The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 3 October 2024 at 09.30 – 13.00
Venue: Kao Park Boardroom, Kao Park, London Road, Harlow CM17 9NA

	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	16
02 Chair and Chief Executive's reports					
09.35	2.1	Chair's Report	Inform	Chair	18
09.45	2.2	CEO Report	Inform	Interim Chief executive	22
03 Risk					
09.55	3.1	Corporate Risk Register	Review	Medical Director	28
10.05	3.2	Board Assurance Framework 2024-25 *Diligent Resources: BAF 2024/25*	Review/ Approve	Head of Corporate Affairs	33
04 Patients					
10.10	4.1	Reports from Quality and Safety Committee 27.09.24: • Part I • Part II	Assure	Committee Chairs	36 43
10.15	4.2	Maternity Report: • Serious Incident (SI) Report • Quarterly Maternity Assurance Update	Assure	Interim Chief Nurse/ Director of midwifery	45 48
10.20	4.3	Nursing & Midwifery Establishment Review (mid year)	Assure	Interim Chief Nurse	57
10.30	4.4	Nursing, Midwifery and Care Staff Levels	Assure	Interim Chief Nurse	69
10.40	4.5	Adult Inpatient Survey Results *Diligent Resources: PAHT Management Report*	Assure	Interim Chief Nurse	86
10.50	4.6	Nursing, Midwifery and Allied Health Professionals Strategy	Note	Interim Chief Nurse	91
10.55	4.7	Learning from Deaths (Mortality) Report	Assure	Medical Director	104
		Break: 11.10 – 11.20			

11.20	4.8	Electronic Health Record (EHR)	Assure	Chief Information Officer	109
05 People					
11.30	5.1	Report from People Committee 30.09.24 including Terms of Reference	Assure/ Approve	Committee Chair	Verbal
11.35	5.2	Workforce Race Equality Standard (WRES)	Approve	Interim Chief People Officer	112
11.40	5.3	Workforce Disability Equality Standard (WDES)	Approve	Interim Chief People Officer	120
11.45	5.4	Annual Report on Medical Revalidation and Compliance Statement	Approve	Medical Director	130
06 Performance/pounds					
11.55	6.1	Report from Performance and Finance Committee 26.09.24	Assure	Chair of Committee	150
12.00	6.2	M5 Finance Update	Assure	Director of Finance	158
12.10	6.3	Integrated Performance Report (IPR) M5	Discuss	Chief Information Officer	168
12.20	6.4	Emergency Preparedness Resilience Response (EPRR) Annual Report	Approve	Chief Operating Officer	182
		Opportunity for members of the public to ask questions about the board discussions or have a question answered			
07 Strategy/Governance					
12.30	7.1	Report from Strategic Transformation Committee 16.09.24	Assure	Chair of Committee	204
12.35	7.2	Report from Leadership Management Team (LMT) Meetings held in September 2024	Assure	Chair of Committee	209
12.40	7.3	Corporate Trustee: Report from CFC.13.09.24	Assure	Chair of Committee	210
12.45	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Any unresolved issues			
	9.2	Review of Board Charter			
	9.3	Summary of actions and decisions	-	Chair/All	
	9.4	New risks and issues identified	Discuss	All	
	9.5	Any other business	Review	All	
	9.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	

The Princess Alexandra Hospital NHS Trust

13.00		Close			

Date of next meeting:5 December 2024

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

Board Membership and Attendance 2024/25			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Interim Chief Executive	Sharon McNally
Non-executive Director	George Wood	Interim Chief Nurse	Giuseppe Labriola
Non-executive Director	Colin McCready	Chief Operating Officer	Stephanie Lawton
Non-executive Director (SID)	Darshana Bawa	Medical Director	Fay Gilder
Non-executive Director	Elizabeth Baker	Director of Finance	Tom Burton
Non-executive Director	Oge Austin-Chukwu		
Associate Non-executive Director	Anne Wafula-Strike	**Executive Members of the Board (non-voting)**	
Associate Non-executive Director	Ralph Coulbeck	Director of Strategy	Michael Meredith
		Interim Director of People	Giovanna Leeks
		Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 6 June 2024 from 09:30 to 13:00

Present:

Hattie Llewelyn-Davis	**Trust Chair (TC)**
Oge Austin-Chukwu (non-voting)	Associate Non-Executive Director (ANED - OA)
Liz Baker	Non-Executive Director (NED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ralph Coulbeck (non-voting)	Associate Non-Executive Director (ANED-RC)
Fay Gilder	Medical Director (MD)
Phil Holland	Chief Information Officer (CIO)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Chief Nurse (CN)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)

In attendance/Observing:

Giuseppe Labriola	Deputy Chief Nurse (DCN)
Laura Warren	Associate Director Communications (AD-C)
Ann Nutt	Chair of Patient Panel (CoPP)
Linda Machakaire	Director of Midwifery (DoM)
Giovanna Leeks	Deputy Chief People Officer (DCPO)
Fionola Devaney	Director Clinical Quality Governance (D-CQG)
Thom Lafferty	Observer – Director of Strategy & Deputy CEO Kingston Hospital

Members of the Public
(none)

Apologies:

Ogechi Emeadi (non-voting)	Chief People Officer (CPO)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)

Secretariat:

Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed all to the meeting.
1.1 Apologies	
1.2	Apologies were noted as set out above. it was noted that the Chief Operating Officer (COO) would step out of the meeting around noon to participate in another meeting.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 04.04.24 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. The majority of actions were closed and updates on the two open ones were as follows:

	TB1.01.02.24/27 – Paediatric Staffing This item was due by September. TB1.04.04.24/09 – System Development Funding The Director of Finance (DoF) informed members this would be picked up in the Planning Update later on in the meeting.
Patient Story: Maternity Services Improvement Story	
1.6	The Chief Nurse (CN) informed colleagues that this story had been deferred and it would be presented to the next Public Board meeting in October. She apologised for deferring the item.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC presented her paper which was taken as read. She thanked the Chief People Officer (CPO) for all her work on the CEO recruitment and also the CEO for the time he had given to talking to the 24 potential candidates. She was pleased to confirm that four candidates had been short-listed.
2.2	The TC then highlighted the section around 'Board Development and Governance Work' and members had no comments. The key underlying element continued to be the ICB and system/acute financial positions.
2.3	The Board was content to note the update.
2.2 CEO's Report	
2.4	This update was presented by the CEO and the key headlines were as follows: • **General Election / Pre-election Guidance:** A link to the NHSE website with additional information on pre-election guidance was provided within the paper. This guidance would remain in force until a new government was formed. • **Industrial Action (IA):** It had been announced that junior doctors / doctors in training would be striking with a 5-day full walkout, from 07.00 on Thursday 27.06.24 until 07.00 on Tuesday 02.07.24. The CEO provided assurance that the organisation would manage the impact of the latest round of IA as it had the previous rounds, • **Operational/Financial Pressures:** The organisation had been placed into Tier 2 for its performance against planned care/cancer care access standards. In terms of planned care, the organisation was struggling to stay on trajectory for meeting its commitment to the national standard of having no 65 week waits by the end of September. Colleagues were looking at how to support access to additional capacity to maximise the number of patients that could be seen electively over the remainder of the financial year. There would be more detail on this at the private session later than day. In terms of the financial position the organisation had submitted a deficit financial plan for 2024/25 of £23.4m, including an in-year efficiency programme of £20.5m. This made up the majority of the current deficit plan of the HWE ICS which totalled £30m. • **Alex Health Implementation:** Strong progress continued to be made with this programme, in partnership with Oracle Health colleagues. • **Integrated Care Board (ICB) / Health & Care Partnership (HCP):** The formalisation of the HCP governance structures reporting into the HWE ICB Board had begun on 01.06.24. In terms of WEHCP priorities, those had now been agreed (obesity in children, cardiovascular disease, frailty/EoL/falls and community urgent and emergency care) along with Programme Leads/Programme Groups to drive the required change.
2.5	In response then to a question from Non-Executive Director Darshana Bawa (NED-DB) the CEO informed members that the organisation's current Head of Performance & Planning (HoPP) had recently been appointed to the joint role of HCP Development Director.

