Key Findings – what the data tells us

- **Metric: Percentage of staff in each of the AFC pay bands 1-9, medical & dental and VSM compared to overall workforce: The p**ercentage of BME Staff employed within the Trust has increased from 33% to 37% compared to last year. The number of BME staff at VSM remain at two headcount from last year
- **Metric: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME:** The % of BME staff appointed in this reporting period was **24%** (compared to 24% in 2021). The % of white staff appointed in this reporting period was **30%** white (compared to 33% in 2021). The relative likelihood of White staff being appointed compared to BME staff is currently 1.25. Any score less than 1 is seen as a positive indicator.
- **Metric: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff**. The likelihood of BME staff entering the formal disciplinary process is now 0.60 times more likely than White staff (compared to 1.15 in 2021). Any score less than 1 is seen as a positive indicator. The numbers of BME staff that entered the formal disciplinary process is 0.42% (0.24% in 2021). The overall number of staff entering a formal disciplinary process remains small.

- **Metric: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:** The likelihood of White staff accessing non-mandatory

training and CPD when compared to BME staff is 1.27 as compared to 1.15 in 2021. However, the percentage of BME staff accessing training and CPD has also increased from the previous reporting period.

- **Metric: BME board membership – Executive Directors: BME Board membership – Non-Executive Directors:** BME representation at board level has increased over the last 3 years from 12% to 18% and 21% in 2022 respectively.

Appendix 2

Percentage of **non-clinical** staff in each Pay band AFC Band 1-9 & VSM

	Apr20-Mar21		Apr21-Mar22	
	White	BME	White	BME
Band 1	72%	17%	71%	14%
Band 2	83%	10%	80%	14%
Band 3	87%	8%	87%	7%
Band 4	91%	6%	90%	7%
Band 5	77%	15%	78%	17%
Band 6	86%	11%	80%	14%
Band 7	80%	17%	84%	12%
Band 8a	76%	24%	82%	15%
Band 8b	82%	14%	70%	26%
Band 8c	67%	33%	64%	36%
Band 8d	100%	0%	91%	9%
Band 9	100%	0%	100%	0%
VSM	78%	22%	78%	22%
NEDS	75%	0%	70%	20%

Percentage of **clinical** staff in each Pay band AFC Band 1-9 & Medical & Dental

Clinical	Apr20-Mar21		Apr21-Mar22	
	White	BME	White	BME
Band 2	75%	21%	67%	30%
Band 3	85%	12%	84%	14%
Band 4	62%	38%	61%	32%
Band 5	30%	65%	24%	71%
Band 6	65%	32%	60%	37%
Band 7	65%	31%	63%	32%
Band 8a	67%	27%	68%	27%
Band 8b	78%	13%	68%	24%
Band 8c	89%	11%	90%	10%
Band 8d	89%	11%	88%	13%
Band 9	0%	0%	100%	0%
Medical & Dental	32%	68%	30%	70%

Indicator	2020	2021	2022
Relative likelihood of white staff being appointed from Shortlisting compared to BME staff across all posts	1.23	1.37	1.25

	2020		2021		2022	
	White	BME	White	BME	White	BME
Relative likelihood of appointment from shortlisting	21%	17%	33%	24%	30%	24%

Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to white staff (two years rolling average)	1.94	1.15	0.60

	2020		2021		2022	
	White	BME	White	BME	White	BME
Likelihood of staff entering formal disciplinary process	0.46%	0.90%	0.21%	0.24%	0.70%	0.42%

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	0.94	1.15	1.27

	2020		2021		2022	
	White	BME	White	BME	White	BME
Likelihood of staff accessing non-mandatory training & CPD	9.75%	10.39%	9.33%	8.09%	14.08%	10.96%

Total Board Members % by ethnicity

	2020		2021		2022	
	White	BME	White	BME	White	BME
Total Board members - % by ethnicity	82.40%	11.80%	70.60%	17.16%	73.7%	21.1%

Achievements for 2021/22

1. ED&I champions on all interview panel at band 8a and above
2. Inclusive recruitment training rolled out across the trust. 155 recruiting managers trained to date
3. Appointment of a dedicated EDI lead role in January 2022Recruitment of trust ED&I lead now in place
4. Rebranding of the staff network to be called REACH (the Race Equality & Cultural Heritage); appointment of a new staff network chair and re-appointment of vice Chair

Areas of Action for 2022/23

Reference	Actions	Lead	Timescale
1	To work with an external partner in developing the REACH staff network to increase their membership, participation and visibility within the Trust, as part of an overall EDI staff engagement strategy	REACH Staff Network	**Review March 2023**
2	Review the process for accessing CPD funded courses to ensure it is accessible to all staff; ensuring the process for distribution and allocation of funded CPD courses is managed consistently and by a diverse decision-making panel	L&OD Team/ EDI Steering Group	**March 2023**
3	Annual agenda to deliver awareness events that are promoting REACH staff network objectives, in addition to Black History month	EDI Steering Group	**Review quarterly**
4	To review the recruitment data relating to shortlisting and appointments to review the impact of introducing of EDI champions and inclusive recruitment training	EDI Steering Group	**Review quarterly**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

5.3

Agenda item:	5.3
Presented by:	Padraig Brady – Head of People Business Partnering
Prepared by:	Padraig Brady – Head of People Business Partnering, Nathaniel Williams – People information manager
Date prepared:	9 November 2022
Subject:	Workforce Disability Equality Standard (WDES) 2022

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	The number of staff identifying as disabled in the Trust has increased compared to the previous reporting period. The Trust has appointed a dedicated lead for Equality, Diversity & Inclusion. The trust has established the Disability and Wellbeing Network (DAWN) There is still a significant information gap of staff declaration relating to disability on the electronic Staff Record (ESR).
Recommendation:	To present the Board with key findings of the Trust's Workforce Disability Equality Standard (WDES) report and subsequent action plan for approval

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, diversity and Inclusion steering group PC.28.11.22
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 WDES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010.
Appendices:	

The Princess Alexandra Hospital NHS Trust

5.3

1.0 Purpose

The WDES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010.

WDES is assessed against 10 evidence-based metrics three of which relate specifically to workforce data, six are based on data from the national NHS staff Survey questions (Not required this reporting period) and the final one considers disabled and non-disabled representation on the Trust board. The report is from April 2021– March 2022.

The data is to enable the Trust to adopt a 'learning organisation' approach and produce an action plan to build a culture of continuous improvement. This will be an essential step in helping to bring about a workplace that is free from discrimination

This report provides a breakdown of PAHT data against the 4 workforce disability equality standard (WDES) indicators for 2021/2022:

Indicator 1

Percentage of staff in AFC (agenda for change) pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.

Table 1 shows percentage of all staff by bands compared to last year

	2021					2022				
All staff	Band 1-4	Band 5-7	Band 8a-8b	Band 8c-VSM	M&D	Band 1-4	Band 5-7	Band 8a-8b	Band 8c-VSM	M&D
Disabled	2%	1%	3%	3%	0%	2%	2%	4%	4%	0%
Non-Disabled	46%	40%	44%	52%	33%	55%	49%	48%	61%	58%
Unknown	52%	59%	53%	45%	67%	43%	49%	48%	35%	42%

Table 2 shows headcount and percentage of disabled and non-disabled **non-clinical** staff by bands

Non- clinical staff	Bands 1-4		Bands 5-7		Bands 8a-8b		Bands 8c-9 &VSM		Non-Executives	
Disabled	13	2%	2	1%	4	6%	2	6%	2	20%
Non-Disabled	413	51%	104	50%	36	55%	22	63%	5	50%
Unknown	390	47%	102	49%	26	39%	11	31%	3	30%

Table 3 shows Headcount and Percentage of disabled and non-disabled **clinical** staff by bands & grade

Clinical staff	Bands 1-4		Bands 5-7		Bands 8a-8b		Bands 8c-9 &VSM	
Disabled	10	2%	25	2%	3	2%	0	0%
Non-Disabled	403	61%	690	49%	58	45%	11	58%
Unknown	244	37%	700	49%	11	53%	8	42%

Table 4 identified the headcount and percentage of disabled and non-disabled medical staff

Medical staff	M&D Consultants		M&D career grade		M&D trainee grade	
Disabled	0	0%	0	0%	2	1%
Non-Disabled	76	37%	73	57%	161	79%
Unknown	127	63%	55	43%	40	20%

Indicator 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from Shortlisting across all posts. This refers to both external and internal posts.

Relative likelihood declines to 1.14 compared to last year (0.87). A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting.

Indicator 3

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

During this reporting period a total of two staff identifying as disabled entered into a formal capability process, compared to a nil return for staff entering a capability process in the last reporting period. Due to the significantly small number of staff involved, the indicator reports as zero (0.00). A figure above 1.00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.

Indicator 4

Headcount and Percentage of the organisations board voting membership and executive board members.

	By Voting membership of the Board		By Executive membership of the Board	
Disabled	1	9%	0	0%
Non-Disabled	8	73%	6	67%
Unknown	2	18%	3	33%

What the data tells us

2.25% of our total workforce have identified as disabled. This is an increase on the previous reporting period

We have seen a increase of staff identifying as disabled in the Bands 8a through to VSM compared to the previous year

staff identifying as disabled in non clinical staff has stayed the same as compared to last year

We have seen an Increase in staff identifying as disabled in clinical staff compared to last year

Achievements from 2021/22

1. ED&I champions on all interview panel at band 8a and above
2. Inclusive recruitment training rolled out across the trust. 155 recruiting managers trained to date.
3. Appointment of a dedicated EDI lead role in January 2022.
4. Recognition of the establishment of a formal Staff forum – Disability and Wellness Network (DAWN)

Identified areas of action for 2022/23:

Action	Actions	Responsibility	Timescale
1	ED&I representation on all interview panels. (currently in place for 8a and above)	People Team/ Division	By June 2023
2	Promote positive action to address representation at the board membership when board vacancies arise	Recruitment Team	Review in June 2023
3	To work with an external partner in developing the DAWN staff network to increase their membership, participation and visibility within the Trust, as part of an overall EDI staff engagement strategy	Trust Board and relevant stakeholder representation	Review in March 2023

4	Develop and implement an action plan to evidence that the Trust meets the requirements to increase it's Disability Confident accreditation from Level 1 to Level 2	EDI Steering Group / Trust Board	March 2023
5	Annual agenda to deliver awareness events that are positively promoting disability in the workplace.	EDI Steering Group	Review quarterly
6	Increase the trust offer to support work placements/ experience for people with learning disabilities	Recruitment/ L&OD	By March 2023
7	A rolling campaign during the year to educate and encourage staff to provide declaration information	People Team/Division	Review quarterly

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 December 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**24 November 2022**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 M7 Financial Results	Y	Y	N	The Trust reported a deficit of £0.3m in month and £11.5m YTD. The financial position in M7 has started to evidence the actions to reduce and slow down the run rate due to the higher levels of expenditure relating to elective recovery including outsourcing\ insourcing, and legacy infrastructure costs such as estates maintenance. The Trust's agency costs, particularly medical staff, remain at levels higher than in previous years.
2.2 Financial Forecast	Y	Y	N	PAF noted the existing financial position of the Trust and agreed the next steps in developing a more robust forecast and approach to exercising more financial controls where necessary. The Trust continues to discuss the anticipated year end forecast with regulators; to date a breakeven position has been reported but the committee discussed the risk to delivering this. A summary of the financial recovery work that has been commissioned was also provided to further highlight the challenge.

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 December 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**24 November 2022**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Capital Update	Y	Y	N	The Trust total CRL 2022-23 is £15.5m which includes £1.4m external funding in the form of PDC). As at M7, YTD capital spend totals £6.1m but the programme is now over committed, however this has been revised down following the latest CWG and is not of concern.
2.4 CIP Update	Y	Y	N	The 22/23 CIP target is £11.7m with savings now identified to the value of the full year plan, YTD M7 savings are £5.3m. The Trust has commissioned Moorhouse Consulting to review its approach to CIPs and to highlight areas to focus on to better identify efficiencies and savings and to support their delivery. PAF agreed the current focus should be on recurrent savings in order to start the new financial year on a sound footing.
2.5 Quarterly Service Line Reporting (EBITDA)	Y	Y	N	SLR was last done in the Trust for Q4 19/20 and the Trust will have Q2 22/23 SLR at the end of January 2023. National Cost Collection (NCC) was submitted in August 2022 and showed the Trust is expensive overall (index of 105). The details evidence the Trust is more expensive in elective activity but less expensive in other points of delivery. It was agreed that whilst valuable, this work should not be a key priority at present until team capacity improves.

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 December 2022**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**24 November 2022**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.6 BAF Risk 5.1 Finance (Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.
2.7 Pathology Full Business Case (FBC)	Y	Y	N	In line with the recommendation, PAF endorsed the Pathology FBC (for a consolidated HWE ICS pathology service) for Trust Board approval.
2.8 Procurement Quarterly Update/Procurement Business Case Benefits Realisation	Y	Y	N	Quarterly ICS Procurement Service Update: Key points to note were that the service was on budget, was projecting over-delivery on its savings target but supply disruption issues continued. HWE ICS Procurement Shared Service Business Case Evaluation: The evaluation has concluded that in the main, the benefits of the business case are being delivered and that the new HWE ICS Procurement Shared Service is now well placed to develop, building on the improvements made to date. Key metrics have now been identified.
2.9 Quarterly e-Health Update	Y	Y	N	Key highlights from the report were: 1) Progress made in relation to staffing challenges within Information Management and Coding 2) Data Quality Maturity Index (July 2022) above national average 3) SUS 2022 freeze position below expected range and 4) Clinical Coding Update with actions to address

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 December 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**24 November 2022**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				below trajectory performance for coding at flex and freeze (due to sickness, maternity leave and high turnover within the team) and team vacancies (currently being supported through NHSP, external contractors and overtime).
2.10 ICS Governance Update	Y	Y	Y	Whilst the Trust was actively involved, this remained work in progress in terms of establishing regimes.
3.1 M7 Integrated Performance Report	Y	N	N	There had been a dip in cancer two week wait performance, particularly in Dermatology, Lower GI and Urology, diagnostics performance had stabilised and pressures at the front door in terms of attendances continued. Theatre productivity had still not returned to pre-COVID levels which was related to preparation time and more medically complex patients.
3.2 BAF Risk 4.1 Winter Resilience	Y	Y	N	This new risk was endorsed by the Committee along with agreement of a risk score of 12.
3.3 BAF Risk 1.3 Recovery Programme	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 15.
3.4 BAF Risk 4.2 ED 4 Hour Standard	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 20

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 December 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**24 November 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 New Hospital Update				NHP has submitted its Programme Business Case to the Major Projects Review Group for consideration at their meeting on 06.12.22 and the national procurement/commercial strategy continues to be fleshed out. The Demand and Capacity (D&C) Model for the new hospital has been reviewed and updated and it is recommended further work on this is put on hold until NHP issue their standard D&C model.
4.2 Estates & Facilities Quarterly Update	Y	Y	Y	The report summarised the performance of Estates and Facilities services from April to September 2022-23 and demonstrated the work underway to address the Trust's challenging infrastructure to ensure business continuity. It was noted that a deep dive into compliance with cleaning standards is being undertaken.
4.3 BAF Risk 3.1 Estate & Infrastructure	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 01 December 2022

Agenda item:	6.2								
Presented by:	Tom Burton, DoF								
Prepared by:	Mark Pockett, DDoF and Wole Ajiboye, Head of FM								
Date prepared:	16th November 2022								
Subject / title:	Month 7 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 to August 2022 (Month 5). The Trust reported a deficit of £0.3m in month 7 and £11.5m Year-to-Date. The Trust continues to discuss the anticipated year end forecast with regulators; to date we have been reporting a breakeven position. The financial position in month 7 has started to evidence the actions to reduce and slow down the run rate including the higher levels of expenditure relating to Elective recovery including outsourcing and insourcing and Estates maintenance costs. The Trust's agency costs, particularly Medical staff, remain at the levels higher than previous years								
Recommendation:	The Board is asked to note the month 5 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:	PAF on 29th September 2022
Risk / links with the BAF:	BAF risks 5.1 and 5.2
Legislation, regulatory, equality, diversity and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

The Princess Alexandra Hospital NHS Trust

Summary finance notes

- 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 £0.3m in month and £11.5m YTD.

- 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.

- 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 outsourcing\insourcing and Estates maintenance costs.

- The Trust's agency costs, particularly Medical staff, remain at the levels seen in previous months.

- Pay is overspent by £1.1m in month and £9.0m year to date against plan. Overall pay has reduced from month 6 due to 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.

- Cash balance is £40.7m as at month 7. The movement form the closing 21/22 cash balance reflects the Trust's YTD deficit together with working capital movements.