2.6	The TC then asked how the impact of IA was being measured in terms of patients. The CEO responded this was not overtly being measured but there were some sub-processes and work underway in the ICB to determine whether different populations were being affected om different ways. The Medical Director (MD) added that during IA, every incident on Datix was analysed to determine any link to IA. EDI and associated data was an area currently being focussed on at the Patient Safety Group (PSG) and the data was evolving all the time. The Chief Operating Officer (COO) then added that her team was doing some work to review the entire waiting list to see whether there were cohorts of patients who had waited longer for their treatment than others. This would be overseen at QSC and the associated report was just being finalised. There were no current concerns from the outputs of this work.
03 RISK/STRATEGY	
3.1 Corporate Risk Register (CRR)	
3.1	This update was presented by the MD and the paper was taken as read. Three new risks had been added since the previous update relating to access to timely breast services, capacity within Oncology and demand for anaesthetic services. It had been agreed that risks with a consequence score of five would be reviewed more regularly and that would be reflected in the next paper to Board in October.
3.2	In response then to a question from Associate NED Oge Austin-Chukwu (ANED-OA) around the risk process, the MD confirmed that a risk would be presented firstly to the Risk Management Group. It would be debated and the wording/risk score agreed. It would then be presented to SMT and if agreed, added to the CRR. That whole process usually took around one month. ANED-OA then highlighted a risk under section 4.2 (Oncology) which had been raised in March 2023 and approved in April 2024. The MD agreed to check the accuracy of this outside the meeting.
ACTION **TB1.06.06.24/10**	**Corporate Risk Register: Review the timeline for approving the Oncology risk under section 4.2 of the paper.** **Lead: Medical Director**
3.3	The TC then asked how the risks around the current estate (given the delay in the new hospital) would be kept under review. The Director of Strategy (DoS) responded there would be a session at the next Trust Board to discuss how to approach future investment in the current infrastructure.
3.4	NED George Wood (NED-GW) then flagged that PAF had discussed the requirement for investment in the maternity services infrastructure. The DoS responded that the key concerns were theatres and maternity but a decant facility would be required in order for these works to take place.
3.5	The CEO then commented that the risk as described in section 3.2.1 related to backlog maintenance. This was in terms of the site being safe, being able to upgrade areas, supporting facilities to comply with the required standards and being able to expand to ensure the needs of the population could be met. He acknowledged the team was on top of this.
3.6	At this point NEW-GW asked whether PAF could undertake a review of services that could be relinquished in order to free up space on the site. The DoS responded there was already a review of fragile services underway and discussions included other acute trusts. The MD commented that PAHT was a district general hospital however and needed to be able to provide a broad range of services. The CEO agreed that PAHT needed to be able to provide as many services as possible locally. He acknowledged however the shift, since COVID, to virtual appointments/PIFU which meant reduced demand on site for outpatient services.
3.7	In line with the recommendation the Board approved the new risks raised on the CRR.
3.2 Board Assurance Framework (BAF) 2023/24	
3.8	This update was presented by the Head of Corporate Affairs (HoCA) who informed members the BAF had been updated for 24/25 and had been through the Board Sub-Committees during May. The IA risk had been reviewed in conjunction with the COO but at this stage it was proposed the scoring would remain the same for now at 20, with a slight revision to the risk narrative. It had also been agreed that the risk around finance would also remain

	unchanged (at 12) to start off the year. The DoF added it would require a lot of work at system level to maintain that risk score.
3.9	In line with the recommendation the Board: - Approved Risk 5.1 (Finance: Revenue) and the proposed risk score of 12. - Noted the remaining BAF risk scores and the revised wording for BAF risk 4.3 (Industrial Action).
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	QSC.31.05.24 ANED-OA informed members that assurance had been provided around workforce challenges and progress towards achieving IQIPS (Improving Quality in Physiological Services) accreditation within Paediatric Audiology. There had been a positive peer review on antimicrobial resistance noting there was still more to do. There had been no further measles cases and cases of Clostridium-difficile remained higher than in the previous year but the organisation was not an outlier in this regard. The organisation's draft Quality Account had been reviewed and the request now was for that to be approved at QSC's June meeting under delegated authority from the Trust Board. Board members agreed with this recommendation.
4.2	QSC2.31.05.24 ANED-OA informed colleagues that middle grade doctor recruitment remained an issue and would continue to be tracked via QSC2. The ongoing hard work of the maternity team was recognised and that the service remained in the process of exiting the Maternity Safety Support Programme (MSSP) with the formal outcome of its application still awaited.
4.3	The DoQI commended the progress made within the service over the previous 18 months acknowledging there was still a bit more to do. The TC agreed that huge progress had been made and she thanked senior colleagues within that service for their leadership.
4.2 Paediatric Audiology Service	
4.4	This item was presented by the COO. For context she informed members that the Care Quality Commission had written to all NHS organisations following a review by NHS Lothian in Scotland regarding failings in the standard of paediatric audiology services that had resulted in delayed identification and missed treatment of children with hearing loss. This review had resulted in a small number of trusts in England then being contacted. QSC had received a presentation from the service at its May meeting which had provided assurance around the four questions posed by the CQC.
4.5	One of the questions had related to IQIPS accreditation and improving quality in physiology services. The service did not currently have that accreditation but the team was working hard to gather the evidence that would be required for inspection. A cautious timeline had been provided for achievement of this which had been challenged at QSC and which the team would now look to bring forward. This would require additional workforce which the service was looking to address. The good news was that the Head of Service had been supporting a neighbouring trust but would return full-time to PAHT at the end of the summer.
4.6	The COO continued that some additional monies had been secured to support a review of patients on the waiting list which had now been reduced by over 1k patients. In terms of incidents there had been one incident in 2015 which had been fully investigated and the learning shared and no further major/severe incidents had been raised since then.
4.7	The Chief Nurse (CN) then emphasised that the Trust had not been singled out by the CQC. It was an overarching NHS requirement and the Board was now required to respond back to the CQC to say it had discussed the service and provided a response to the questions posed.
4.8	At this point NED-GW asked whether there were firm plans to support children in terms of audiology services in West Essex. The CEO responded that one of the drivers in the system and within West Essex was around child health generally to ensure that children had access to the right services at the right time (screening/diagnostic) so this would, in his view, be picked up under the local banner of the 'child development' work being developed.

4.9	The TC summarised by stating that the work to respond back to the CQC was noted and the response back from the CQC would be awaited.
4.3 Maternity Updates – Maternity Serious Incident (SI) Report	
4.10	This item was presented by the Director of Midwifery (DoM) and key headlines were: • 1 new maternity incident declared since the last report for April 2024. • 0 maternity incidents closed since the last report in April 2024. • 7 SIs under investigation (1 with MNSI (Maternity & Newborn Safety Investigations).
4.11	The newly declared incident had related to a missed skull fracture in a newborn. Top incident themes in the last two years were neonatal death, HIE (hypoxic ischaemic encephalopathy), and CTG interpretation. In terms of addressing these themes the DoM informed members that all mortality incidents were reviewed by a multidisciplinary panel including external stakeholders. This was then reported onto a national database where themes and trends from the cases were collated. Action plans were then initiated from every review and those formed part of the assurance process for the Maternity Incentive Scheme and Saving Babies Lives Care Bundle v3.
4.12	In response to the above, the Chief People Officer (CPO) added that in terms of the governance, incidents were also discussed at the Safety Champion meetings where elements could be triangulated and lessons learned pulled out. The Safety Champion visits also supported the process in terms of being able to see whether staff understood process and were embedding learning.
4.13	NED-DB asked whether ICB SI data was available. The CN responded there was a LMNS (Local Maternity & Neonatal System) dashboard which the Trust would adopt and which would also support QSC2 oversight. The CEO added there was a clear section in the ICB public board papers on maternity/comparisons. NED-DB asked how the Trust compared with its peers. The DoM drew members' attention to section 5 of her paper and the graph which provided the national/LMNS picture on stillbirths. The Trust sat below both of those rates. Top themes nationally and within the LMNS were similar. CTG interpretation was a national issue.
4.14	The TC then asked for some detail around the time taken to close open SIs. The Director – Clinical Quality Governance (D-CQG) responded that following the move to PSIRF in January, the majority were now investigations rather than SIs. There were currently five historical open SIs, with two having been closed that month (so the reduction would be evident in the next iteration of the paper).
4.15	In line with the recommendation the Board agreed the paper provided assurance the Maternity Service was continually monitoring compliance and learning from SIs.
4.16	<u>Questions from the Public</u> The Chair of the Patient Panel (CoPP) highlighted the risk around the Pharmacy dispensing system on page 32 of the papers and the fact it had been a risk for a while. The MD responded there had been a long discussion on this at the Risk Management Group and a conversation with the Chief Pharmacist. Some capital monies had now been allocated for this and mitigations were in place so she had asked for the risk to now be re-scored. The CEO provided added assurance that patients would not go without their medications.
4.4 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.17	This update was presented by the CN. There had been an increase in the unregistered, registered and overall fill-rate in April 2024. No ward had reported average fill rates below 75% for registered nurses against the standard template during the reporting period. The overall fill rate had increased to 108.7% (↑5.2%), while the healthcare support worker fill rates had also increased by 7.3% to 119.4%. The overall registered fill rate had also increased by 4.2% to 103.6%, and the registered fill rate for nights had decreased by 1.1% to 102.1%. This was all testament to the work to drive down the nursing vacancy rate in the organisation.

4.18	In terms of enhanced levels of care, the organisation was being responsive to those patients requiring additional support and was working to ensure therapeutic intervention rather than 'over-providing' care.
4.19	The CN continued that the number of occasions/shifts where the reported fill rate had fallen below 75% across the wards was available in Table 5. This had decreased by 41 occasions in April to 58 and now included Maternity which had 26 in month, a decrease of 4. Nightingale Ward had fallen below its standard template on 22 occasions in April. In addition, John Snow Ward's healthcare support worker template was under review and was part of a wider review of all ward rosters led by the Deputy Chief Nurse (DCN). Work had started to track red flags against known quality indicators (pressure ulcers and falls) and currently there was no correlation with those.
4.20	In terms of care hours per patient day, Model Hospital data for February 2024 showed the Trust with a CHPPD of 7.5 against the national median of 8.3**.** Table 4 in the paper also now showed the Trust's total CHPPD against its peers (East and North Hertfordshire NHS Trust and West Hertfordshire Teaching Hospitals NHS Trust) which was fairly aligned.
4.21	ANED Ralph Coulbeck (ANED-RC) highlighted that redeployment to Maternity appeared routine and he asked what that meant in practice. The CN responded this was solely within Maternity Services and did not mean nursing staff from across the hospital would be redeployed into Maternity Services. The CC summarised by noting the overall good news.
4.5 Learning from Deaths Update	
4.22	This update was presented by the MD. She reminded members there had been an outstanding data issue with the HES M10 dataset. Telstra would provide updates on when this would be resolved however this had affected data being available for recent reporting periods. Consequently the Trust had also provided its own data to Telstra which enabled it to have confidence in what the data was saying – and this was that HSMR and SMR were improving and below expected (fewer deaths than expected) placing the Trust third regionally. She had reviewed the data again the previous day (up to February) and that position had been sustained.
4.23	The MD continued there was a M13 data submission where all coded data for the previous 12 months was submitted. This position would be available for the next Board meeting. However, she had confidence in the local data and was in no doubt this was a good news story. The trend over time was showing sustained continuous improvement that was incremental month-on-month which provided additional assurance.
4.24	The MD then informed colleagues that she had reviewed the requirement for reporting of avoidable deaths to the Board so additional detail would now be provided in the paper going forward. There had been one avoidable death in-year which had gone to the Coroner but there had been no concerns around prevention of future deaths because there had been assurance the organisation had learned from this. She was then pleased to update that 95% of medical certificates of Cause of Death had been issued by the Trust within 72 hours in March 2024, achieving the national target of 95% - a huge effort and a marker of the quality of care.
4.25	In terms of structured judgement reviews (SJRs) a huge amount of work had been undertaken to reduce the backlog down to 130 from over 200. Reporting from these was now on a bi-monthly basis and the aim by the end of the year was to have these done within six weeks of notification. A process was therefore now being built to support this objective.
4.26	In response to the above the DoS commended the teams for the work done in achieving this position. The MD acknowledged the comment and added that improvements in coding, and particularly in palliative care coding had contributed to the improved position. Documentation had been another improvement and the introduction of the new Alex Health system should further improve this. Improvements in clinical/nursing vacancies should also be noted, along with improvements in training and a focus on the medical workforce under GMC enhanced monitoring.

4.27	The CEO agreed the above was a good news story and the organisation needed to get better at promoting its successes. The TC responded that would be something for the Communications team to consider/action.
ACTION TB1.06.06.24/11	**Consider how to improve communication around good news stories. Lead: Associate Director of Communications**
4.28	The CEO then suggested a future Board Development session on the long-term programmes of work which had contributed to the improvements across a range of indicators. The TC agreed.
ACTION TB1.06.06.24/12	**Consider a future Board Development session on the successful long-term programmes of work that have led to improvements across a range of indicators in the IPR. Lead: Executive team**
4.29	The TC thanked the MD for her update and would look forward to the M13 position at the next meeting. It had been noted there would be some additional detail in the next paper and a challenge to the Communications team to 'tell the story' along with a future Board Development session on improvements/successes to date.
4.6 Electronic Health Record	
4.30	This update was presented by the Chief Information Officer (CIO). In terms of progress he informed members that training bookings were going well particularly amongst Nursing, Midwifery & AHP colleagues, for whom training would begin on 12.08.24. Dates were now out for all staff groups and the new training facility had arrived on site and was ready for Alex Health training, and beyond.
4.31	The CIO continued the work around organisational readiness and the 'start, stop, continue' initiative was underway. Key areas of focus for go-live would be Outpatients and Maternity in terms of ensuring systems/process were ready. There was significant work underway around communications across the organisation.
4.32	In terms of risks and issues, the CIO reminded colleagues that the programme timeline was ambitious, given the requirement to exit the current Cambio contract.
4.33	The TC asked about the timing of the next gateway. The CIO responded this was in August, and related to testing. There would be a report back to September to update on that, at which point the programme would only be weeks away from go-live.
4.34	At this point NED Liz Baker (NED-LB) reminded members she had been asked to provide some NED support to the programme. She had therefore spent time with the team and was a member of the Alex Health Programme Board. She highlighted the consistent messaging around the programme and that the team was currently working well. She would continue to meet with key individuals on a monthly basis to provide continued assurance/triangulation.
4.35	NED-DB then asked what level of IT support was being provided to the organisation taking into account varying levels of IT literacy. The DoQI responded there had been work across all staff groups to identify levels of digital maturity. There were currently circa 300 Alex Health Ambassadors and there would also be some clinical navigators to support colleagues at go-live. Transformation Facilitators were also linking in with the training plans in order to raise the profile further. 'First Look Friday' sessions had also been running for a while now to share and socialise what Alex Health would mean for individuals.
4.36	ANED Anne Wafula-Strike (ANED-AWS) commented there appeared to be a huge amount of support on offer. She asked whether colleagues were receptive, and embracing the new system. The DoQI replied that the response had been mixed. The nursing workforce was hugely engaged but there were other pockets of staff who were clearly anxious. The CIO added that colleagues were taking time to understand exactly where those pockets were and who required support.
4.37	The TC summarised by acknowledging that go-live was not the end of the programme and there would need to be continued support for staff going forward from there. As an outcome of the discussion above there would be an agreed process during July for delegating any decision-making given the Board would not meet during August.

05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	PC.29.05.24 NED-DB updated that bank and agency expenditure remained a focus and the reasons for temporary spend would now be mapped. The CPO then informed members that in terms of the Freedom to Speak Up end of year report, the most common theme for cases was behaviours from other staff/line management. It had been agreed the new Head of EDI would triangulate the data sources and present a more detailed report to a future meeting.
5.2 Fit & Proper Persons Annual Report	
5.2	The CPO presented this item and apologised the update was verbal. Some final checks were being completed in order to meet the extended guidance and she requested approval by Chair's action following circulation offline of the final report.
5.3	The TC then added that some information was still outstanding (social media elements) but being worked on and it was hoped the report would be ready later that day or the following day. It was agreed therefore that the Board would delegate authority for final sign-off of the report to the Trust Chair, upon its completion. The final report would also be circulated to the Board.
ACTION **TB1.06.06.24/13**	**Fit & Proper Persons Annual Report to be circulated to the Board.** **Lead: Chief People Officer**
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	PAF.30.06.24 NED-CM updated that in terms of revenue support, PAF had supported a request to commence the application process to enable the draw-down of funding in Q2 if required. The application required Board approval and PAF had therefore recommended that the Board approved the commencement of that process (recognising the cash position may improve).
6.2	In terms of the final operating plan, the date for submission was 12.06.24. The Board was therefore being asked to delegate authority for approval of the final plan to the Trust Chair, PAF Chair, CEO and DoF.
6.3	In terms of PQP, the full costing of the 24/25 programme was being finalised, with £10.1m costed to date against the target of £18.5m. This was a conservative figure and based on delivery in accordance with the revised PQP criteria.
6.4	PAF had supported the business case for development of the Supply Chain sponsored Inventory Management System (IMS).
6.5	The Board approved the commencement of the process for the draw-down of funding in Q2 if required and also the request for delegated authority related to the operating plan submission, as set out above.
Break 1054 to 1105	
6.2 Annual Operating Plan	
6.6	This update was presented by the DoF. He reminded members the Trust had submitted a deficit plan of £25.4m on 02.05.24 for the 2024/25 financial year. At a system level the plan submission at that time was £44.9m. Subsequent to that submission, discussions had taken place within the ICS and with NHSE regionally and nationally to further improve the plan position. As of 29.05.24 the Trust's position had further improved by £2m to a revised deficit position of £23.4m. The ICS position had improved to align to the NHSE control total of £30m deficit.
6.7	The DoF continued that the organisation had been very clear on the drivers of its deficit and the CEO had presented a report to the ICB about the structural challenges and investment decisions over time. The ICB CEO had accepted this position and would work with PAHT to resolve the issues raised in it. The Board noted the £25.4m deficit but accepted that this would be negotiated with the ICB as part of the system wide figures. Some budgeting