Trust Board

NHS
The Princess Alexandra Hospital
NHS Trust

October - Month 7

Financial Performance

Financial Position

Summary financial results

NHS
The Princess Alexandra Hospital NHS Trust

	FY Budget	Month 7			YTD - Oct		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS Clinical SLA Income	318.4	26.5	26.7	**0.2**	185.7	186.0	**0.3**
Non NHS Clinical Income	12.4	1.0	1.3	**0.2**	7.3	8.3	**1.1**
Non Clinical Income	1.2	0.1	0.1	**0.0**	0.7	1.2	**0.5**
Income Total	**332.0**	**27.7**	**28.1**	**0.4**	**193.7**	**195.6**	**1.9**
Pay							
Substantive	(203.2)	(17.0)	(15.5)	**1.5**	(118.3)	(108.2)	**10.1**
Bank	(5.0)	(0.4)	(2.5)	**(2.1)**	(2.9)	(16.5)	**(13.5)**
Agency	(5.9)	(0.5)	(1.0)	**(0.5)**	(3.6)	(9.2)	**(5.5)**
Pay Total	**(214.2)**	**(17.9)**	**(19.0)**	**(1.1)**	**(124.8)**	**(133.8)**	**(9.0)**
Non-Pay							
Drugs & Medical Gases	(28.1)	(2.4)	(2.3)	**0.1**	(16.4)	(15.4)	**1.0**
Supplies & Services - Clinical	(19.2)	(1.6)	(1.5)	**0.2**	(11.3)	(12.2)	**(0.9)**
Supplies & Services - General	(5.2)	(0.4)	(0.3)	**0.1**	(3.0)	(2.9)	**0.1**
All other non pay costs	(46.9)	(3.9)	(4.0)	**(0.1)**	(27.5)	(33.0)	**(5.5)**
Non-Pay Total	**(99.4)**	**(8.4)**	**(8.1)**	**0.3**	**(58.2)**	**(63.5)**	**(5.3)**
Financing & Depn							
Non NHS Clinical Income	(4.7)	(0.4)	(0.3)	**0.1**	(2.8)	(2.5)	**0.3**
All other non pay costs	(14.0)	(1.2)	(1.0)	**0.1**	(8.2)	(7.3)	**0.9**
Financing & Depn Total	**(18.7)**	**(1.6)**	**(1.4)**	**0.2**	**(10.9)**	**(9.8)**	**1.1**
Grand Total	**(0.3)**	**(0.2)**	**(0.3)**	**(0.2)**	**(0.3)**	**(11.5)**	**(11.2)**

Summary financial results

The Princess Alexandra Hospital NHS Trust

Monthly Summary

- As reported in previous months the YTD deficit has been driven by the higher staffing, insourced and out sourced activity related to elective recovery and 104 week waits, continuing Covid-19 related expenditure and higher estates costs.

- Working with the Trust and operational colleagues the level of overspend has been discussed and challenged at various forums including the weekly PRMs .The financial position has started to evidence the ongoing actions to reduce and slow down the run rate.

Elective Recovery Fund (ERF) Income & Expenditure

The Princess Alexandra Hospital NHS Trust

	Apr 22 Actual	May 22 Actual	Jun 22 Actual	Jul 22 Actual	Aug 22 Actual	Sep 22 Actual	Oct 22 Actual	YTD
Income	0	1,016	508	508	508	558	844	3,941
Expenditure	(654)	(813)	(458)	(610)	(623)	(219)	(312)	(3,689)
Surplus/(Deficit)	**(654)**	**203**	**50**	**(102)**	**(115)**	**339**	**532**	**252**

- YTD the Trust has recognised £3.9m of ERF income at month 7, half of the total ERF planned income of £6.7m for 2022/23. The month 7 position includes the ERF income related to Specialised Commissioning contracts, notification of this income was received during month 7.

- No ERF clawback from the ICB has been confirm by NHSE for 22/23.

- The Trust's direct costs of delivering this elective recovery activity is £3.7m. The higher expenditure has been the linked to the use of insourcing and outsourcing to deliver the increased activity. The use of these services has reduced from Month 6 and we are starting to see the financial impacts of the actions taken to reduce and slow down the run rate

Workforce

The Princess Alexandra Hospital NHS Trust

	FY Budget	Month 7			YTD - October 2022		
		Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Pay							
Substantive	203,236	17,013	15,485	(1,528)	118,258	108,184	(10,074)
Bank	5,043	419	2,475	**2,055**	2,946	16,459	**13,513**
Agency	5,948	474	1,014	**539**	3,642	9,160	**5,518**
Total Pay Cost	**214,227**	**17,907**	**18,973**	**1,067**	**124,847**	**133,803**	**8,957**

	Month 7				YTD - October 2022			
	Permanent £'000	Bank £'000	Agency £'000	Total £'000	Permanent £'000	Bank £'000	Agency £'000	Total £'000
Pay								
Medical	4,530	771	669	**5,970**	31,729	5,062	6,070	**42,861**
Nursing	5,729	1,178	216	**7,123**	40,137	8,228	1,354	**49,719**
Scientific, Therapeutic & Tech	1,914	95	94	**2,104**	13,322	582	943	**14,847**
Ancillary	652	247	(3)	**896**	4,534	1,626	(3)	**6,157**
Admin & Clerical	1,634	184	37	**1,855**	11,454	960	797	**13,210**
Snr Managers	972	0	0	**972**	6,705	0	0	**6,705**
Maintenance & Works Staff	53	0	0	**53**	304	0	0	**304**
Total Pay Cost (Actual)	**15,485**	**2,475**	**1,014**	**18,973**	**108,184**	**16,459**	**9,160**	**133,803**

- Total staff cost of £19.0m in month and £133.8m year to date
- Substantive Pay is continues to underspend due to vacancies, these are backfilled using bank and agency staff often at higher costs .
- Medical staffing accounts for £6.1m (66%) of the total agency usage year to date.

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

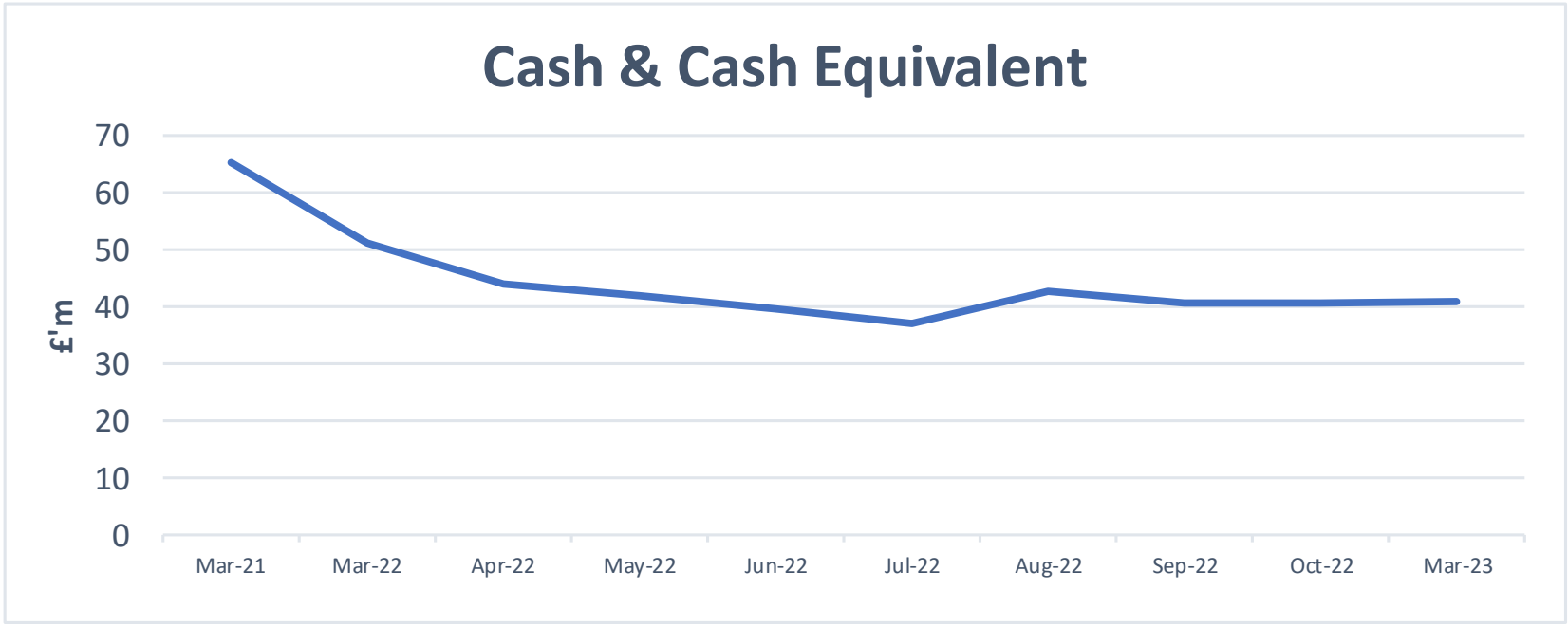
Statement of Financial Position	31 Mar 2022 £m	30 September 2022 £m	31 October 2022 £m	In Month Variance £m	YTD Variance £m
Non-current assets					
Property, plant & equipment	149.1	147.7	148.9	1.2	(0.2)
Intangible assets	11.0	9.9	10.1	0.2	(0.9)
Trade & other receivables	0.6	0.6	0.6	-	-
Total non-current assets	**160.7**	**158.2**	**159.6**	**1.4**	**(1.2)**
Current assets					
Inventories	5.2	5.2	5.2	-	-
Trade & other receivables	12.0	12.4	12.8	0.4	0.8
Cash & cash equivalents	51.1	40.7	40.7	0.1	(10.3)
Total current assets	**68.2**	**58.2**	**58.7**	**0.5**	**(9.5)**
Total assets	**228.9**	**216.4**	**218.3**	**1.9**	**(10.7)**
Current liabilities					
Trade & other payables	(45.8)	(44.0)	(46.3)	(2.2)	(0.5)
Provisions	(1.6)	(1.3)	(1.3)	-	0.3
Borrowings	(0.0)	(0.0)	-	-	-
Total current liabilities	**(47.4)**	**(45.4)**	**(47.6)**	**(2.2)**	**(0.2)**
Net current assets/ (liabilities)	**20.8**	**12.8**	**11.1**	**(1.7)**	**(9.7)**
Total assets less current liabilities	**181.6**	**171.0**	**170.7**	**(0.3)**	**(10.9)**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.5)	(1.0)	(1.0)	-	0.5
Borrowings	-	-	-	-	-
Total non-current liabilities	**(1.5)**	**(1.0)**	**(1.0)**	**-**	**0.5**
Total assets employed	**180.0**	**170.0**	**169.6**	**(0.3)**	**(10.4)**
Financed by:					
Public dividend capital	327.8	327.7	327.7	-	(0.1)
Income and expenditure reserve	(147.8)	(158.9)	(159.3)	(0.3)	(11.5)
Revaluation reserve	-	1.2	1.2	-	1.2
Total taxpayers' equity	**180.0**	**170.0**	**169.6**	**(0.3)**	**(10.4)**

- **Non Current Assets** have increased in month reflecting the capital expenditure in month.
- **Trade and Other Receivables** are in line with the balances from month.
- **Cash balances** remain at £40.7m
- **Trade and Other Payables** have increased due to slightly higher levels of unpaid invoices at the end of October

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	Mar-23	
65,242	51,075	44,051	42,022	39,522	37,129	42,725	40,667	40,741	40,795	↑



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 December 2022

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	21 November 2022
Subject / title:	M7 2022/23 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	x

6.3

Key issues:

Patients		
Patients	**Pressure Ulcers**	Has now entered special cause variation with eight months below the mean
	Falls per 1000 bed days	Have now entered positive special cause variation, with a statistically significant seventh month below the mean
People		
People	**Appraisals**	Still in special cause variation, with performance consistently at or near 80%
	Statutory and Mandatory Training	In special cause variation, and showing a statistically consistent trend. Following an increase in September, we have seen performance dip back to its consistent level at or near to 86%
	Sickness Absence	Has spiked into special cause variation due to increase above the upper control limit. This followed an increase in sickness rate in August
Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Has returned to special cause variation due to a signifcant dip in performance from August, and the lowest it has been since January
	Cancer 62 day pathway	Performance remains in negative special cause variation. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
	Diagnostics	Whilst performance remains in common cause variation; after a downward trend, performance has stabilised in October
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained constant for the last three months following a small increase in July. We have also seen the second month of reduction in 78 week patients
	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 four months and remains in special cause variation
Pounds		
Pounds	Surplus	The Trust reported a deficit of £0.3m in October (Month 7) and year to date deficit of £11.5m (planned deficit in month of £0.2m and year to date of £0.3m). 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. Planned savings for month 7 are £1.4m (£4.9m year to date). The FY forecast waste\efficiency is currently £11.7m, the YTD identified savings are £5.3m, which is made up of £0.6m recurrent savings and £4.7m non-recurrent savings. Work continues within each divsion to deliver additional schemes and savings.
	Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes external PDC for the ongoing new hospital project of £1.1m. As at Month 7 the year to date capital spend total is £6.1m, excluding the impact of IFRS 16. Whilst further national support will be available to the Trust it is fully anticipated the capital programme will be fully utilised in 22/23. Note: some additional PDC may be made available for digital programmes but this will be confirmed in due course
	Cash	The Trust's cash balance is £40.7m. The cash reserves have been boosted in recent years due to the national Covid support received by the Trust, this balance will reduce in 22/23 as we continue to run with a deficit. 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

Your future | Our hospital

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.24.11.22 and QSC.25.11.22
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 October 2022

modern • integrated • outstanding

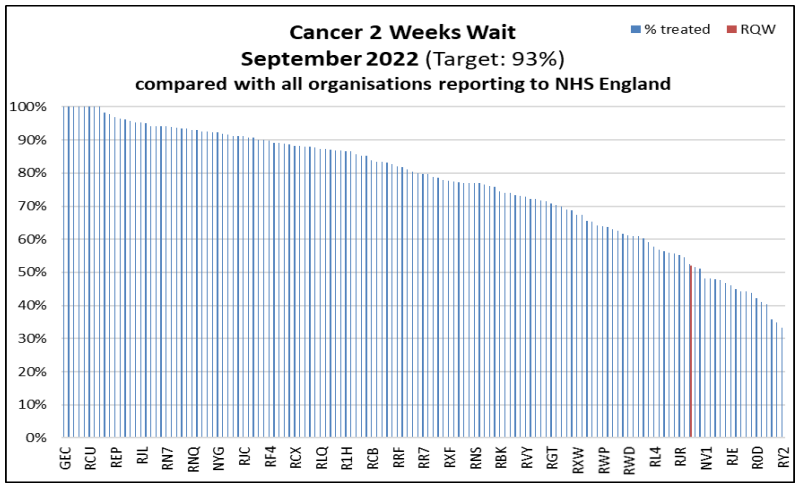
patient at heart • everyday excellence • creative collaboration

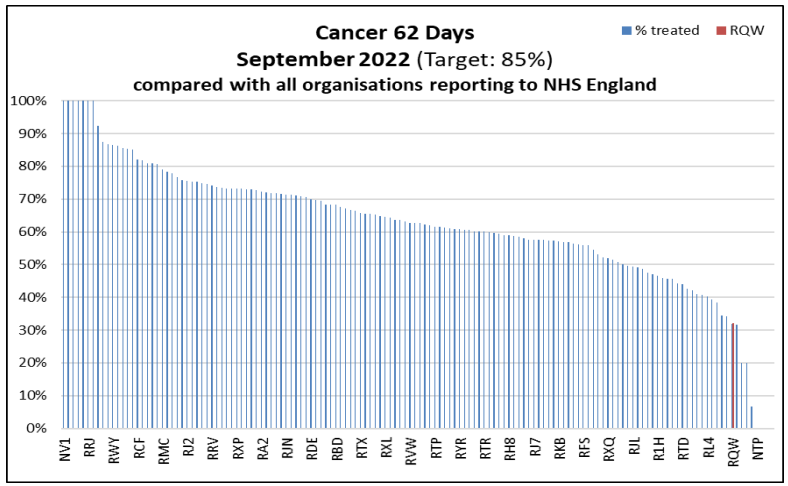
Patients		
Patients	Mothers delivering in birthing unit/home	Has now entered special cause variation with eight months below the mean
	Falls minor, moderate & severe	Have now entered positive special cause variation, with a statistically significant seventh month below the mean
Pounds		
Pounds	Surplus	The Trust reported a deficit of £0.3m in October (Month 7) and year to date deficit of £11.5m (planned deficit in month of £0.2m and year to date of £0.3m). 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. Planned savings for month 7 are £1.4m (£4.9m year to date). The FY forecast waste\efficiency is currently £11.7m, the YTD identified savings are £5.3m, which is made up of £0.6m recurrent savings and £4.7m non-recurrent savings. Work continues within each divsion to deliver additional schemes and savings.
	Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes external PDC for the ongoing new hospital project of £1.1m. As at Month 7 the year to date capital spend total is £6.1m, excluding the impact of IFRS 16. Whilst further national support will be available to the Trust it is fully anticipated the capital programme will be fully utilised in 22/23. Note: some additional PDC may be made available for digital programmes but this will be confirmed in due course
	Cash	The Trust's cash balance is £40.7m. The cash reserves have been boosted in recent years due to the national Covid support received by the Trust, this balance will reduce in 22/23 as we continue to run with a deficit. 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