	challenges had been corrected and were set out in the paper meaning there were now robust budgets for maternity leave, backfill and changes to the UTC. The Board noted that the challenge remained around the final number and how to deliver this. Conversations with system, finance colleagues and operational colleagues would conclude that week in terms of the final number.
6.8	At this point the TC asked whether the plan had been endorsed by PAF. The DoF confirmed that it had.
6.9	In response to the above NED-GW asked how buy-in from colleagues was achieved, given the number of moving parts. The DoF responded that divisional budgets would not change. If there was additional income then this would be held centrally. NED-GW asked whether there would be any additional PQP challenge. The DoF responded he didn't think so. If there was any allocation on non-recurrent monies that would go centrally to improve the plan.
6.10	In response to the above conversation the CPO added there were two new elements that year in terms of ownership. The senior leadership team structure had been strengthened and the DoF's team was being supported by a deputy who was running financial budget management training for managers. Both were ensuring shared messaging and supporting the quality agenda.
6.11	NED-DB then asked about current engagement with the PQP programme. The DoQI responded this remained positive along with attendance at meetings. Colleagues were optimistic in terms of delivery, recognising what would be a very challenging year ahead, financially.
6.12	The TC summarised by confirming that the Board noted the annual plan and that decision-making had already been delegated. The pressures on staff in terms of delivering budgets was noted and there was recognition of the huge amount of work from the DoF and team in terms of finalising the plan.
6.3 Finance Update M1	
6.13	This update was presented by the DoF. He updated members that in M1 the plan had been for a £2m deficit, with delivery at £3.1m deficit. This was £1.1m adverse to the submitted plan for £25.4m for the year. Elective recovery income had performed at plan including the additional income stretch. Temporary staffing costs above vacant substantive posts remained a challenge into the year, impacting on PQP delivery and the ability to remain within plan.
6.14	ANED-RC asked whether the delivery described above was against £25.4m or £23.4m. The DoF confirmed it was against the former. ANED-RC responded he had been struck by the non-pay variance. The DoF responded this position was still to be understood in terms of the year-end crossover and the new financial system. It could therefore have been overstated but that would be clarified at M2.
6.15	The TC summarised by stating there was cautious optimism at the close of M1.
6.4 Integrated Performance Report (IPR) M1	
6.16	This update was presented by the CIO and the key headlines were as follows: **Falls:** An overall reduction and positive trend over the previous four months which was encouraging and backed up the safety and quality data. **Appraisal:** Performance was now out of special cause variation and showing a fifth consecutive improving data point. **78 week waits:** Four consecutive improving data points so some measurable improvement. **ED 4 hour standard:** Performance in March had been in special cause variation with a move then to common cause variation, with the current position now showing no indicators of improvement.
6.17	The COO then added that at the end of May there had been three 78 week capacity breaches which was a reduction from the previous month. The position for June was much stronger, with 20 high risk patients as of the previous day. The 65 week position was more challenging and the team was working hard to address this.

6.18	The COO continued that in terms of the ED 4 hour target, performance at the end of May had been 64.2% against the trajectory of 64.1%. The trajectory for June was 68% so a big step up.
6.19	The TC summarised by stating the Board had noted the report, which had also been discussed at Sub-Committees that month.
Opportunity for members of the public to ask questions about the board discussions or have a question answered.	
6.20	The Chair of the Patient Panel (CoPP) commended colleagues on their work around the new electronic health record (EHR). She asked what plans were in place for a potential cyber attack/system failure and was this risk on the BAF. The CIO responded there was work underway around this but it was complex. The organisation had been assessing its systems following the recent attack against a London trust and it was confident Trust systems were protected. The cyber risk was on a local risk register but he agreed this needed to be added to the BAF which he would undertake to do.
ACTION **TB1.06.06.24/14**	**Consider adding the risk of a cyber attack to the BAF.** **Lead: Chief Information Officer**
6.21	In response to a further question from the CoPP the CIO provided assurance a robust communications plan was in place in the event of a cyber attack/system failure including linking in with primary care. The CEO added that a recent internal audit had been around data security and the organisation had received substantial assurance from Internal Audit colleagues around that. He clarified that the attack on the London trust had not been on that individual organisation but on its pathology system provided by a third party.
6.22	In response to the above NED-GW commented that assurance from third parties should be demanded in terms of cyber checks. The CIO responded this was undertaken via the associated contract and as part of the Data Security & Protection Toolkit (DSPT).
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	This update was presented by NED Liz Baker (NED-LB). She informed members there had been some small changes to the Committee's terms of reference (ToR) to 1) Make it more explicit that a key activity of STC was to monitor developments in the Healthcare Partnership and 2) That Place Directors for West Essex and East & North Hertfordshire should be core attendees for part II of the meeting going forward. STC had endorsed both changes for Board approval. The West Essex Place Director had attended for Part II of the meeting and had led a good discussion on the HCP Programme which the Committee would monitor going forward.
7.2	The TC summarised by stating that the Board had noted the update and approved the Committee's revised ToR.
7.2 Report from LMT Meetings Held in May	
7.3	This item was presented by the CEO and key areas for escalation to the Board included the following: • **ITU business case:** Surgery division had presented an introduction to the ITU business case. The full business case would be presented to SMT and LMT in June 2024. The full business case must have the full alignment of all the divisions on models of care/workforce model. The need to gain partnership support for the case was agreed (ICB, region and the Critical Care Network). • **Dragon Medical Online (DMO):** LMT had approved a hard stop date of 10.06.24 for use of legacy systems. For areas where this was challenging, a clinical risk assessment had to be completed to inform the actions required to enable compliance. • **Triple Lock** – A copy of the Triple Lock application process was circulated to LMT members for familiarisation.
7.4	NED-DB asked how colleagues were finding the new structure for SMT/LMT meetings. The CEO responded that with SMT now reporting into LMT, there were fewer agenda items which

	was leading to more detailed discussions. The CN added that there had been agreement to evaluate the position in six months' time and to understand the impact on the SMT membership in particular.
7.3 Report from Audit Committee	
7.5	This update was presented by NED-GW and key points to note were as follows: **External Audit Update:** The audit was going well and would be finalised for Extraordinary Audit Committee on 24.06.24. The Board would be asked to delegate authority to key individuals in the event it was not possible to sign off the accounts as scheduled on 24.06.24. **Internal Audit Progress Report**: The CIO and team had received substantial assurance on the DSPT audit. The team had been thanked for their efforts. The Head of Internal Audit had given an indicative opinion of Moderate Assurance, subject to three remaining reports being completed although the opinion was unlikely to change.
7.6	In response to the request for delegated authority for the final sign-off of the annual accounts, the Board approved this request with authority delegated to the CEO, DoF, the TC, NED-CM and NED-GW, if the scheduled Extraordinary AC did not go ahead on 24.06.24.
7.7	The TC commended colleagues for being on track so far, given the complexities that had arisen in the previous year.
7.4 ICB Medium Term Plan	
7.8	This item was presented by the CEO and was for information only. The paper in the pack had been presented to the ICB Public Board and contained the medium term plan for the system, including an overarching plan, priorities and a range of appendices to enable system colleagues to identify those priorities. Local HCP priorities for West Essex were aligned with those of the ICB.
7.9	NED-GW highlighted the lack of a plan for dentistry, particularly given 28% of five year olds were now experiencing tooth decay. He asked whether there were plans to invest in West Essex. The CEO responded there were plans (focussed on by the ICB), acknowledging it had not been listed as a priority.
7.10	NED-LB then asked whether there were actionable programmes of work with accompanying owners/target dates. The CEO responded there was a bit of both at system level. The Trust needed to play its role and do all it could for its patients. It had PQP/Transformation plans some of which were internal, but some of which were linked to WEHCP or to wider system solutions, for example Pathology.
7.11	ANED-RC then commented that the success of the plan was dependent upon the leadership focus and alignment of priorities/resource. He asked about levels of confidence in the success of the plan. The CEO responded that for the West Essex population there were some good developing plans with good engagement across partners and clear leads. He did not know enough about the other HCPs. There was a programme management team at ICB level with directors responsible for different elements of work.
7.12	ANED-RC then highlighted that some HCPs were moving faster than others. He asked whether the WEHCP was well placed to move quickly and was there a view on end-state models. The CEO confirmed that WEHCP was well placed to move quickly and acknowledged that. In terms of the end state e conversations which had started pre-COVID needed to be revisited.
7.13	The TC asked whether a Board session on the 'Governance of Place' might be helpful. The CEO responded that might be helpful in three to four months' time. The TC responded she would schedule that in for the autumn and reminded members that the PAHT Board had been due to invite the HWEICS CEO/Chair to a future meeting to discuss the HCP strategy anyway.
ACTION **TB1.06.06.24/15**	**Arrange a Board Development session on the 'Governance of Place'.** **Lead: Trust Chair/Director of Strategy**

7.14	At this point in the meeting the CoPP announced it was the CEO's last public board meeting and she would like to thank him for his years of service to the hospital and community and to wish him well in his new role.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Any Unresolved Issues?	
9.1	There were no unresolved issues.
9.2 Review of Board Charter	
9.2	It was agreed that the Board had adhered to its charter.
9.3 Summary of Actions and Decisions	
9.3	These are noted in the shaded boxes above.
9.4 New Issues/Risks	
9.4	The CIO would work up a risk around cyber security for the BAF.
9.4 Any Other Business (AOB)	
9.5	There were not items of AOB.
9.5 Reflections on Meeting	
9.6	Members agreed there had been some good discussion.
	The meeting closed at 13:00

Signed as a correct record of the meeting:	
Date:	03.10.24
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 03.10.24

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.01.02.24/27	Paediatric Staffing	Review of Paediatric staffing levels to be presented to the Trust Board in September (following presentation to PAF).	CN	TB1.12.09.24	This will come through the full year establishment review via People Committee and to Board in January 2025.	Proposed for closure
TB1.06.06.24/10	Corporate Risk Register	Corporate Risk Register: Review the timeline for approving the Oncology risk under section 4.2 of the paper.	MD	TB1.03.10.24	Risk id 646 current score 4 x 4 = 16 relates to increase in activity and delays to accessing the first oncology outpatient review. Although staff recruited they are not yet in post so RMG is recommending to LMT that it is added to the corporate risk register and the score remains as is until staff in post, when the risk score can be revised downwards.	Proposed for closure
TB1.06.06.24/11	Good News Communication	Consider how to improve communication around good news stories.	AD-C	TB1.03.10.24	There are a series of good news stories that are available to view on the Trust's website: News and events | Princess Alexandra Hospital (pah.nhs.uk) The Trust also publishes *Proudest Moments* each week, which all the organisation's people and NEDs receive.	Proposed for closure
TB1.06.06.24/12	Board Development	Consider a future Board Development session on the successful long-term programmes of work that have led to improvements across a range of indicators in the IPR.	Exec Team	TB1.03.10.24	Added to Board development plan.	Proposed for closure
TB1.06.06.24/13	Fit & Proper Persons Annual Report	Fit & Proper Persons Annual Report to be circulated to the Board.	CPO	TB1.03.10.24	Actioned.	Closed

ACTION LOG: Trust Board (Public) 03.10.24

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.06.24/14	Board Assurance Framework	Consider adding the risk of a cyber attack to the BAF.	CIO	TB1.05.12.24	Risk is being scoped and will be presented to December PAF.	Open
TB1.06.06.24/15	Board Development	Arrange a Board Development session on the 'Governance of Place'.	TC DoS	TB1.03.10.24	Added to Board development plan.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors - 3rd October 2024

Agenda item:	2.1							
Presented by:	Hattie Llewelyn-Davies							
Prepared by:	Hattie Llewelyn-Davies							
Date prepared:	26th September 2024							
Subject / title:	Chair's Report							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	
Key issues:	To inform the Board about my work; to increase knowledge of the role; to evidence accountability for what I do.							
Recommendation:	The Board is asked to discuss and note the report.							

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

Previously considered by:	Not applicable
Risk / links with the BAF:	No specific risks identified but NED walkabouts are linked to BAF risk 1.1 (clinical outcomes)
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below. My role as Freedom to Speak up Guardian informs my work in this area also.
Appendices:	Walkabout Action Notes. Board Development Programme.

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 Recruitment of the Chief Executive:

The successful recruitment process for our new CEO culminated in the appointment of Thom Lafferty. I am delighted to announce that Thom starts work with us on 4th November 2024. He attended our recent Annual General Meeting and has been meeting many of his new colleagues in the interim.

I am proud of the quality of the applicants we received for the role and the number. It reflects the growing reputation of PAHT.

Very sadly just after the end of the recruitment process Ogechi Emeadi, Chief People Officer died very suddenly. The whole Board is deeply in her debt for the amazing work she did for us, her values and her commitment. She is greatly missed.

3.0 Board Recruitment:

I am very pleased to announce that Oge Austin Chukwu has been appointed to our Board as a Non-Executive Director. Oge joined us as an associate NED following an external advert.

We will go out to advert shortly to recruit an associate.

We have also been asked by NHS England to host a NEXT Director, which I am glad to be able to do. (The role of NEXT Director is a role that is part of a national programme to develop the skills and experience of people who have the potential to be NEDs in the future). I have met and informally interviewed the candidate and she will join us shortly.

Our last NEXT Director placement was Darshana Bawa, now a full NED and our Senior Independent Director.

4.0 System involvement:

I continue to be involved with the ICS and wider system.

I have been invited to sit on the appointment panel for the New Chair of West Herts Hospitals Trust. I am currently mentoring three recently appointed chair of Trusts.
I have recently delivered a workshop on behalf of the DNDN (Disabled NHS Directors Network) for all twelve of the main executive search firms that work in the NHS.
I continue to attend the first hour of the Patients Panel monthly meetings to ensure liaison between the board and the Patients Panel.

5.0 Staff resilience and Board visibility:

The NEDs continue to do regular visits to our services,
Attached is the action note that has arisen from our regular visits.
My thanks go to all the staff teams who have hosted our visits. In response to a new national initiative, we have established a programme of monthly visits to our Emergency Teams and Urgent Treatment Centre. Reports of action from these will appear on the action note from our normal visits.

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

Author: Hattie Llewelyn-Davies. Trust Chair.
Date: 28th May 2024.

Chair's action matrix: version 5.1

Team: PAHT Chair and non-executive directors

Updated: September 24

Non-Executive Directors initials:		Others
HLD: Hattie Llewellyn-Davies (Chair) GW: George Wood (senior independent) CM: Colin McCready OA: Oge Austin-Chukwu (Associate)	DB: Darshana Bawa AWS: Anne Wafula-Strike (associate) LB: Liz Baker (Associate)	PP: Patient Panel FtSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
19/08/2024 10/09/2024	NA	Colposcopy	Cancelled	NA	NA	NA
10/07/2024	HLD	Outpatient call centre	Best visit. Evidence based, massive progress made, ambitious for reducing waits.	NA	NA	Progress report presented to QSC and teams were commended on progress.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) 3 October 2024

Agenda item:	2.2							
Presented by:	Sharon McNally - Interim CEO							
Prepared by:	Sharon McNally - Interim CEO							
Date prepared:	30 September 2024							
Subject / title:	CEO report							
Purpose:	**Approval**	**X**	**Decision**	**X**	**Information**		**Assurance**	
Background / Proposal:	This report provides an update since the last Board meeting on the key changes, challenges and successes. The report is framed around our 5 strategic priorities: Patients, People. Performance, Places and Pounds.							
Recommendation:	The Trust Board are asked to note the update.							

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

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks.
Legislation, regulatory, equality, diversity and dignity implications:	– Regulatory – Board requirement to assure itself of suitable practices and processes in place to minimise the risk to patient safety in relation to long waits for planned care and urgent care – Regulatory – recognition of our inability this year to meet our regulatory requirement to breakeven financially without support – EDI – impact of long waits for planned and urgent care on our different populations and the potential for a disproportionate impact – EDI – ongoing need to ensure that our recovery plans and our PQP plans are quality and equality impact assessed to prevent any unintended consequences or unequal impact on colleagues or patients – EDI – all the developments to our culture are underpinned by a proactive recognition of the need to ensure and to support EDI for all, for example, access to and ability to use digital enhancements (Alex Health)
Appendices:	None

Chief Executive's Report
Trust Board: Part I – 3 October 2024

It has been a privilege to lead the organisation as the interim CEO since the beginning of August whilst we wait for our substantive CEO Thom Lafferty to join us on November 4th. I would like to thank my executive team colleagues for their continued dedication and wonderful support over this period, and our amazing colleagues across PAHT for their on-going commitment to deliver compassionate, skilled care to the patients that we serve.