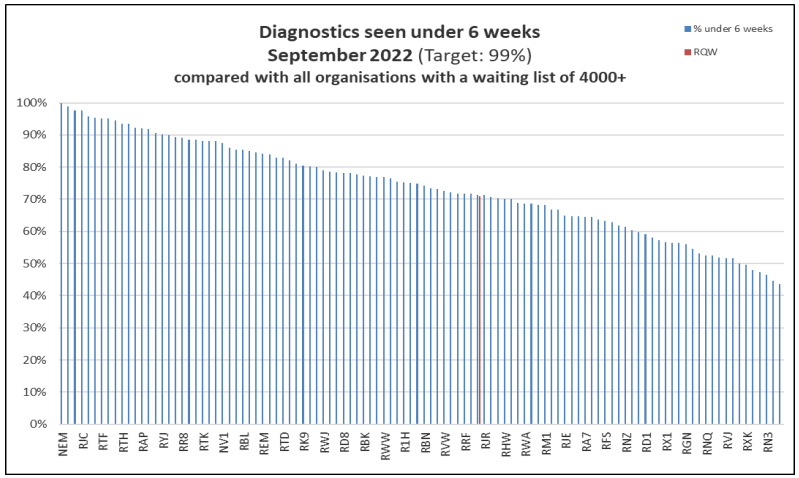
People		
People	Appraisals	Still in special cause variation, with performance consistently at or near 80%
	Statutory and Mandatory Training	In special cause variation, and showing a statistically consistent trend. Following an increase in September, we have seen performance dip back to its consistent level at or near to 86%
	Sickness Absence	Has spiked into special cause variation due to increase above the upper control limit. This followed an increase in sickness rate in August
Performance		
Performance	RTT	Performance remains in special cause variation, but recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Has returned to special cause variation due to a signifcant dip in performance from August, and the lowest it has been since January
	Cancer 62 day pathway	Performance remains in negative special cause variation. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
	Diagnostics	Whilst performance remains in common cause variation; after a downward trend, performance has stabilised in October
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained constant for the last three months following a small increase in July. We have also seen the second month of reduction in 78 week patients
	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 four months and remains in special cause variation

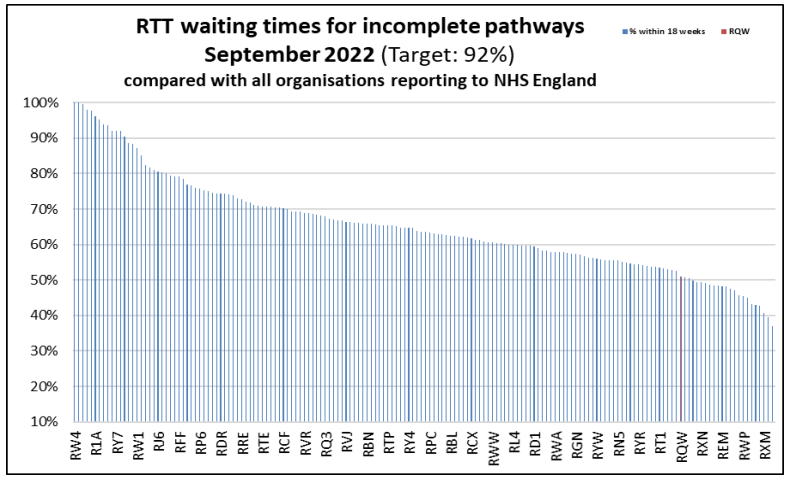
Summary

National Benchmarking









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

A&E Performance (all types)
October 2022 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Y02428 Y03007 NNJ14 NQTE4 NDJ AAH NNJ0H NNFA7 RWX NQT5H RQ3 RDR AD913 REP RL4 RQX RBS RN7 RXN RNZ RM1 RBD RRF R1K RXC RWG RJE RBL RHM RJZ RM3 RF4 RBT RLQ RD1 RWA

Benchmarking

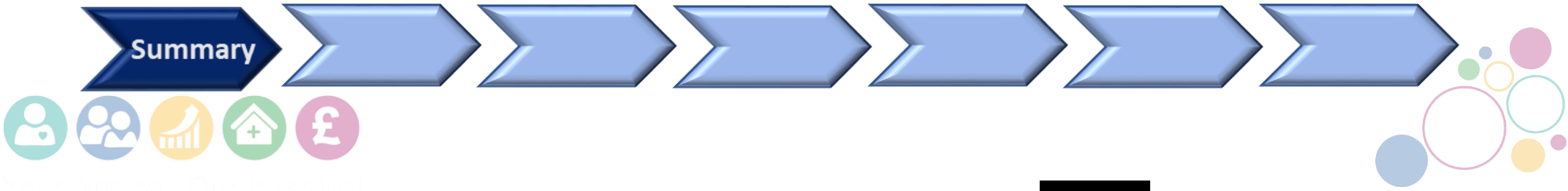
The difference between common and special cause variation

Common Cause Variation

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

Special Cause Variation

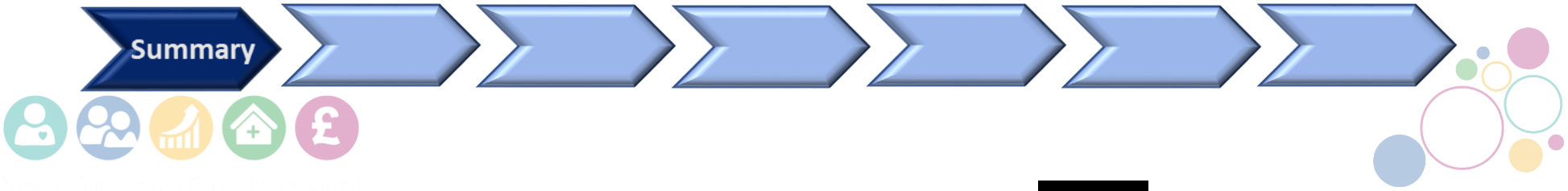
- Is due to irregular causes that are not inherent in the design of the process
- Results in an unstable process that is not predictable
- Also known as non-random or assignable variation
- Shown as blue or orange markers on our SPC charts



How is special cause variation defined and identified

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

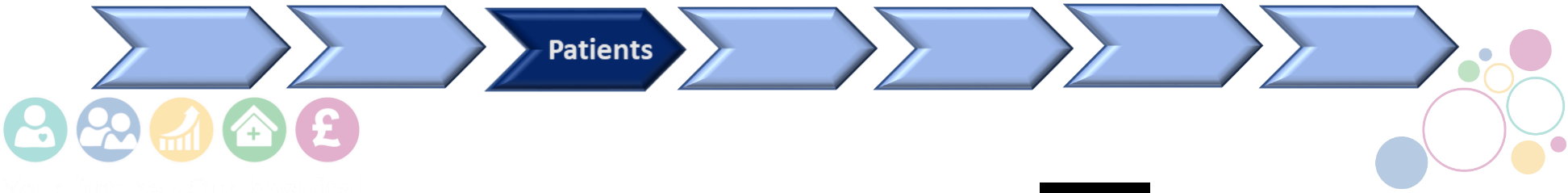
- A single point outside of the upper or lower control limits
- A run of points above or below the average (mean) line.
- Six consecutive points increasing or decreasing
- Two consecutive points near the upper or lower process control limits



Patients

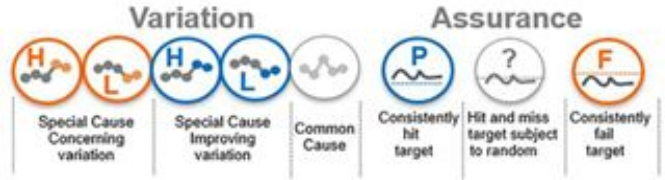
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

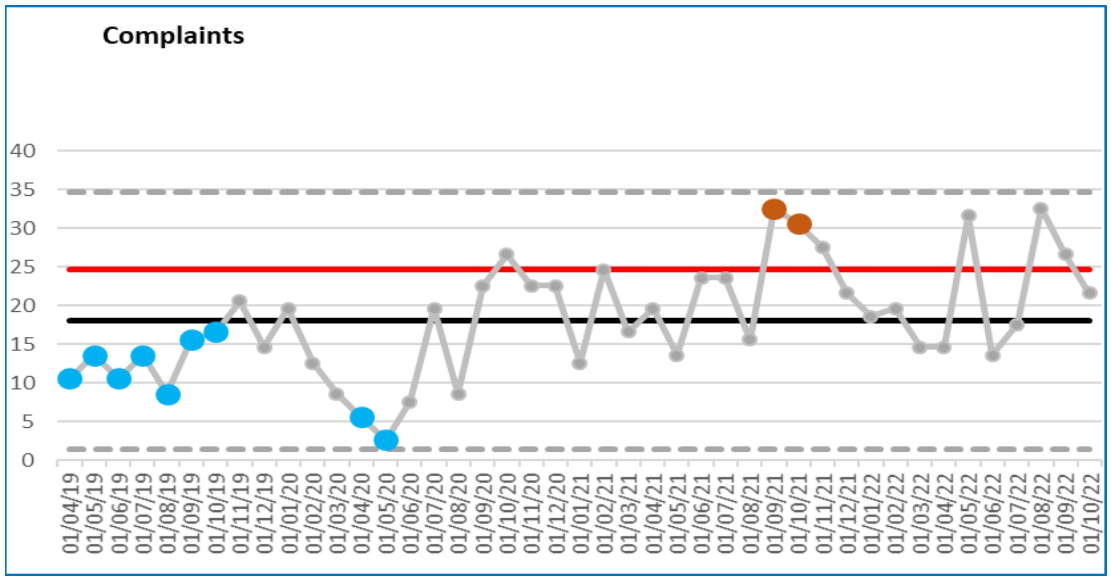
Patients Summary		**Board Sub Committee: Quality and safety Committee**	
Focus Area	**Description and Action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Breast Feeding	Breast feeding rates at delivery. PAHT are undertaking UNICEF assessment of Gold standard achievement in December	For recognition	N/A



KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Oct 22	22	25			18	2	35
Compliments	Oct 22	83	50			114	-87	316
PALS	Oct 22	501	none			289	154	425
Complaints closed within target	Oct 22	5	none			5	-3	14
% of complaints where an extension has been agreed	Oct 22	45%	none			44%	12%	75%
Mixed Sex Accommodation Breach	Oct 22	8	0			7	-4	19
Serious Incidents	Oct 22	1	none			4	-4	12
MSSA	Oct 22	2	none			1	-1	3
CDIFF	Oct 22	0	none			5	-3	13
Hand Hygiene	Oct 22	96%	none			92%	77%	107%
eColi	Oct 22	4	3			1	-1	4
Klebsiella	Oct 22	1	2			1	-1	3
Pseudomonas	Oct 22	1	1			0	-1	2
Falls per 1000 bed days	Oct 22	6	9			8	6	11
Falls total minor, moderate & severe	Oct 22	18	13			24	10	38
Pressure Ulcers per 1000 bed days	Oct 22	2	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Oct 22	3	3			5	-3	12
Total number of mothers delivering in birthing unit/home	Oct 22	3%	20%			10%	-1%	22%
Number of mothers delivering in Labour Ward/Theatres	Oct 22	97%	75%			89%	76%	102%
Number of women due to deliver at PAH adjusted for misc/TOPs	Oct 22	324	375			330	272	388
Smoking rates at booking	Oct 22	8%	none			9%	3%	14%
Smoking rates at delivery	Oct 22	8%	6%			10%	5%	15%
Breast feeding rates at delivery	Oct 22	73%	74%			76%	67%	85%
Total Planned C-Sections	Dec 21	20%	none			15%	8%	23%
Total Unscheduled C-Sections	Dec 21	21%	none			18%	13%	24%

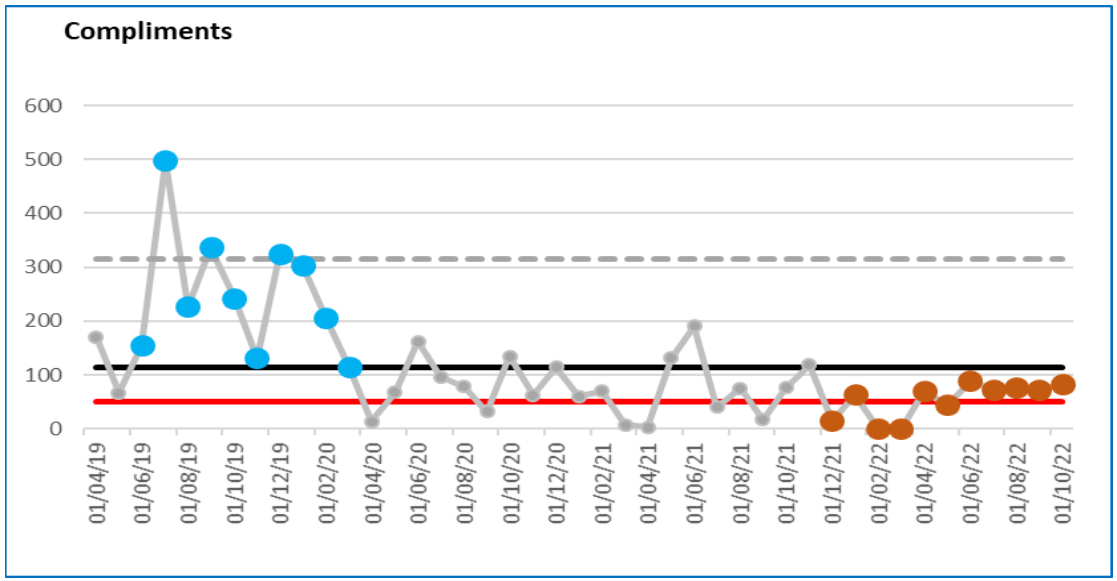
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Oct 22	3%	none			4%	1%	7%
CTG training compliance midwives	Oct 22	89%	85%			73%	55%	91%
CTG training compliance doctors	Sep 22	63%	85%			75%	51%	99%
Still births	Oct 22	0	none			1	-2	3
Patients detained under MHA	Oct 22	0	none			0	-1	2
Patients detained under section 136	Oct 22	6	none			1	-2	3
Mental health patient incidents	Oct 22	14	none			12	-1	24
Mental health patient complaints	Oct 22	1	none			0	-1	1
Mental health patient PALS	Oct 22	3	none			2	-1	5
Patients with LD and Autism accessing inpatient services	Oct 22	28	none			25	5	45
Patients who died in their preferred place of death	Jan 22	54%	none			57%	21%	92%
C-DIFF Hospital onset healthcare associated	Oct 22	0	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Oct 22	0	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Oct 22	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Oct 22	0	none			1	-3	5
Covid-19 new positive inpatients	Oct 22	146	none			138	-97	373
MRSA	Oct 22	0	0			0	0	0
Births	Oct 22	336	none			322	267	376
Instrumental births	Oct 22	23	none			25	5	45
Pre- term births	Oct 22	0	none			21	4	39
Continuity of carer	Oct 22	8%	none			24%	13%	34%
Women booked in month	Oct 22	369	none			363	297	429





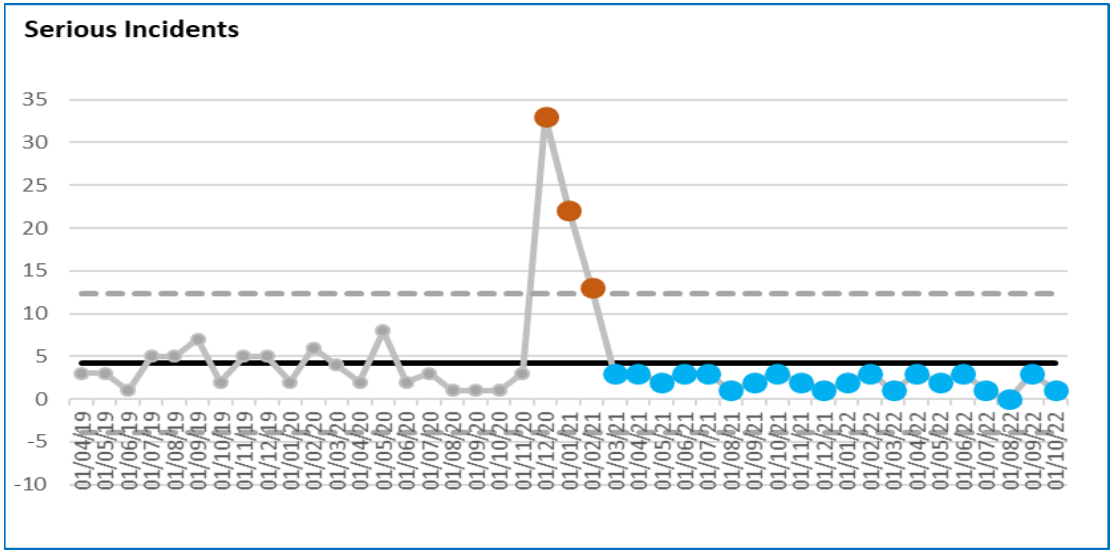
Oct-22
22
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation	Complaints increases reflects operational issues.	Thematic analysis captured in our patient safety and experience (Quality) strategy with key actions in place. Review of our complaints management process underway to ensure strengthen complaints process. Re timeliness of response: objective to return to pre-pandemic levels. Case management support. Process workshops and divisional PSQ recruitment ongoing.	No cases older than 6 months by March 2023.



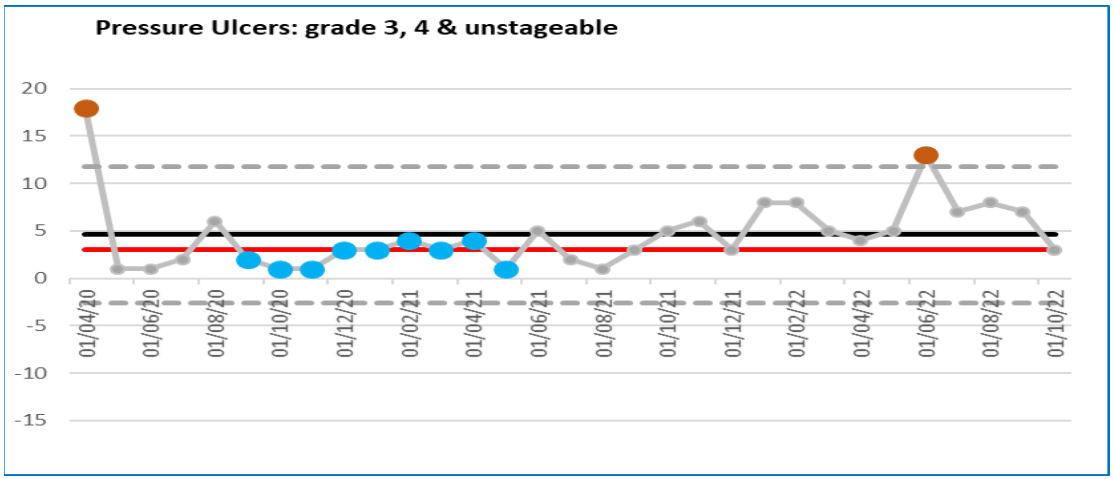
Oct-22
83
Variance Type
Special cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

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



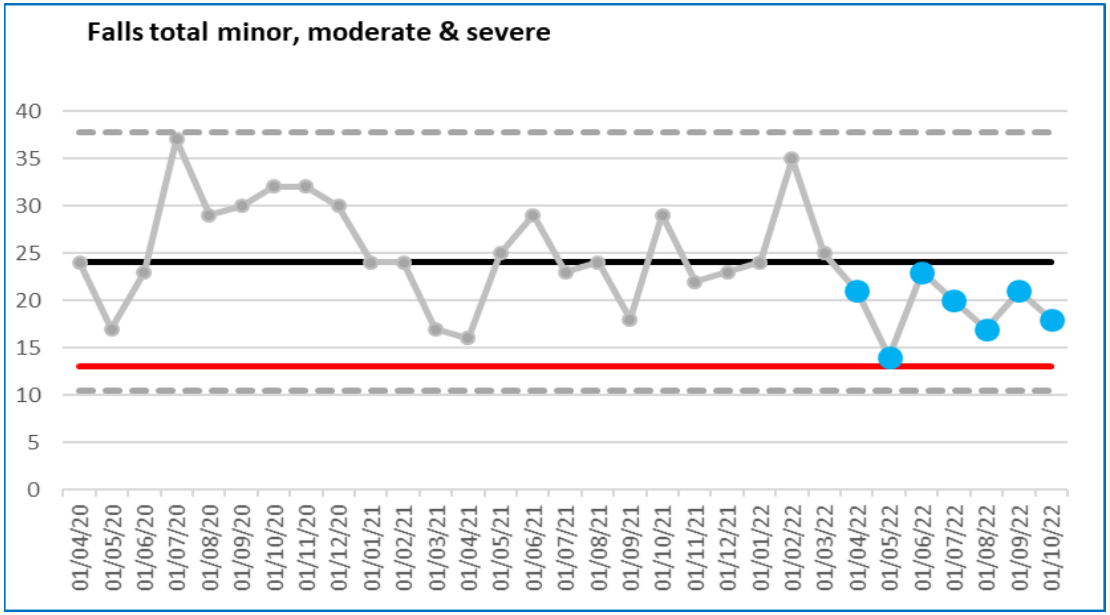
Oct-22
1
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent

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. One serious incidents was raised during October 2022. In month two SI were closed. The trust has 13 serious incident investigations open at this time	Daily local review of incidents by each divisional team is completed with appropriate second stage review at the incidents management group. IMG submits a monthly report on both incident themes & serious incidents onto the Patient Safety Group.



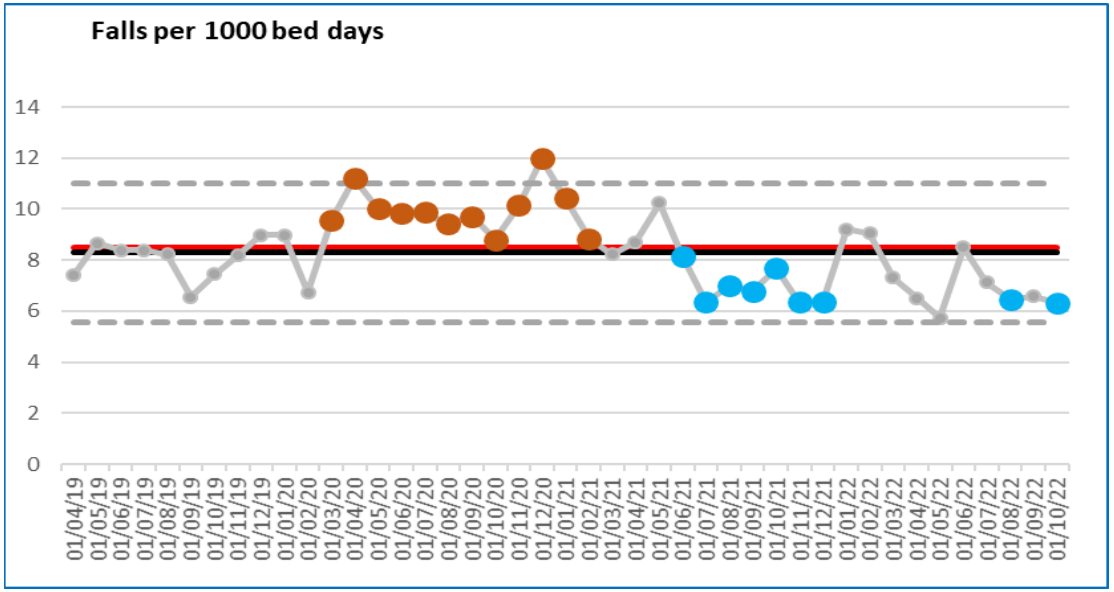
Oct-22
3
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers (PU): grade 3, 4 & Unstageable	Common cause variation while hit & missing the target	There were a total of 35 hospital acquired pressure ulcers (HAPUs) in October 2022, 1 less than September. However there was a significant decrease in moderate harms from 7 to 3, one of which is likely to be a minor harm once fully investigated. All remaining pressure ulcers were minor harms predominantly on the heels/feet and sacrum/buttocks. Sadly, 2 patients were nearing end of life when a pressure ulcer developed.	As part of the Tissue Viability Training programme the pressure ulcer study day in September was a great success with very positive feedback from all 23 Registered Nurses especially the 'practical interventions and tips' for preventing pressure ulcers. New pressure ulcer training dates for 2023 will be added to Alexnet once the training needs analysis for clinical staff has been completed aligned to the Pressure Ulcer Prevention Strategy. TVN's will continue to conduct SSKIN audits and assist in the investigations for harm free care to highlight trends for action planning. All resources continue to be available via AlexNet, Youtube, ward folders and Xdrive.	PU prevention strategy in place



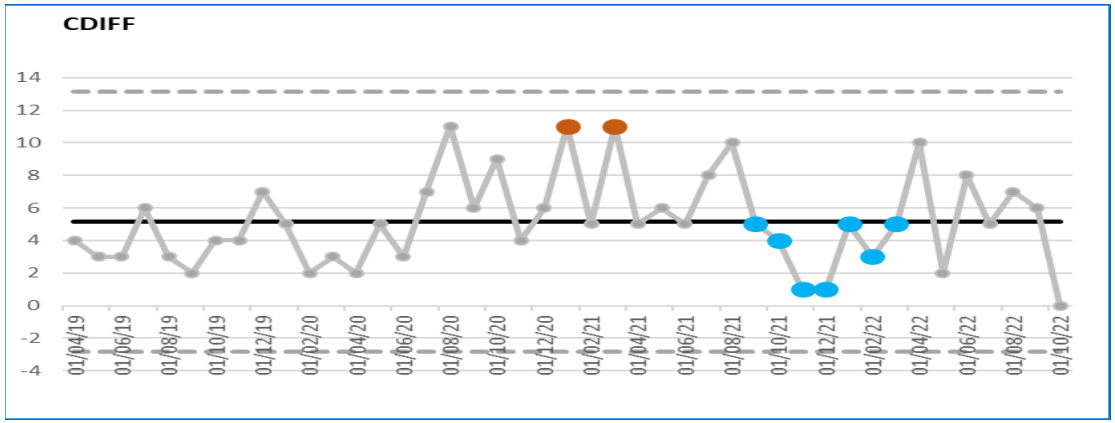
Oct-22
18
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

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 and also to maintain falls with harm per 1000 occupied bed days at below 5.	New falls strategy in place for 2022/23.New method for validating falls with harm is in place	Nil at this point



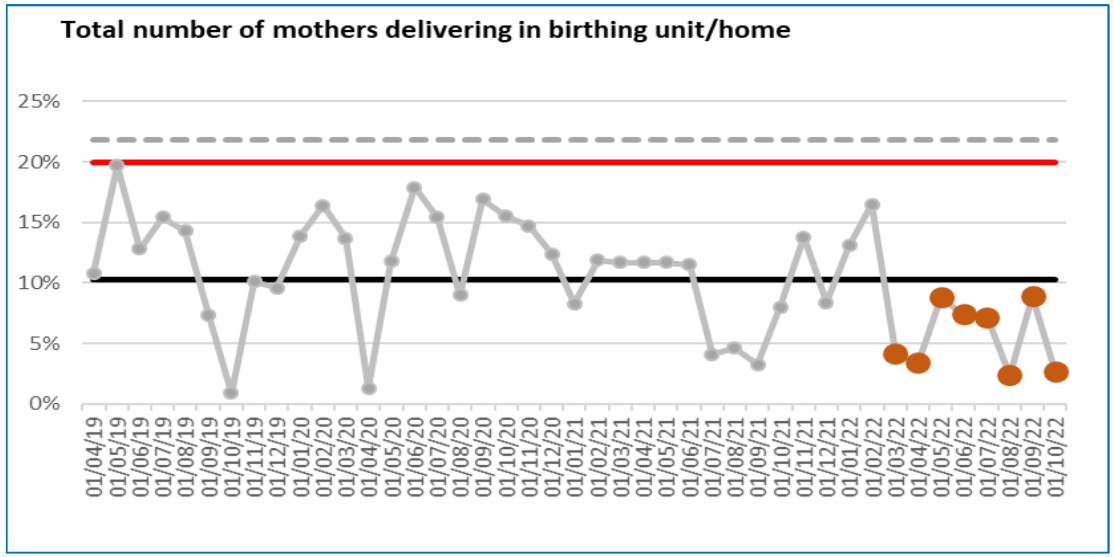
Oct-22
6.33
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

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	



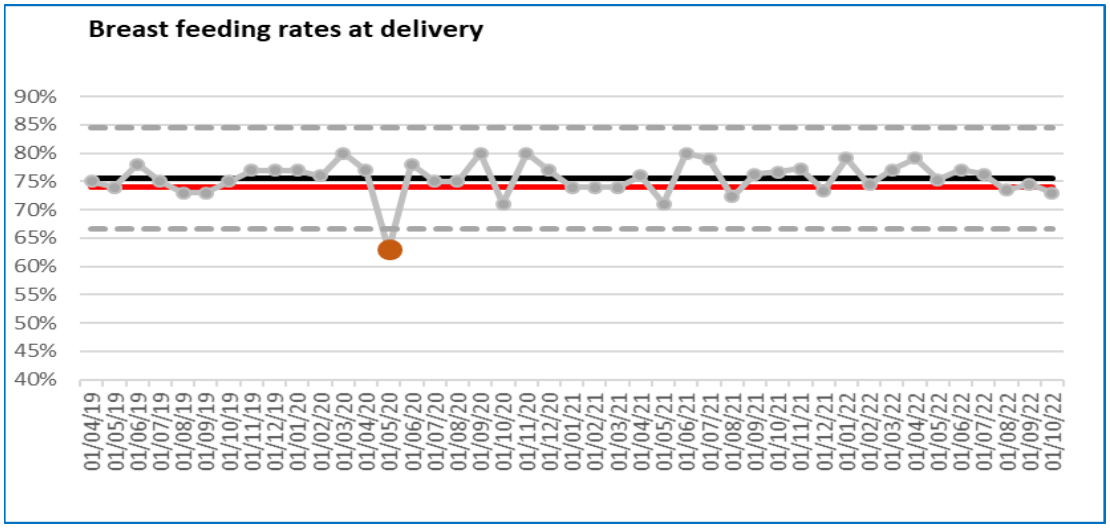
Oct-22
0
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

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



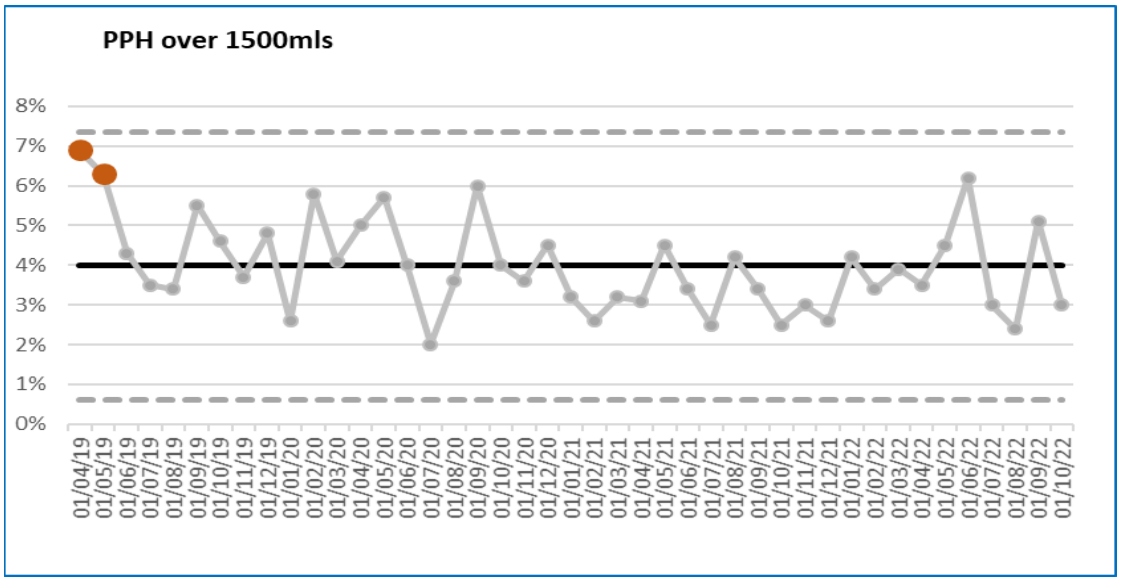
Oct-22
2.7%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

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



Oct-22
73.0%
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.	Recent initiative include; to reduce the number of unknown method of baby feeding at delivery alongside other Baby Feeding data quality initiatives



Oct-22
3.00%
Variance Type
Common cause variation
Target
Not set
Target Achievement

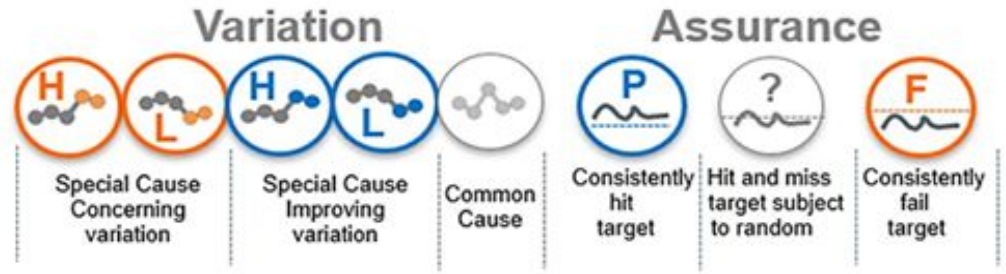
Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	All massive obstetric haemorrhages are reviewed to ensure the appropriate management was followed, including a thematic review of high risk factors	The labour admission risk assessment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

Places

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

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Catering	Refurbishment of main kitchen started and cook chill meals for patients being served until refurbishment completed. New dinner trolley process implemented, trolleys remain on wards and food it taken to them, currently unable to provide food waste figures as process for returning food waste to main kitchen to be developed.	For information	
Estates	Current system is not providing the information required for percentage of jobs attended, however all emergencies are attended immediately. Once the new MICAD system in introduced will be able to provide accuate figures and reports	For information	
Facilities	Sheila Connolly - Strategic head of property services and facilites left the trust on 31.10.2022, replacement being sought	For information	

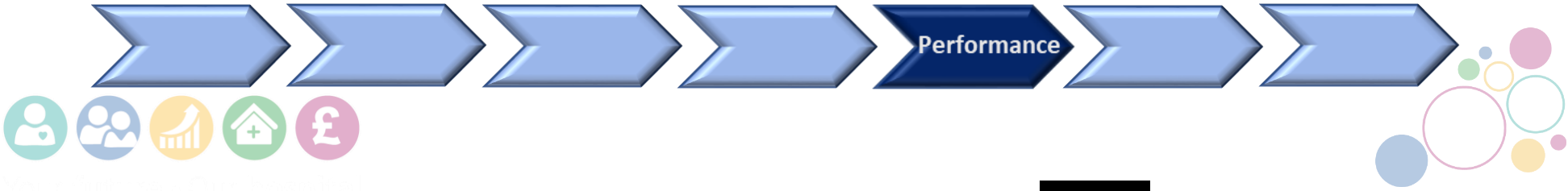
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Sep 22	93%	95%			95%	91%	99%
Meals Served	Oct 22	47706	42120	H		38439	26806	50072
Catering Food Waste	Sep 22	2%	4%	L		5%	-1%	10%
Domestic Services (Cleaning) 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