This report provides an update since the last Board meeting on the key changes, challenges and successes.

1. Our Patients

1.1 Inpatient survey results
The interim chief nurse is bringing a paper to Board today to provide an update following the August publication of the CQC National Adult Inpatient Survey Results (2023). The outcome of the survey shows that whilst we are making good progress with improvement there is more to do. We need to maintain a strong focus to ensure that all of our patients receive a good experience across all of our services and interactions with our people. I would like to take this opportunity to reconfirm both my commitment, and that of our teams, to continuous learning and improvement.

1.2 Alex Health implementation
We continue to make substantial progress in our partnership with Oracle Health to implement our Alex Health programme over first weekend of November. At the time of writing, we have successfully completed our technical full-dress rehearsal (FDR) and will be in our operational FDR period. The FDR period enables significant learning for our final cut over plan which commences at the end of October. As we head to our Go Live weekend, a number of critical milestones will be within our planning and oversight. This includes our data quality and migration, our ability to achieve adherence with statutory reporting post go live, the completion of integration testing for pathology and ensuring we meet the 80% threshold of colleagues trained prior to go live.

The programme has a strong governance framework in which the key risk and milestones are managed. I am also pleased to note that there continues to be a good level of organisational engagement in the implementation of Alex Health.

Importantly, aligned to our vision, the Oracle Health Millennium solution will get us to HIMMS Level 6 and be a key enabler for how we can transform how our team's work. Our patients will benefit from improved experiences, better clinical outcomes and improved safety as a result.

1.3 National reports

1.3.1 In May 24, Dr Penny Dash was asked to conduct a review into the operational effectiveness of the Care Quality Commission (CQC). The purpose of the review was to examine the suitability of the CQC's single assessment framework methodology and the ratings for health and care providers. The interim report was published 26 July, highlighting a number of opportunities for improvement. A substantive report will be published later this autumn with recommendations for how the independent regulator will take forward regulatory assessments.

Review into the operational effectiveness of the Care Quality Commission - GOV.UK (www.gov.uk)

1.3.2 In September 24, the government published the commissioned Independent Investigation of the National Health Service in England. Led by Lord Darzi, the report assessed patient access, quality of care and overall performance of the health system. The report recognised and validated the challenges faced by the NHS, the impact on the nation's population and the emotional burden faced by the staff working in the NHS. Lord Darzi recommended the following major themes be taken forward through the emerging 10-year health plan, these include:

- Re-engage staff and re-empower patients
- Lock in the shift of care closer to home by hardwiring financial flows.
- Simplify and innovate care delivery for a neighbourhood NHS.
- Drive productivity in hospitals.
- Tilt towards technology.
- Contribute to the nation's prosperity.
- Reform to make the structure deliver.

We look forward to the publication of the 10-year health plan. The plan is scheduled to be further developed and co-produced by the public, patients and healthcare staff over the coming months and publish in spring 2025. The focus of delivering the overarching health mission is set around 3 mission shifts: From hospital to community, from treating sickness to preventing it, from analogue to digital. The mission shifts are aligned to the Herts and West Essex Medium Term Plan and PAHT 2030.

2. Our People.

2.1 Since the Board last met in public, we have suffered the sad and tragic death of Ogechi Emeadi (Gech) after a short illness. Gech worked as our executive director of people, OD and communications (CPO) for 6 years; a talented, well- respected leader at PAHT and across the NHS. Gech leaves us with a strong legacy through her delivery of health and well-being support, championing clear and strong values and a positive culture of inclusivity. Gech remains strongly in our thoughts.

2.2 On Saturday September 14th, I was delighted to attend the Cultural Celebration for our People. Organised brilliantly by our REACH network, the event brought together over 300 people to celebrate the diversity of our people. The event held a tribute to Gech, a poignant and sad moment of reflection but also a recognition and celebration of her amazing impact across our teams. The event was a truly wonderful evening showcasing talent, friendship, inclusivity and joy.

2.3 I would like to thank Giovanna Leeks, who has stepped up into the interim CPO position, Giuseppe Labriola (interim chief nurse) and Jo Ward (interim deputy chief nurse) for their support, and their adaptability over the leadership transition period.

2.4 Across this calendar year a number of PAHT people and teams have been shortlisted for national awards. This is a real credit to them and further supports the profile of PAHT. I would like to take this opportunity to acknowledge their achievements. Our most recent national recognition is for two of our nurses who have been shortlisted in the Nursing Times Workforce Awards – Kristle Brava, international nurse educator and manager who has been shortlisted in the Practice Educator of the Year and Charlotte Collings, recruitment and retention nurse who is shortlisted in the Diversity and Inclusion Champion of the Year category. The final takes place on 28 November.

2.5 Following a lengthy period of industrial action, a total of 44 days of action, the junior doctors committee (JDC) in England accepted the Government's recent pay offer of 22.3 percent, with 66 percent of junior doctors voting in favour of the deal. The industrial action has caused a

significant impact on waiting lists and care provided. The deal also brings into force the title of resident doctors in place of the current reference of junior doctors.

I would like to extend my thanks to our staff over the periods of industrial action, for the support shown to each other and for their tireless focus on the safety of our patients. We welcome the stability that the end of IA brings to enable us to plan effectively and with greater certainty to provide timely care and access for our patients.

We wait to hear updates from the Royal College of Nursing (RCN) following the rejection of the government's 5.5% pay award in September, and we continue to work across our system partners to minimise any impact of the ongoing British Medical Association (BMA) work to rule for GPs.

3. Our Operational Performance

Whilst we remain under Tier 2 monitoring for performance against our planned care and cancer care access standards, we continue to have a strong improvement focus across both our operational and our financial performance.

The key drivers and detailed information supporting the operational pressures are outlined in the Integrated Performance Report and associated items on the Board agenda later.

Headlines for our performance includes:

3.1 Planned care
We have made improvement with our routine elective recovery and achieved 0 78+ week waits at the end of July with 1 patient breaching the standard at the end of August. We continue to focus on reducing all our waits, and striving to meet our agreed trajectory against the national expectation for 65+ week waits by end September.

Following great teamwork across our estates and surgical teams, in August we opened additional day case theatre capacity and have been successful in streamlining our ophthalmology pathways to drive efficiency. This additional theatre capacity enables us to review and maximise additional activity through the remaining theatres. This supports our drive to reduce waiting times for our patients and help the delivery of our financial target.

PAH has been one of three trusts in the East of England consistently achieving the cancer 28-day faster diagnosis this standard. Our 62-day cancer performance continues to improve, and we are achieving the trajectory as set out within our 2024/25 plan.

3.2 Urgent Care
Our urgent care performance and flow continues to be challenged with the demand for our services remaining high, impacting on our financial pressures, and exacerbating our imbalance between non-elective and elective activity. Despite this, there have been some positive improvements since the beginning of the year in delivering against the 4-hour standard. However, the improvements in performance we achieved over the beginning of the year have plateaued over the last few months. We continue to have a keen focus on further improvement and recognise the timeliness of being seen and treated within our emergency department impacts on our patients and our community.

Operational teams are holding a number of workshops over the coming weeks in preparation for winter to test out scenarios and operationalise the plans to support patient flow and experience for all our patients.

We continue to collaborate closely with all partner organisation in the West Essex and East and North Hertfordshire places and across the HWE ICS to support our patients safely and effectively.

4. Places

4.1 The results of the general election that took place in July (2024) have changed the political landscape for the geography that PAHT serves. Of the five MPs covering this area there are three new Labour MPs and two are pre-existing conservative MPs. Michael Meredith, director of strategy and estates, and I have met Chris Vince, MP for Harlow, where he highlighted his support of PAHT and our plans for a new hospital - a positive and collaborative conversation.

The Labour Party made a pre-election commitment (June) to meet the Conservative's New Hospital Programme (NHP). In July, Chancellor, Rachel Reeves, announced a spending review that includes the NHP. On 20th September, in line with the review, we received a letter confirming our new hospital is included with the scope of the review which aims improve the deliverability of the schemes within the programme. Whilst further details are not available currently, we continue to work with the revised guidance from the New Hospital Programme team for New Hospital 2.0. to ensure our readiness to move forward with the scheme.
I would also like to reassure our community that the safety of our patients and people is paramount and this is supported by our building maintenance plans and keeping our hospital as safe and operational as it can be whilst awaiting further updates."

5 Our Pounds

A detailed paper is included within the Board agenda providing a comprehensive update of our financial position. Our financial position remains challenging with a £1.4m adverse to plan position reported in M5. We continue to focus on delivery of our financial target and work closely with our Division and Corporate Services teams on our recovery plans.