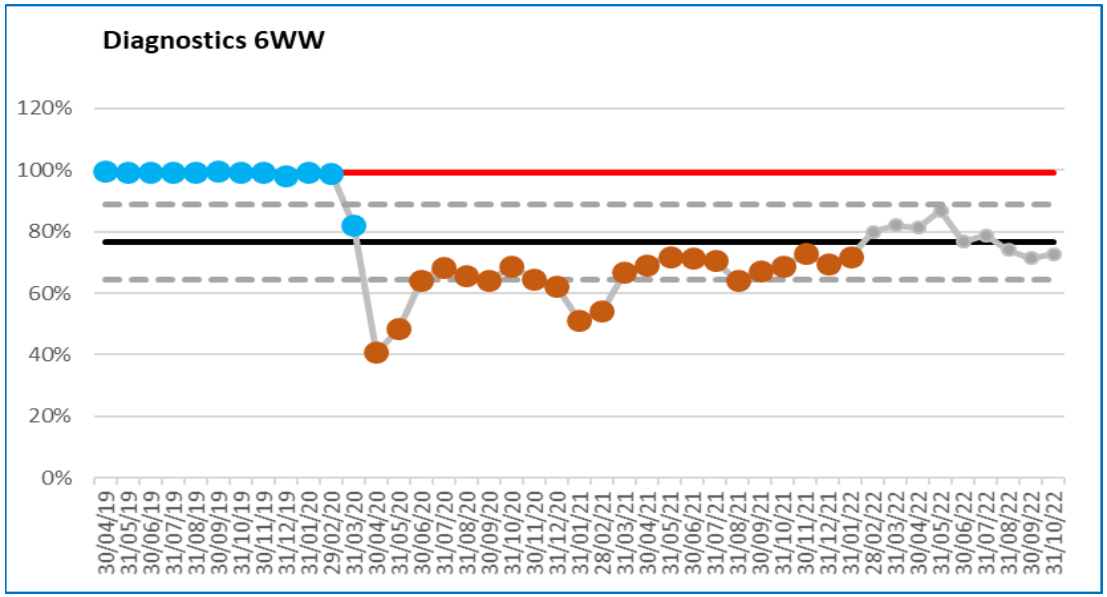
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Emergency Care	Continued increased attendances through the emergency department and decreased flow through the hospital impacting all the key standards. We have included the shadow new emergency standarda of 12 hours in the department in the IPR this month.	For increased visibility and awareness	31/03/2023
RTT/18 weeks	The number of patients waiting over 52 weeks has started to decrease this month and the Trust is ahead of the 78 week recovery trajectory. The Trust is well paced across the region in this performance.	For recognition	31/03/2023
Diagnostics	CT is achieveing the national standard of 95% by 31/3/23 and MRI is close at 92.4%. Most specialities improving performance, but audiology has poor performance and a detailed acion plan is being put in place.	For increased visibility and awareness	31/03/2023
Cancer	Significant increases in referrals over the past few months and staff vacancy have impacted the first appointment standard. 28 day diagnosis standard is steady and an action plan is in place to improve this alongside the CQUIN. Continued focus on diagnosing and treating the patients that have waited the longest. The Trust is making some of the best progress in the Region.	For increased visibility and awareness	31/03/2023



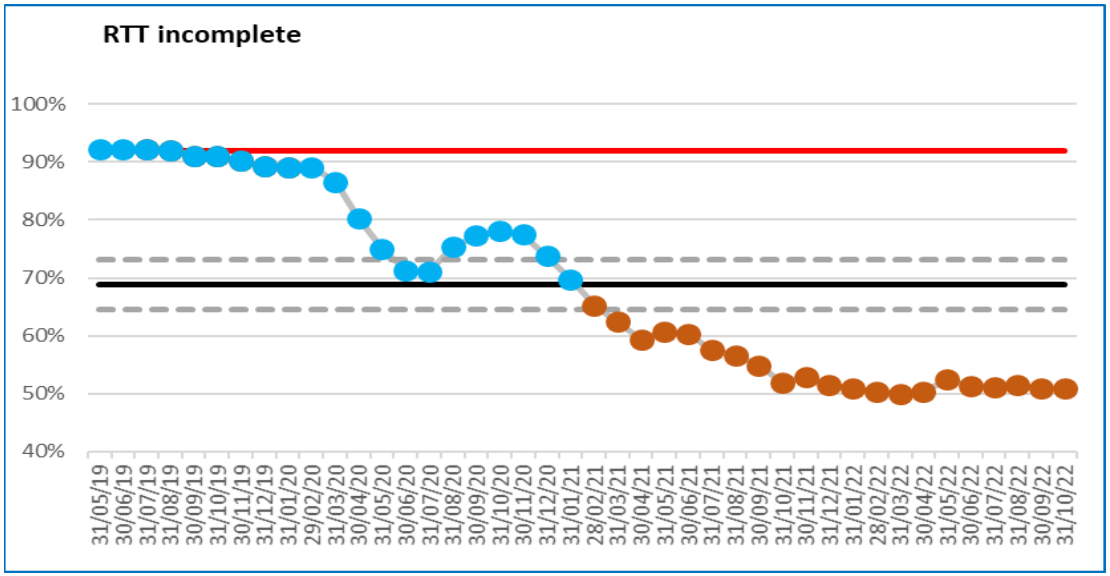
KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Oct 22	51%	92%			69%	64%	73%
RTT admitted	Oct 22	42%	90%			51%	27%	74%
RTT Non admitted	Oct 22	75%	95%			85%	82%	88%
RTT PTL vs RTT PTL & ASIs	Oct 22	79%	none			92%	89%	94%
Cancer 31 days First	Sep 22	91%	96%			93%	84%	102%
Cancer 31 days Subsequent Drugs	Sep 22	94%	98%			98%	91%	106%
Cancer 31 days subsequent surgery	Sep 22	67%	94%			91%	56%	127%
Cancer 2WW	Sep 22	52%	93%			80%	61%	100%
Cancer 62 day shared treatment	Sep 22	32%	85%			65%	44%	87%
Cancer 62 day screening	Sep 22	31%	90%			64%	11%	117%
Cancer 62 Day Consultant Upgrade	Sep 22	69%	90%			82%	59%	105%
Cancer 28 day faster diagnosis	Sep 22	68%	75%			67%	51%	82%
4 Hour standard	Oct 22	53%	95%			72%	64%	80%
ED attendances	Oct 22	11961	none			9341	7224	11458
ED Admitted performance	Oct 22	18%	95%			43%	29%	58%
ED non admitted performance	Oct 22	59%	95%			80%	71%	88%
ED Arrival to Triage	Oct 22	36	15			46	28	64
ED Triage to examination	Oct 22	291	60			110	78	142
ED Examination to referral to specialty average wait	Jul 22	23	45			101	82	120
ED referral to be seen average wait	Aug 22	30	30			78	53	104
Seen by specialty to DTA	Oct 22	136	60			99	76	122
DTA to departure	Oct 22	432	30			237	102	371
Ambulance handovers less than 15 minutes	Oct 22	8%	100%			24%	13%	35%
Ambulance handovers between 15 and 30 mins	Oct 22	28%	0%			40%	31%	48%
Ambulance handovers between 30 and 60 mins	Oct 22	31%	0%			23%	13%	33%

KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Oct 22	33%	0%			13%	3%	23%
Diagnostics 6WW	Oct 22	73%	99%			77%	64%	89%
Patients with a Length of Stay more than 7 days	Oct 22	202	80			156	104	209
Bed occupancy	Oct 22	91%	85%			89%	81%	96%
Discharges between 8am and 5pm	Oct 22	781	none			715	473	957
Discharges between 5pm and 8am	Oct 22	769	none			711	462	959
LOS non elective	Oct 22	5.1	5.1			4.1	3.2	4.9
LOS elective	Oct 22	3.1	4.2			2.4	0.9	4.0
Short Notice clinical cancellations	May 22	4	none			42	-31	116
OP new to follow up ratio	Oct 22	2.0	2.3			2.1	1.8	2.4
OP DNA Rate	Oct 22	6.1%	8.0%			5.0%	3.9%	6.1%
52 Week waits	Oct 22	1804	0			936	656	1215
Proportion of Majors Patient treated within 4 hours in ED Paeds	Oct 22	28%	95%			75%	59%	91%
Patients with a Length of Stay more than 21 days	Oct 22	62	25			47	23	72
12 Hour waits in ED from Arrival	Oct 22	1712	0			626	277	976
12 Hour Trolley waits in ED from DTA	Oct 22	187	0			88	-9	185



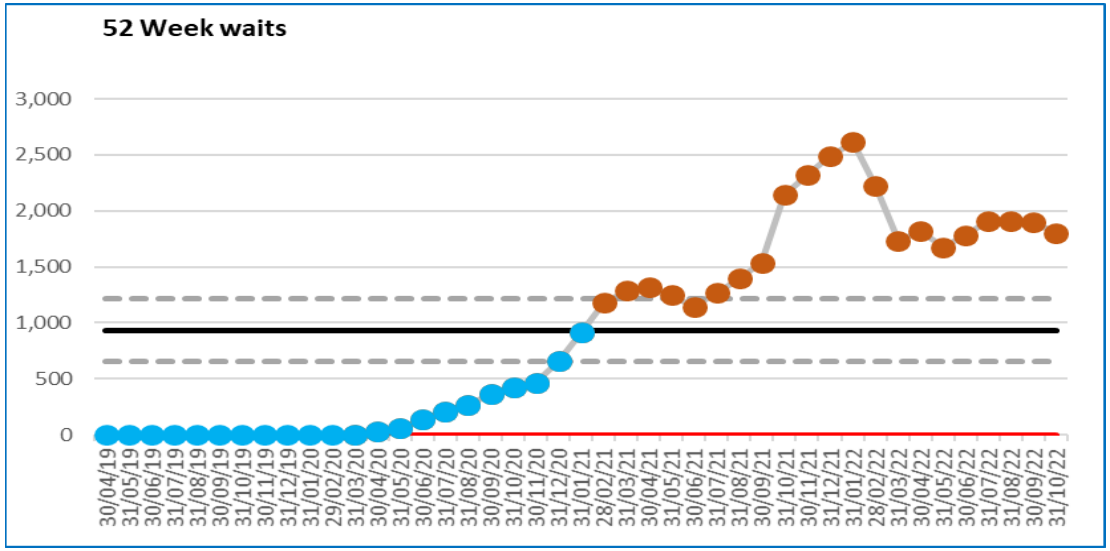
Oct-22
72.64%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	There is a backlog of diagnostic requests which have built up as a result of covid restrictions. Increased referral levels (+20%) continuing. In addition vacancy and sickness in some modalities creating pressure on capacity.	Additional capacity is being delivered as extra sessions & use of independent sector providers. "Smart" booking of longest waiting patients. Additional temporary staff being sourced to support additional capacity.	Clinical prioritisation (99%) of waiting list & review of long waiting patients on DM01 waiting list. A number of modalities are improving month by month. CT is achieveing 98.96%, MRI 92.4%



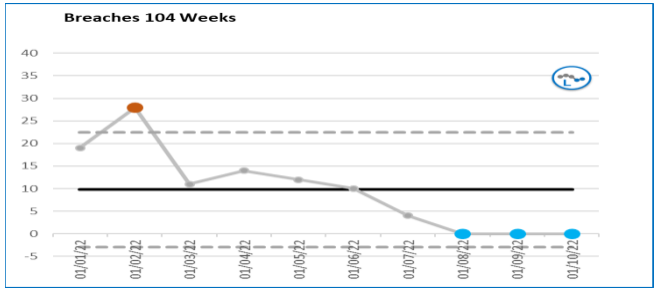
Oct-22
50.9%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

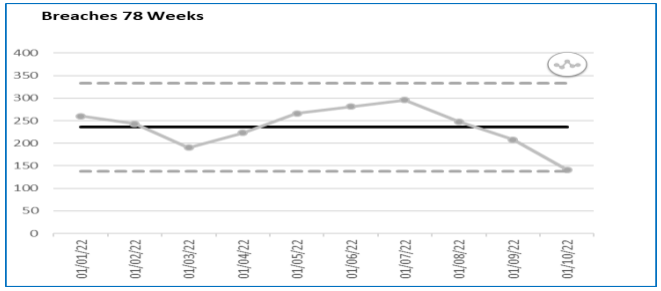
Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective 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 in addition to the longest waiting patients. Elective theatre capacity now restored to pre pandemic levels. Virtual & face to face clinics & additional sessions being put on where possible. Recovery trajectory in place spanning 2 years. Weekly oversight from healthcare groups. All specialties remain under constant review	Admitted backlog clinically prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews of long waiting patients & harm reviews being put into place.

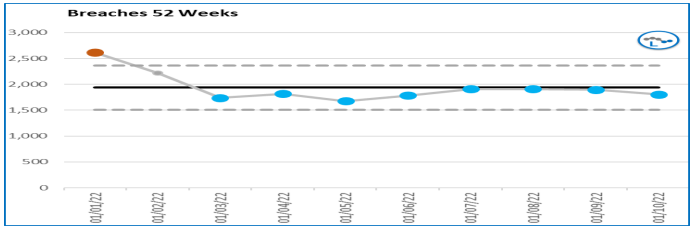


Oct-22
1804
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

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 high numbers of long waiting lower clinical priority patients. Balance between emergency & elective capacity is an ongoing challenge.	Weekly PTL meetings ensuring long waiting patients booked effectively. Trajectory to reduce patients waiting longer than 78 weeks created and being monitored. Currently ahead of trajectory. Specialty level action plan to ensure achievement of trajectory. Close monitoring of long waiting patients numbers through weekly performance meetings.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm. No harm identified to date.



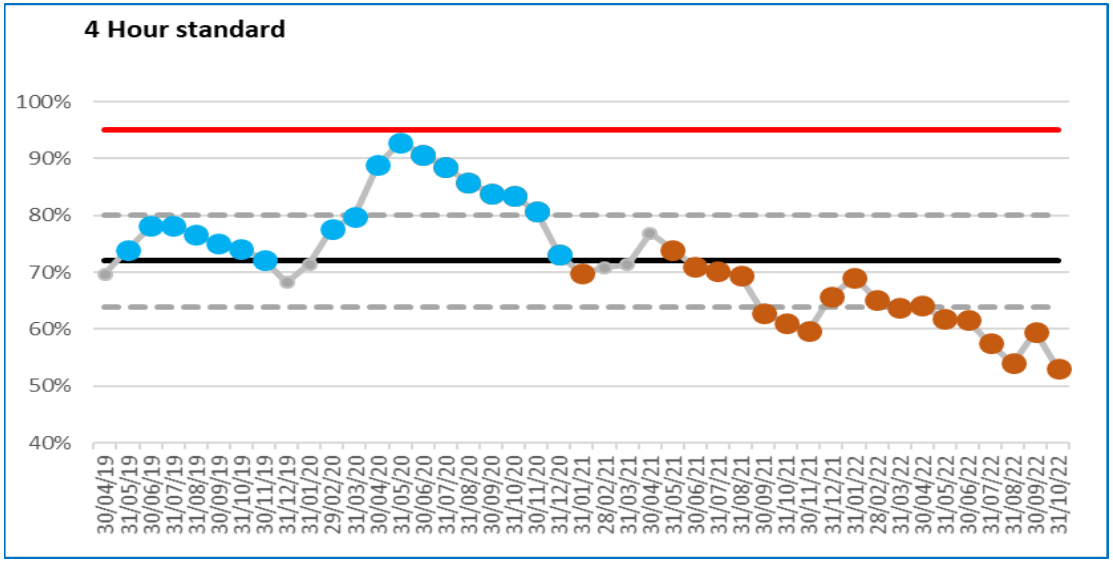




Oct-22

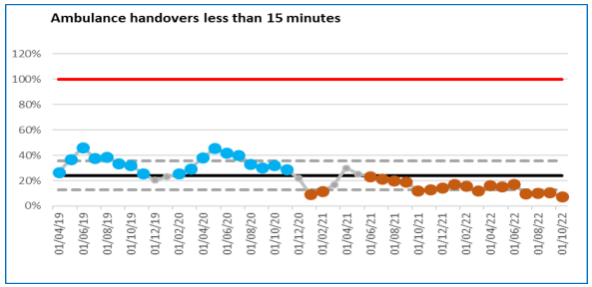
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

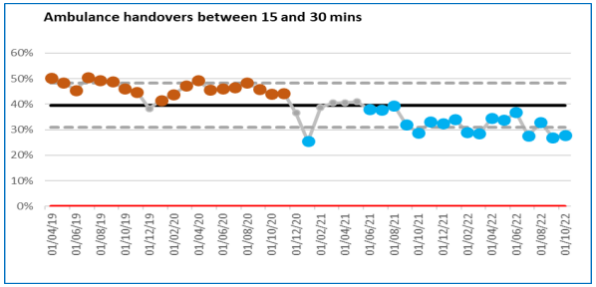

Background	What the chart tells us	Issues	Actions	Mitigation
Breaches	Special cause concerning variation and consistently failing target	The impact of Covid 19 emergency demand on elective capacity has created a backlog of long waiting patients. In addition booking patients in clinical priority order means lower acuity patients waiting longer for appointments and treatment.	Weekly PTL meetings ensuring long waiting patients booked effectively. Trajectory to reduce patients waiting longer than 78 weeks created and being monitored, ahead of trajctory to date. Specialty level action plan to ensure achievement of trajectory. Close monitoring of long waiting patients numbers through weekly performance meetings.	No 104 week patients from August 2022 onwards. Over 52 week patients are being sent questionnaire and if condition has worsened being booked into earlier appointments. Harm reviews being carried out where appropriate.

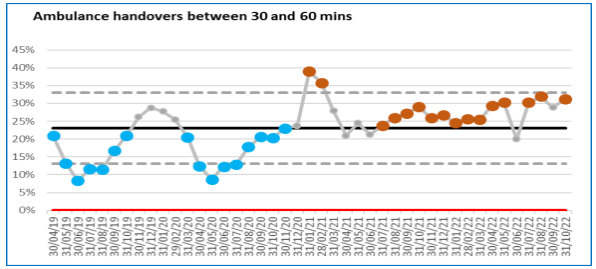


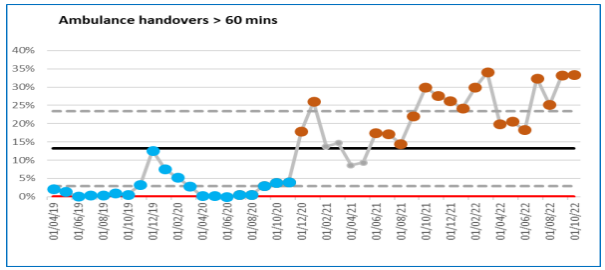
Oct-22
52.98%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and divisional oversight continues through the Urgent Care Board & CQC Quality Project workstream. Internal, Regional and national discharge projects in place. National "100 day challenge" implemented to improve flow and ED performance. Winter plan prepared across ICS and in place with increased emergency resources, with additional SDEC capacity being created w/c 28/11.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours. Implementation of NerveCentre has improved triage response and clinical prioritisation of patients.



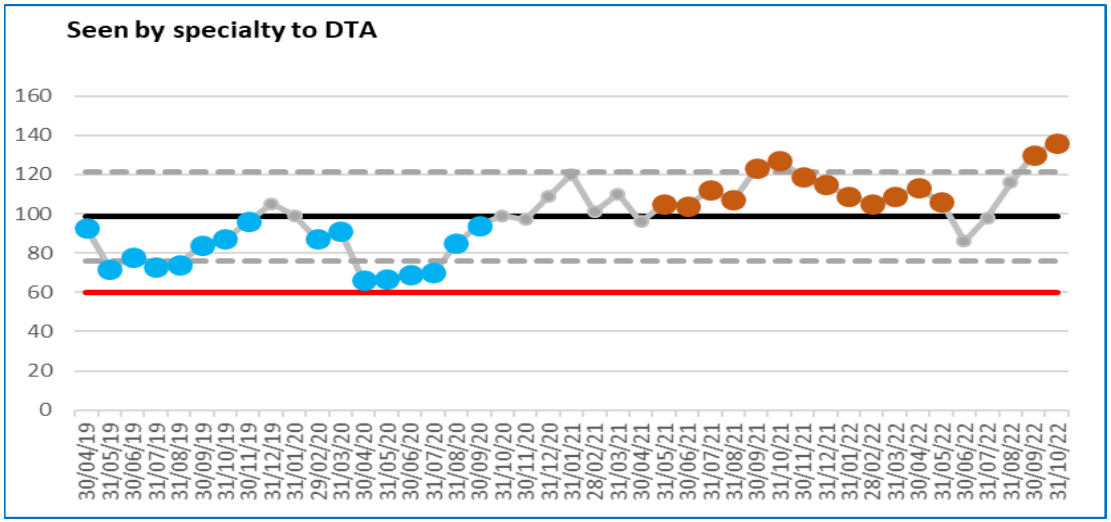






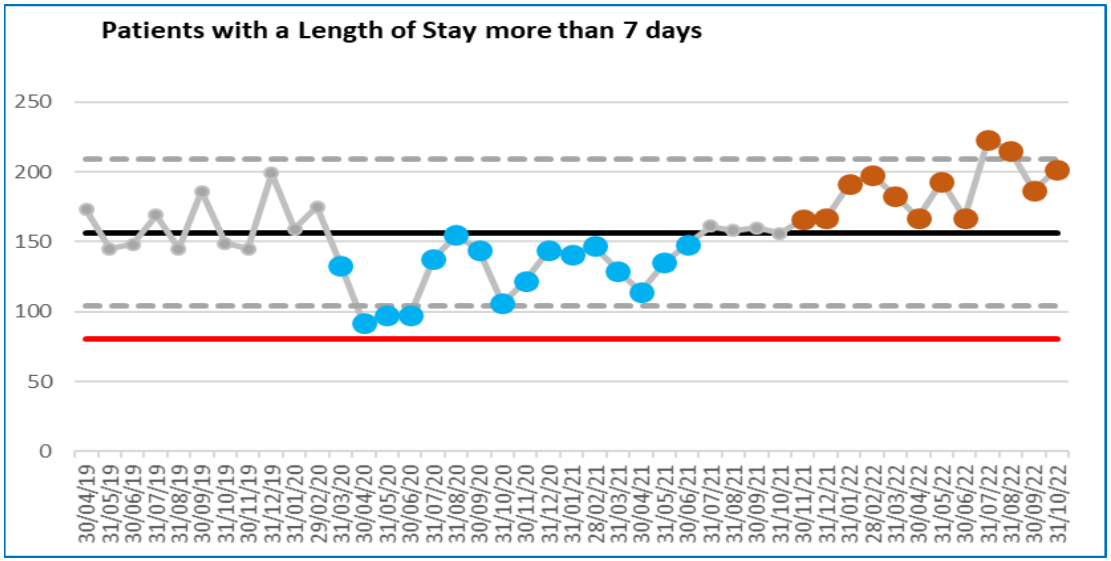
Oct-22
31.3% 30-60 min
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

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 walk in attendances and delays in bed availability for admissions from the emergency department.	Ongoing improvement programme monitored through Urgent Care Board. Daily system call with EEAST to enact load levelling and manage volume across the acute Trusts. Drop & Go service maintained despite extreme pressure. Implementation of NerveCentre & separate ambulance triage team improving assessment within 15 mins. Winter plan developing to create 24/7 ambulance cohort area	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



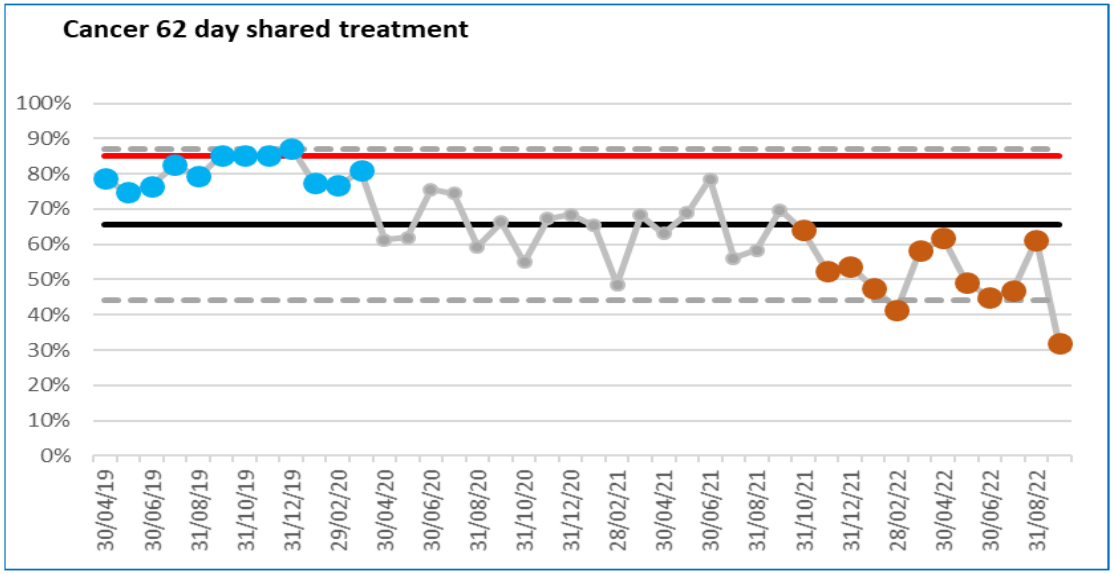
Oct-22
136 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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 including imprvements in data quality of recording attendance in the department. 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



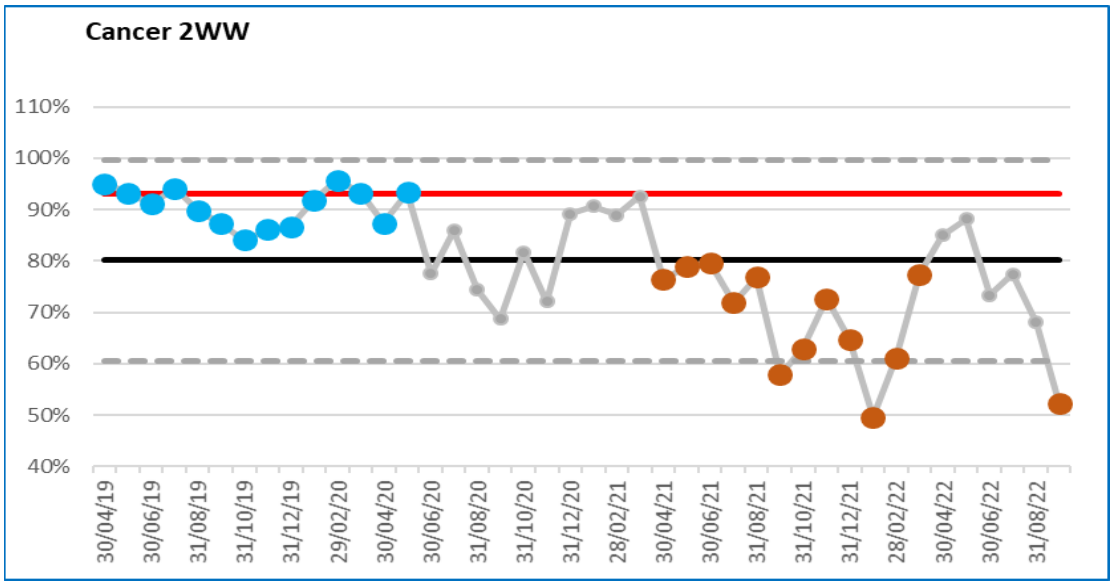
Oct-22
202
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

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 is failing consistently	CCG & ICS plans for attendance avoidance. Geriatric silver line has commenced. PAHT Admission avoidance – SDEC, Patient at Home, Virtual Ward, facilitated discharge. Weekend HIT teams to facilitate discharges Daily LOS meetings Out Improvement plan actions	Review via daily bed meetings, daily system meetings & weekly capacity planning meetings. NHSEI review of long stay patients highlights consistent levles of 7 day patients around the mean.



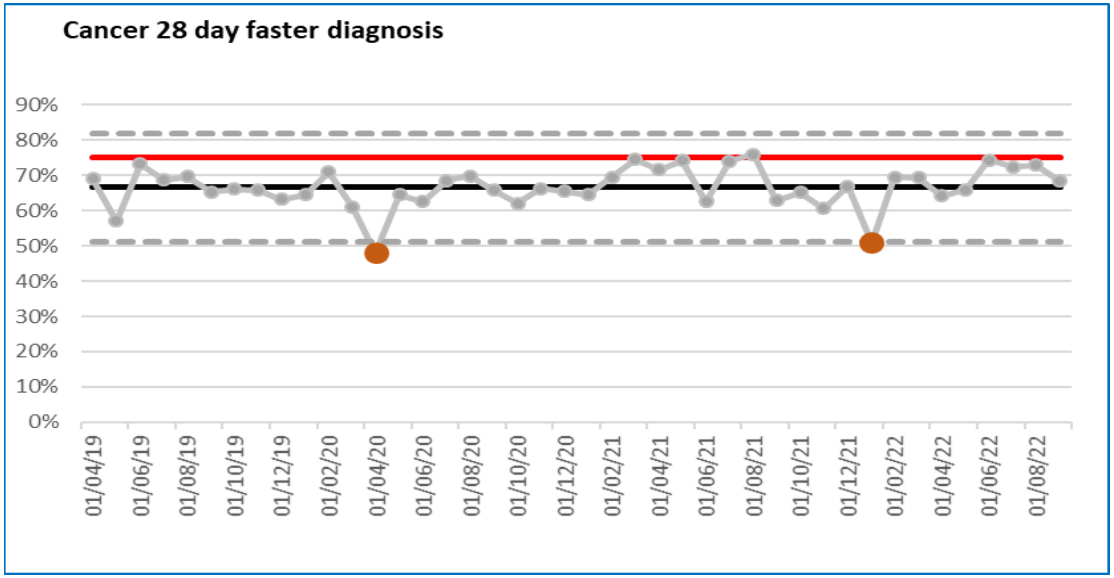
Sep-22
31.87%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	Backlogs of patients waiting for treatment created by Covid emergency pressures and recent increases in referral rates have increased the demand for limited capacity. The Trust continues to treat the longest waiting patients first.	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 has been steady and is expected to decrease as cancer admin staff vacancies have been filled and are being trained.	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.



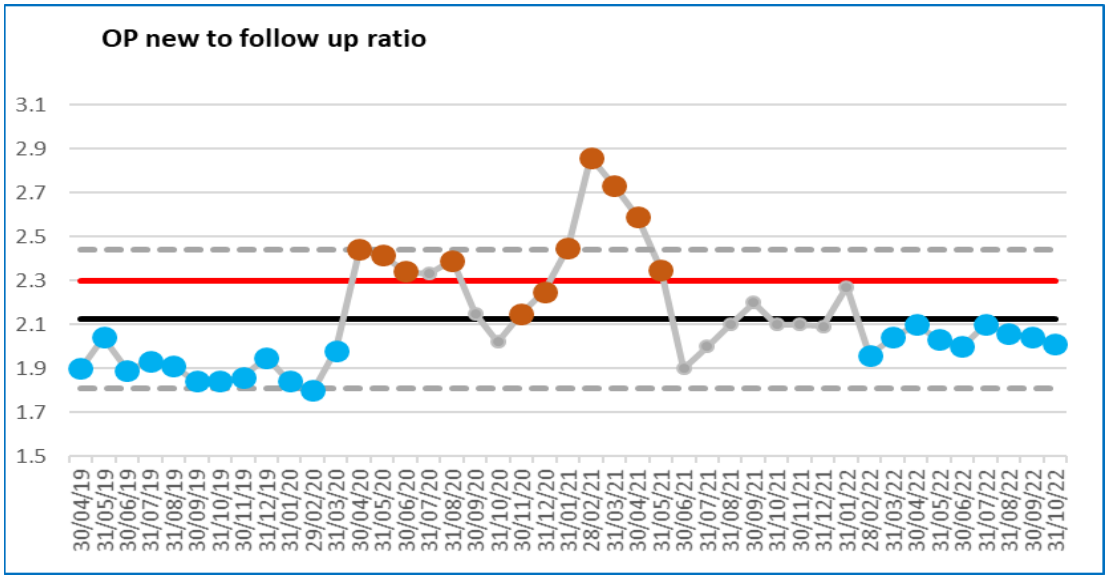
Sep-22
52.40%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target	Ongoing increased referrals, May (15% higher), August (11% higher) & September (7% higher). Staff shortgaes to due to combination of annual leave and sickness reduced capacity.	Only 2 of the 10 tumour sites achieved the national standard in September. Close review of capacity versus demand, escalation to services if mismatched. Straight to test in lower GI endoscopy booking improvements continuing. CQUIN actions for Lung and Urology will create improvements.	Close review of 28 day diagnosis standard for each tumour site failing 2ww. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting. Siginificant improvements in October & November to date



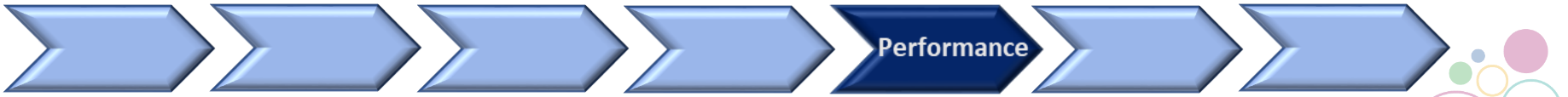
Sep-22
68.34%
Variance Type
Common cause variation
Target
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 28 day faster diagnosis	Common cause variation and hitting and missing target radomly	Backlogs of patients waiting for diagnosis created by Covid emergency pressures and recent increases in referral rates have increased the demand for limited capacity.	Development of Lung, Upper GI and Prostate faster diagnosis pathways as part of a CQUIN. Other tumour site actions in the cancer Recovery Action plan which is finalised and being tracked.	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.



Oct-22
2.01
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

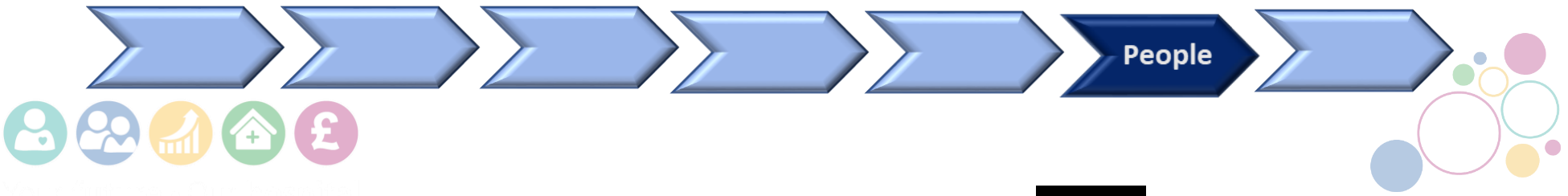
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	Balance of new to follow-up activity has returned to within target.	Ongoing monitoring & increased volumes of activity to support recovery. Unbooked follow-up patients are increasing and actions to address this backlog such as PIFU, validation, clinical review being implemented.	Close monitoring of the clinical high risk cohorts of patients vis System Access Board & CCG challenge sessions.