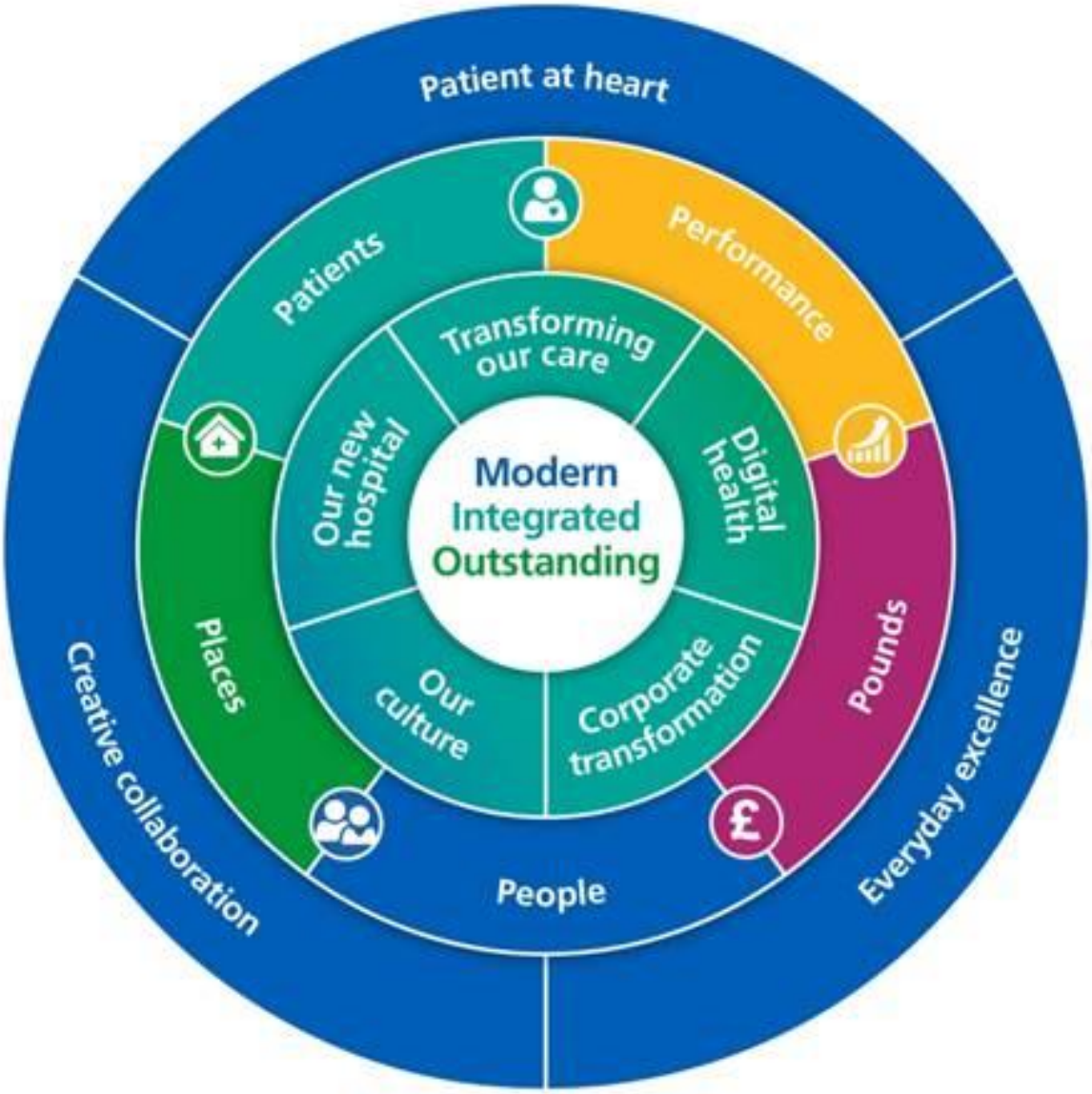
I would like to note the continued drive for transformation though our PQP programme with good level of organisational engagement and leadership. An example of the progress made can be seen through the significant improvement to our agency spend achieving 3.1% against a 3.2% cap in M5 and our progress to reduce our vacancy rate to 7.98% (August).

As previously reported in the CEO report, the structural drivers impacting the financial position of PAHT are well understood by system colleagues and have been supported by non-recurrent funding annually for the last 7 years; none of which is built into our position for 2024/25.

Transformation of services, in partnership with health and care colleagues, in a planned, phased and integrated way is required to achieve cost reductions over the scales faced by the Trust and the system. We recognise our role, the importance of system wide working and the development of the local Health and Care Partnerships are fundamental this transformational shift.

Author: **Sharon McNally, Interim CEO**
Date: **30 September 2024**

PAHT 2030 Roundel; outlining our vision, priorities, objectives and values.



The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 3 OCTOBER 2024

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:	26 September 2024							
Subject / title:	Corporate Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents a summary for Trust risks scoring 15 and above for all our services. It is a snapshot of risks across the Trust and was taken from our Datix database 20 August 2024. The overall number of risks approved for inclusion onto the corporate risk register that score 15 and above is 31 and can be seen in table 1. Table 2 details the numbers of risks by category and those that breach the Trust appetite tolerance. Section 3 provides detail of the three risks scoring 20 approved for placement on the Corporate risk register (CRR). None of these risks are new. • Quality - safety – emergency access standard (risk id 85) and referral to treatment constitutional standard (risk id 497) • Statutory / regulatory compliance - associated with the ability to provide hazardous materials decontamination (risk id 611) Section 4 - There are no new risks scoring 16 that have been approved by RMG / LMT for adding to the Corporate register since Jun24. Section 5 - There are no new risks scoring 15 that have been approved by RMG / LMT for adding to the Corporate register since Jun24. Section 6 is a new addition to this paper and shows the number of risks that have a score of 15 or above, and are awaiting a further review by RMG and LMT, so are not yet on the corporate risk register. This includes new risks that are due to be reviewed during the meeting this paper is being presented at.							
Recommendation	Trust board is asked to review and discuss the contents of the corporate risk register							

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

Previously considered by:	Risk Management group 10-9-24 Leadership Management group 24-9-24

	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks, closed risks and those that they require assistance with for discussion at Risk Management Group on a monthly basis.
Risk / links with the BAF:	There is a direct link between the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity	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 risks scoring 15 and above on the Corporate Risk Register, with the data extracted from the Datix system on 20.08.24. Risk is managed as a dynamic process across services, this paper will continue to be updated during August 2024.

The Trust Risk Management Group (RMG) meets monthly and reviews risk by exception on rotation according to the annual work plan (AWP).

In accordance with the Risk Management Strategy and Policy, risk is assessed and reviewed against category, appetite and risk tolerance levels.

This paper covers risks that have been agreed for placement on the corporate risk register, as well as those operational risks that are completing the process for inclusion onto this register, this includes risks that:

a) have a current score of 15 or more
b) exceed the risk categories appetite tolerance level and cannot be managed locally

In addition to the corporate risk register there is an operational risk register that includes risks that are being managed locally within our corporate and divisional teams. Operational registers also include risks that meet the criteria for the corporate register that have not yet been

- submitted to RMG
- re-submitted to RMG following divisional / corporate team review of feedback from RMG / LMT
- are new and awaiting review by the RMG.

Both corporate and operational registers now also include trust wide risks. These are risks that have the potential to affect services / teams across the organisation. Their management is led by the relevant subject matter expert with input from affected services / teams.

2.0 Context

The corporate risk register is a snapshot of risks across the Trust at a specific point in time and is made up of risks that have a current score of 15 as well as those risks that breach the risk tolerance levels and are not being managed at a local level.
Consideration is also given to patient safety risks with a consequence of 5.

There are 31 risks that meet the criteria and have been approved for inclusion onto the corporate risk register. RMG continues with the review of corporate and divisional risks escalated for inclusion onto the corporate register.

A separate paper is completed and submitted to the Leadership Management Team (LMT) meeting to ensure all leaders are sighted to these risks, it is this group that RMG submits the recommendation for items to be placed on the corporate register. LMT will discuss and agree requests or ask services to complete a review with feedback for those risks not approved.

The annual work plan will continue to be reviewed and updated to ensure that it reflects learning from this new way of working.