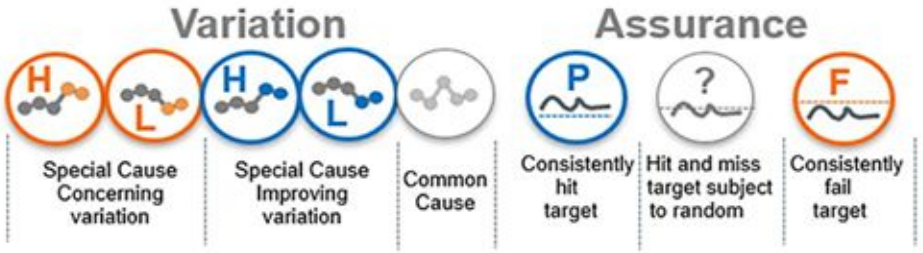
People

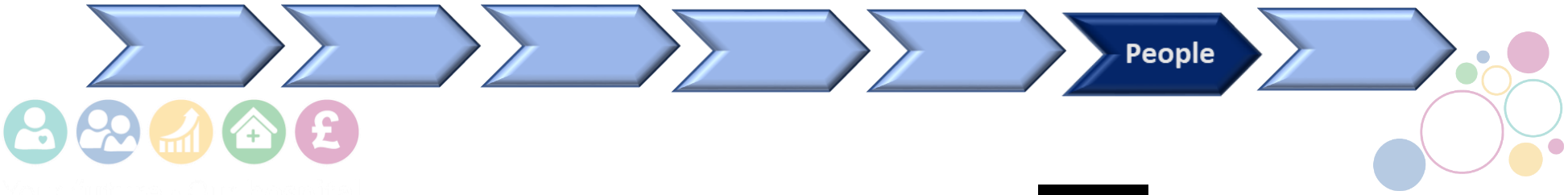
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

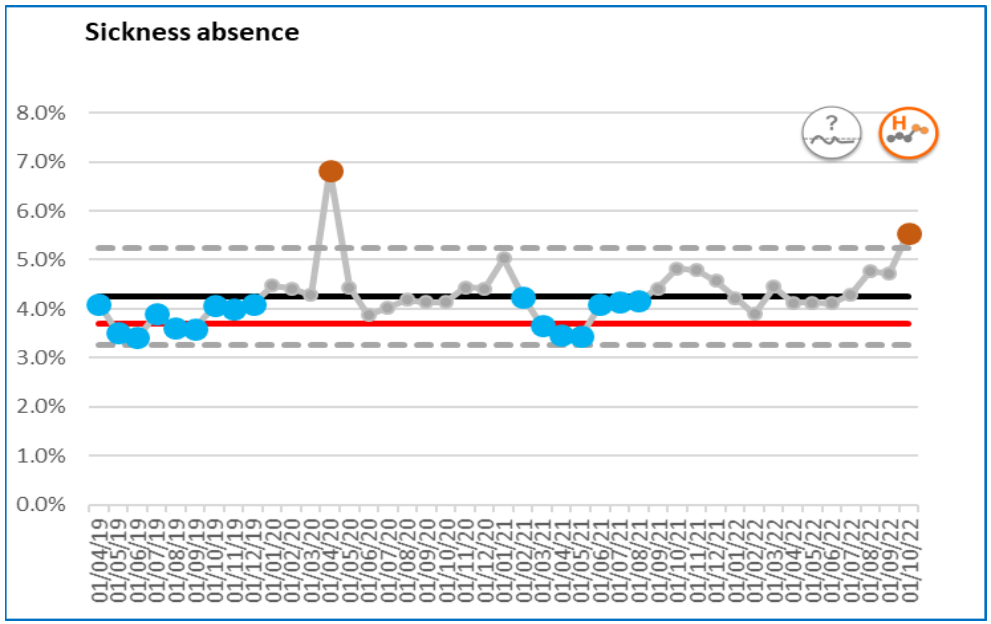
People Summary	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness absence	Sickness absence has increased this month to just over 5% - 3.4% relate to short term absence and 2.2% to long term absence. Sickness absence worshops are being delivered across the trust 77 managers have attended to date. Sickness absence support and guidance provided to managers at divisional meetings	For information	Q4
Vacancy	Overall trust establishment is decreasing. Highest vacancies sit within AHP (14.5%), Estates and Facilities (17.2%). Bespoke recruitment days planned during Q3/4. I nternational recruitment pipeline planned for nursing, allied health professionals and medical staff	For information	Q3/4
Turnover	The trust voluntary turnover has been increasing over the last 12 months. Leaving reasons are linked to health and wellbeing/ fatigue, promotion and moving area for a better cost of living. There are a number of initialtives in place to address these that are being undertaken both locally and as part of the ICS. Continued promotion of the trusts health and wellbeing offer including support from the Harlow hub (supporting cost of living) and citizens advice bureau. The recruitment and L&OD team are organising an in house recruitment and development to take place in February 2023	For information	Q4



KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Oct 22	80.0%	90.0%	L	F	81.4%	76.7%	86.0%
Agency staffing spend	Oct 22	5.4%	15.0%	H	P	5.3%	2.5%	8.1%
Bank staffing spend	Oct 22	13.4%	15.0%		P	11.8%	9.5%	14.2%
Vacancy Rate	Oct 22	9.6%	8.0%		?	9.4%	7.9%	10.9%
Staff turnover - voluntary	Oct 22	17.7%	12.0%	H	?	12.5%	11.6%	13.4%
Sickness absence	Oct 22	5.6%	3.7%	H	?	4.3%	3.3%	5.2%
Statutory and Mandatory training	Oct 22	85.0%	90.0%	L	?	88.1%	85.4%	90.9%

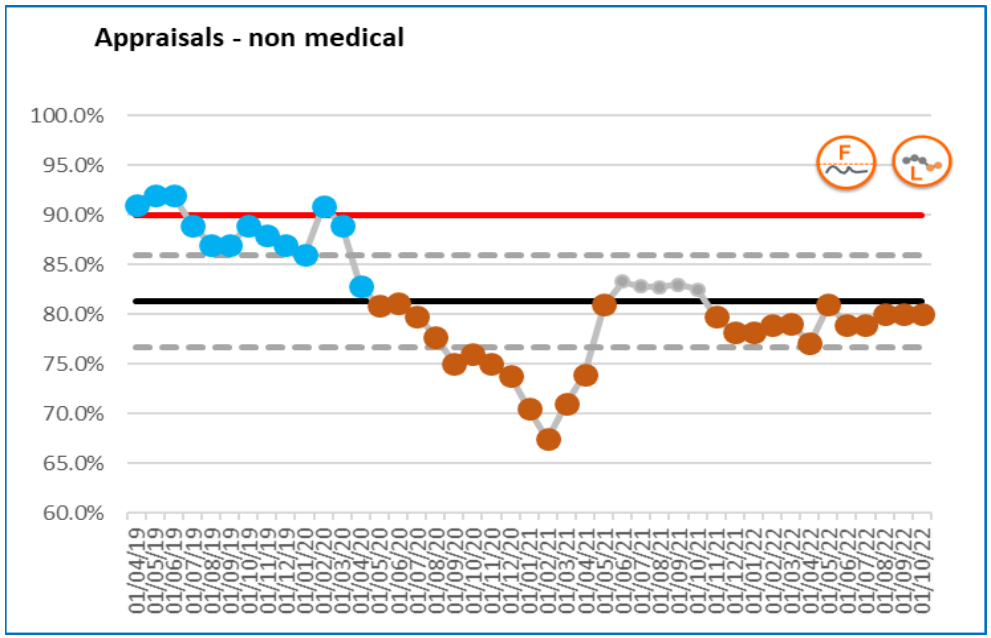






Oct-22
5.60%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

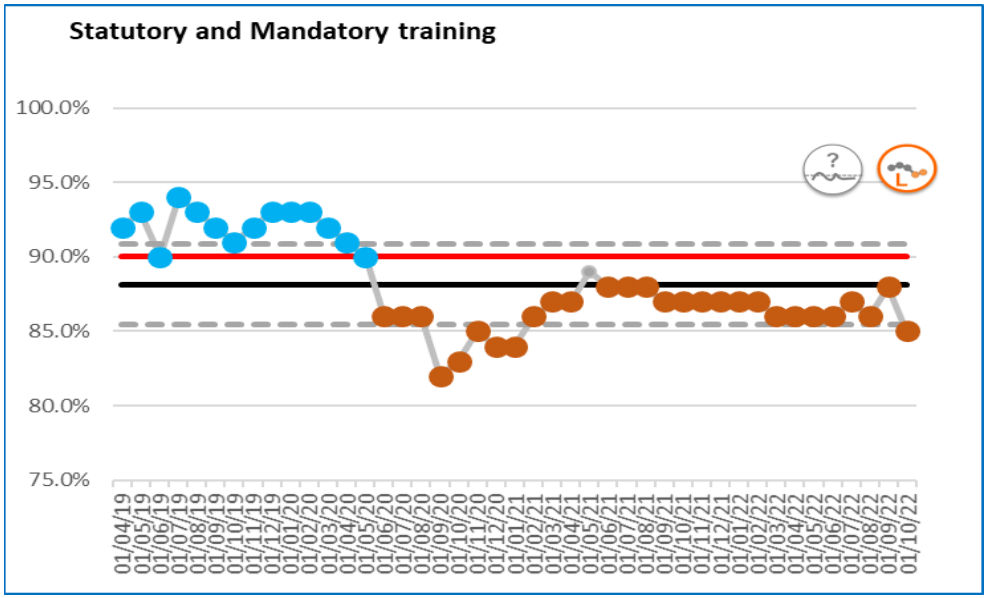
Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Sickness absence has increased this month to just over 5% - 3.4% relate to short term absence and 2.2% to long term absence	Sickness absence worshops are being delivered across the trust 77 managers have attended to date. Sickness absence support and guidance provided to managers at divisional meetings	Absences recorded contemporaneously and advice & guidance to managers on COVID & testing guidelines



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

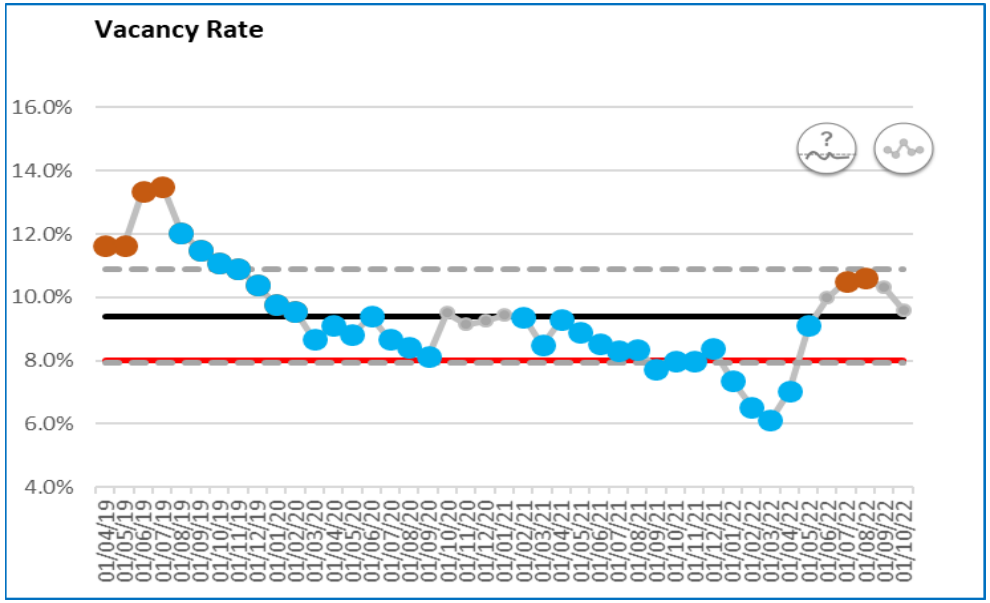
Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Overall appraisal rates remain static.	Accuracy of data checked with managers due to staff moves, secondments and absence. Training and coaching on appraisal systems taking place with the the ESR team	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



Oct-22
85%
Variance Type
Special cause variation
Target
90%
Target Achievement
Consistently failing target

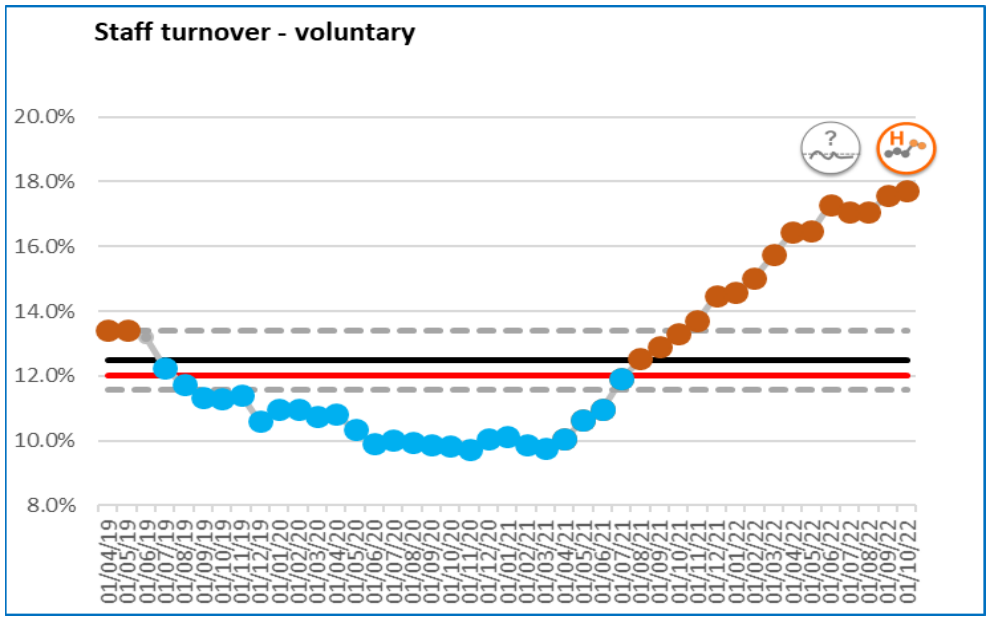
Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Special cause concerning variation & consistently failing target	Training compliance has dropped again in Oct. Challenges of protected time to complete training cited.	Again accuracy of data is being checked with managers due to staff moves, secondments and absenceThere 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



Oct-22
9.60%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Overall trust establishment is decreasing. Highest vacancies sit within AHP (14.5%), Estates and Facilities (17.2%)	Bespoke recruitment days planned during Q3/4. I nternational recruitment pipeline planned for nursing, allied health professionals and medical staff	Vacancy rates are discused in monthly divisional meetings and PRMs. Recruitmen plans agreed with divisions

People



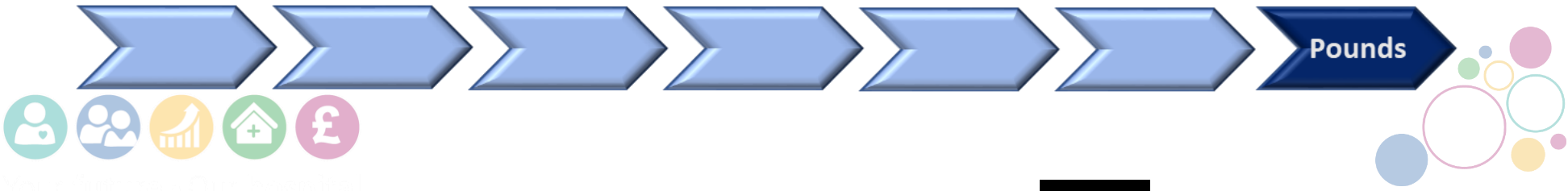
Oct-22
17.74%
Variance Type
Special cause variation
Target
12.00%
Target Achievement
Consistently failing

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. Leaving reasons are linked to health and wellbeing/ fatique, promotion and moving area for a better cost of living	There are a number of initialtives in place to address these that are being undertaken both locally and as part of the ICS. Continued promotion of the trusts health and wellbeing offer including support from the Harlow hub (supporting cost of living) and citizens advice bureau. The recruitment and L&OD team are organising an in house recruitment and development to take place	Retention initiatives are discussed at recruitment and retention steering groups. Staff survey action plans in place for divisions

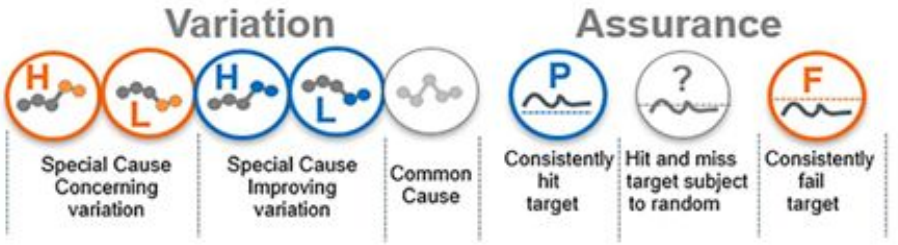
People

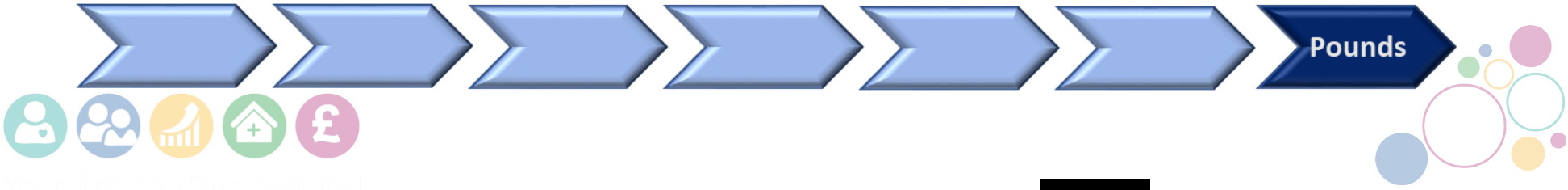
Pounds

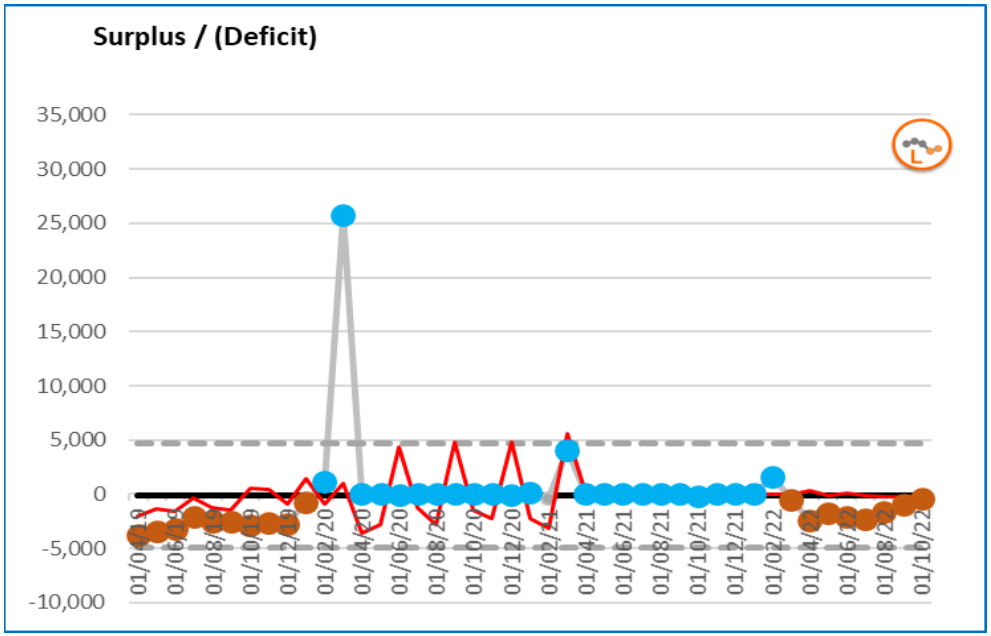
Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust reported a deficit of £0.3m in October (Month 7) and year to date deficit of £11.5m (planned deficit in month of £0.2m and year to date of £0.3m). 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. Planned savings for month 7 are £1.4m (£4.9m year to date). The FY forecast waste\efficiency is currently £11.7m, the YTD indentified savings are £5.3m, which is made up of £0.6m recurrent savings and £4.7m non-recurrent savings. Work continues within each divsion to deliver additional schemes and savings.	For information	
Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes external PDC for the ongoing new hospital project of £1.1m. As at Month 7 the year to date capital spend total is £6.1m, excluding the impact of IFRS 16. Whilst further national support will be available to the Trust it is fully anticipated the capital programme will be fully utilised in 22/23. Note: some additional PDC may be made available for digital programmes but this will be confirmed in due course	For information	
Cash	The Trust's cash balance is £40.7m. The cash reserves have been boosted in recent years due to the national Covid support received by the Trust, this balance will reduce in 22/23 as we continue to run with a deficit. 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)	Oct 22	-344	0			-137	-4935	4661
CIP	Oct 22	4211	0			619	-605	1842
Income	Oct 22	28109	0			26659	17036	36281
Operating Expenditure	Oct 22	-27083	0			18559	9175	27943
Bank Spend	Oct 22	-2475	0			1288	276	2300
Agency Spend	Oct 22	-1014	0			509	-121	1139
Capital Spend	Oct 22	2417	0			2303	-3422	8029
Cash Balance Actual	Oct 22	40741	75000000			4315978	-1349922	9981878



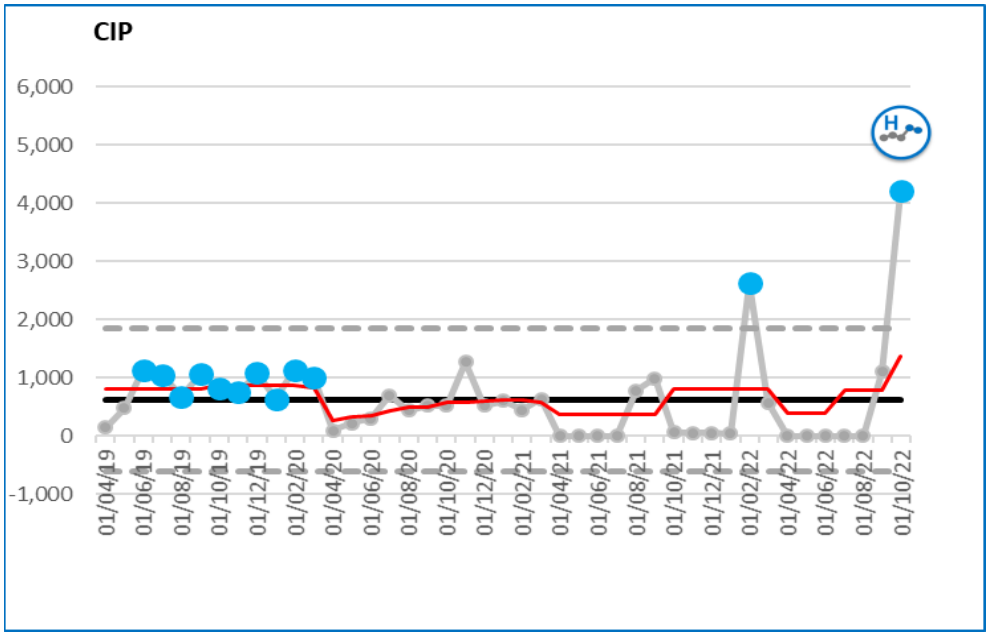




Oct-22
-344
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

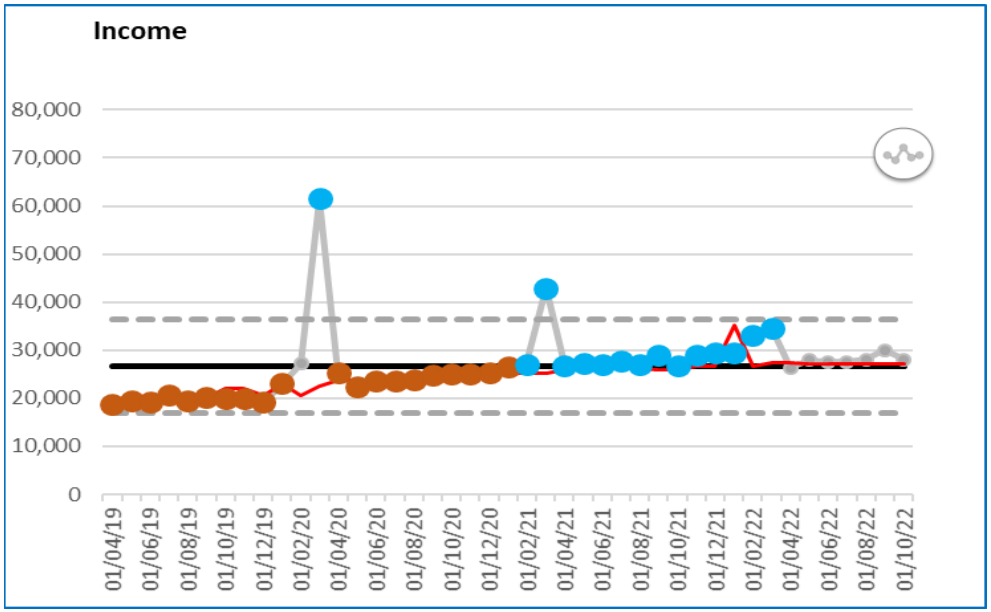
Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target			

Pounds



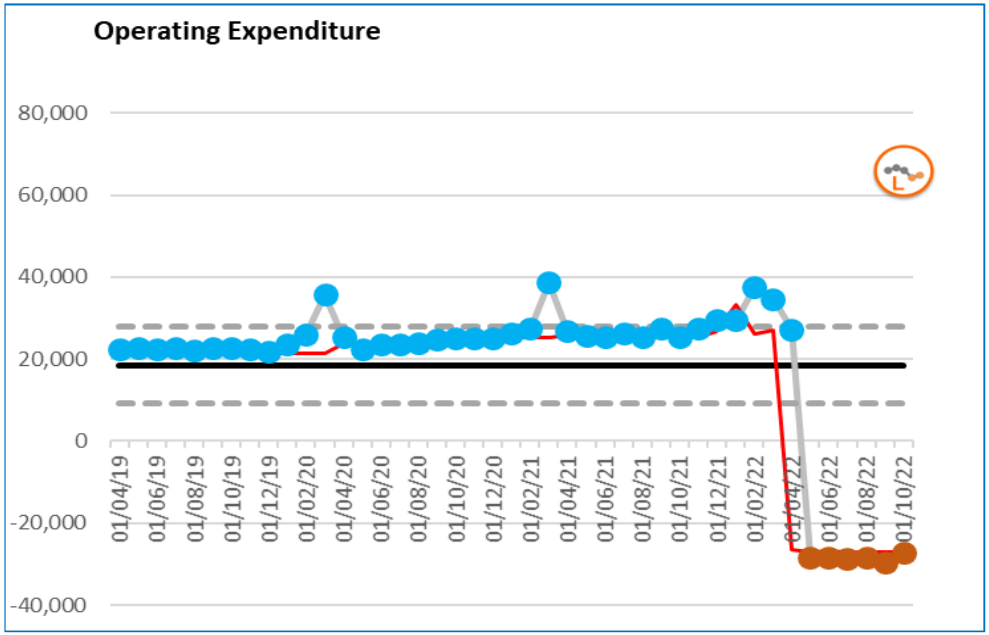
Oct-22
4211
Variance Type
Common cause variation
Target
801
Target Achievement
Inconsistently passing and falling short of the target

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



Oct-22
28109
Variance Type
Special cause improving variation
Target
26684
Target Achievement

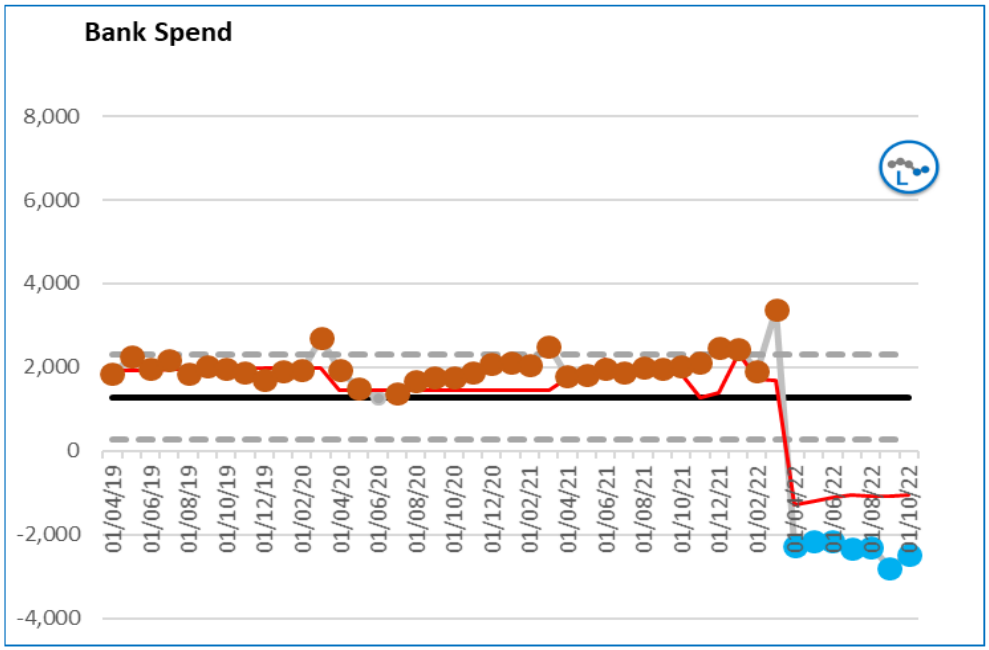
Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation			



Oct-22
-27083
Variance Type
Common cause variation
Target
26709
Target Achievement

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

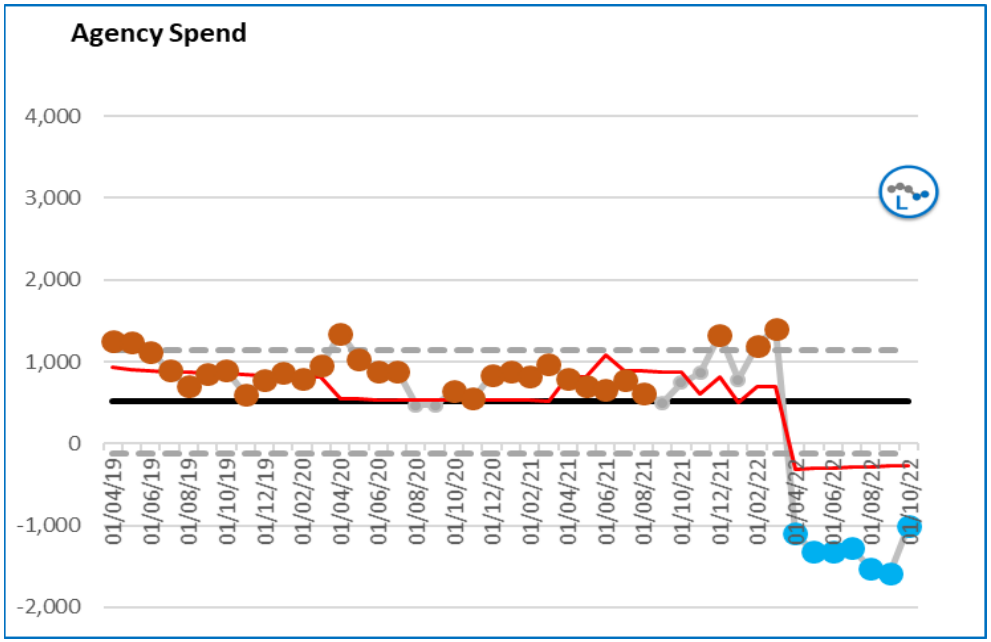
Pounds



Oct-22
-2475
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

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

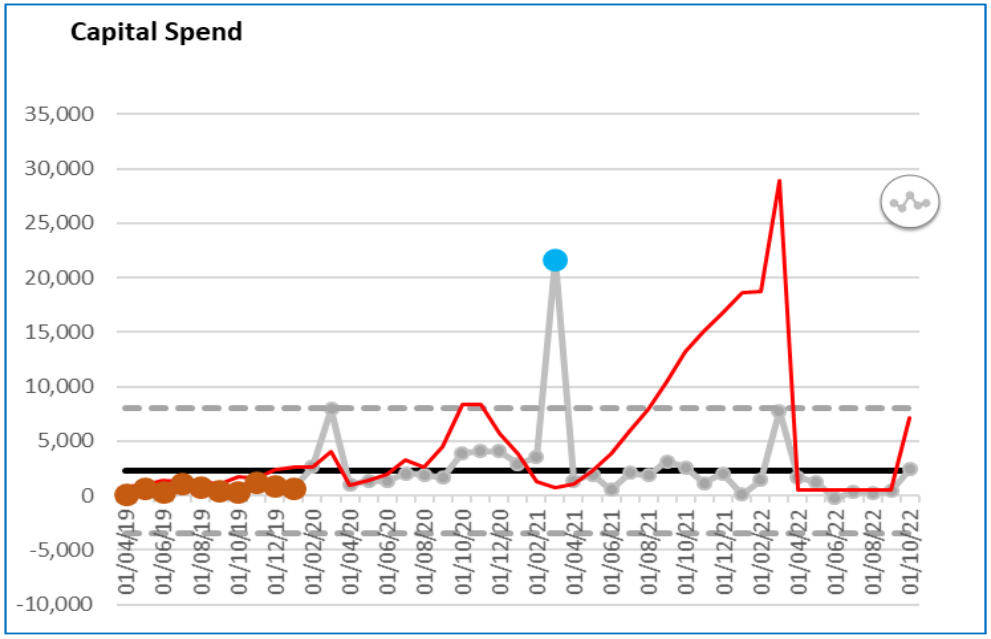
Pounds



Oct-22
-1014
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



Oct-22
2417
Variance Type
Common cause variation
Target
18682
Target Achievement
Inconsistently passing and falling short of the target

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

Pounds

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board –1st December 2022 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy – Chairman
DATE OF MEETINGS: **01.11.22 and 15.11.22**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in November

1 November 2022:

- OD Consultancy at PAHT
- Therapies Workforce Position
- Recovery Dashboard
- Business Planning Process 2023/24

15 November 2022:

- Medical Workforce Resilience (Kingsmoor) Business Case- Approved
- Business Planning Update
- Standing Financial Instructions
- JAG Action Plan
- Quality Briefing
- Quality PMO report
- Clinical Strategies Update
- This is Me @ PAHT
- Industrial action
- Recovery Snapshot
- Significant Risk Register
- Finance update