The breakdown by service for all risks scoring 15 and above is detailed is in table 1

Table 1 - Risks scoring 15 or more	Risk Score	

	15	16	20	25	Totals
Cancer & Clinical Support	0 (1)	6 (6)	0 (1)	0 (0)	**6 (8)**
Corp - Estates & Facilities	1 (1)	0 (0)	0(0)	0 (0)	**1 (1)**
Corp - IM&T	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	1 (1)	0 (0)	**1 (1)**
CHAWs Child Health	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
CHAWs Women's Health	1 (1)	1 (1)	0 (0)	0 (0)	**2 (2)**
Medicine	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Surgery	0 (0)	2 (3)	0 (0)	0 (0)	**2 (3)**
Urgent & Emergency Care	2 (2)	1 (1)	0(0)	0 (0)	**3 (3)**
Trust wide	2 (2)	9 (10)	2 (2)	(0)	**13 (14)**
Totals	**6 (7)**	**22 (24)**	**3 (4)**	**0 (0)**	**31 (35)**

The numbers of corporate register risks and those risks with a current score less than 15 that exceed their risk appetite tolerance is recorded in table 2. This is detailed by risk category. Divisions and services consider those risks that breach appetite and score less than 15 and are able to submit these by exception to the RMG who will consider.

Table 2 – Number of risks by category that exceed appetite tolerance	Risk Appetite tolerance level	Risk Score					Totals
		10	12	15	16	20	
Quality – Safety	≥ 10	18 (20)	67 (62)	12 (5)	19 (16)	2 (2)	**118 (105)**
Quality – Patient Experience	≥ 12		11 (9)	0 (0)	2 (2)	(0)	**13 (11)**
Quality – Clinical Effectiveness	≥ 12		15 (16)	2 (1)	4 (1)	0 (1)	**21 (19)**
People	≥ 15			2 (0)	4 (3)	1 (0)	**7 (3)**
Statutory Compliance & Regulation	≥ 12		11 (11)	2 (1)	(0)	3 (1)	**16 (13)**
Finance	≥ 12		5 (3)	0 (0)	0 (0)	0 (0)	**5 (3)**
Reputation	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**
Infrastructure	≥ 15			1 (0)	1(1)	(0)	**2 (1)**
Information and Data	≥ 10	0 (0)	7 (7)	0 (0)	1 (0)	1 (0)	**9 (7)**
Systems and Partnerships	≥ 15			0 (0)	1 (1)	0 (0)	**1 (1)**

3.0 Summary of risks scoring 20

There are 3 risks with a score of 20 on the corporate risk register. A summary of these risks and action & mitigations is below, information is taken from divisional risks:

3.1 Quality – Safety:

3.1.1 Emergency care access standard

- There is a risk that patients may deteriorate as a result of failing to deliver the ED four-hour access standard.

Risk id 85: is a Trust wide risk and is on the corporate risk register.
Actions / mitigations: Use of the Manchester Triage tool and Nerve Centre to improve clinical information and prioritisation of patients. Improvement trajectory agreed and oversight by the Urgent Care Board.

3.1.2 Referral to treatment constitutional standards

- There is a risk that patients waiting over 52 weeks for treatment may deteriorate and come to clinical harm. The numbers of patients waiting over 52 weeks increased significantly during Covid 19 pandemic and there is insufficient capacity to treat them all within the constitutional standard.
  Risk id 497: is a Trust wide risk on the corporate risk register
  Actions / mitigations: Regular meetings to review patient target lists (PTL), with priority for long waits. Cancer PTL reviewed every 24-48hrs. Daily circulation of PTL for escalation and long wait plans. Trajectory to reduce number of patients waiting >52 weeks with oversight by the Elective Care Operational Group and System Access Board.

3.2 Statutory Compliance and regulation:

Hazmat decontamination capacity and capability

- There is a risk that should a hazardous materials incident occur, PAHT will not be able to discharge their duties of decontamination for several people presenting themselves for dry or wet decontamination. That is caused by insufficient equipment, storage space (for equipment) and trained staff.
  Risk id 611: raised in December 2023 and placed on the corporate risk register in March.
  Actions / mitigations: Purchase additional equipment for decontamination, undertake a baseline assessment to assess existing equipment, develop a training schedule and ensure this is accessible to staff. There is some equipment in place and staff who are trained to use it. New storage facility now on site and work is taking place to connect.

4.0 There are no new risks scoring 16 added to the corporate risk register since June 2024

5.0 There are no new risks scoring 15 added to the corporate risk register since June 2024

6.0 Recommendation

Trust board is asked to review and discuss the contents of the corporate 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 – 3 October 2024

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 2024/25

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

Key issues:

The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated for 2024/25 with executive leads and reviewed at the relevant committees during September 2024.

The wording for Risk 2.3 has been updated as reflected on Appendix B. This was discussed at People Committee on 30 September 2024.

The risk scores have not changed this month and are summarised in Appendix B.

The HEE engagement visit is scheduled to take place on 2 October 2024 and depending on the outcome of that visit, the risk score for Risk 2.1 (GMC enhanced monitoring) may require further review.

The full BAF is available in the resources section of Diligent.

Recommendation:

The Board is asked to:

- Note the BAF risk scores and the revised wording for BAF risk 2.3

Trust strategic objectives:

Patients	People	Performance	Places	Pounds
x	x	x	x	x

Previously considered by:	STC, QSC, PC and PAF in September 2024.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard

Board Assurance Framework Summary 2024.25

Risk Ref. Committee	Risk description	Year- end score (Apr 24)	June 24	October 2024					Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequities in our local population										
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16					↔	12	I-CN 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					↔	12	CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15	15	15					↔	10	COO
1.4 STC	EHR There is a risk to the delivery of safe and high quality care caused by the Trust relying on an unsupported and unstable EHR if Alex Health is not deployed by October 2024 and is delayed beyond the end date of the Cambio support contract	16	16	16					↔	12	CIO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a culture that supports engagement, recruitment and retention and results in further improvements in our staff survey results as we strive to be a model for equality, diversity and inclusion										
2.1 PC	GMC enhanced monitoring: There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services.	20	20	20					↔	10	MD
2.3 PC	Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust	16	16	16					↔	8	I-CPO
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	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					↔	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.	20	20	20					↔	9	DoS
	Strategic Objective 4: Our Performance - we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators										
4.1 PAF	Seasonal pressures: Risk that the Trust will be unable to sustain and deliver safe, high quality care during seasonal periods due to the increased demand on its services.	12	12	12					↔	12	COO

Board Assurance Framework Summary 2024.25

4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	20	20	20					↔	12	COO
4.3 PAF/ (QSC for patient harms)	Industrial action: There is a risk that patient safety will be impacted by further industrial action	20	20	20					↔	8	COO/MD/CN
	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	Risk that the Trust will fail to meet the financial plan due to the following factors: An annual plan has been set to deliver a deficit plan of £23m inclusive of a CIP requirement of c. £18.5m in 2024/25 and ERF delivery at c. 115% of 2019/20. The original plan was proposed at £30m and has only been revised down by agreed stretches relating to ERF. We have articulated the risk we are bearing as a provider. Inflation remains high, productivity remains a challenge and there is risk around income from the part move to a PbR basis. Cash will be a challenge in year with the potential deficit driving the Trust towards an adverse cash position.	16	12	12					↔	8	DoF

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 October 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Journey Through the Emergency Department for a Mental Health Patient	Y	Y	N	There had been some significant improvements in terms of assessment, length of stay, collaboration with partners (for better patient experience and safe care) and training but there was still more to do. QSC noted: • Improvements in ED in terms of mental health assessment and the environment. • A focus on improving the safety and therapeutic environment for patient assessment/care. • A renewed focus on high intensity users with EPUT. • Training remained a significant risk due to the size and diversity of roles within the workforce. • Lead Nurse for Mental Health and CYP Liaison Nurse leading improvements at PAHT and with system partners. • An improved understanding and administration of the Mental Health Act.
2.2 Update on Mental Health Strategy	Y	Y	N	The paper provided an update on the mental health strategy, highlighting key achievements and risks to delivery. Progress was being made in delivery however, it was recognised that this work needed a strong focus to continue to drive improvements and maximise opportunities. Progress would be tracked via the Mental Health Quality Forum and Vulnerable People Group.

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 October 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Reports from Feeder Groups	Y	Y	N	Reports were received from the following groups: • Report from Infection Prevention & Control Committee (July) • Report from Strategic Learning from Deaths Group • Report from Clinical Compliance Group • Report from Clinical Effectiveness Group • Report from Patient Safety Group (PSG) (August & September) • Chair's Report from Patient Experience Group
2.4 Infection Prevention & Control (IPC) Monthly Update	Y	Y	N	Key highlights were: • Thresholds for 2024-25 had been published; higher thresholds had been allocated for all alert organisms. • *C.difficile* - there was a focus on the key control domains, including environmental cleaning. • One MRSA bacteraemia - peripheral IV cannula related • An Mpox outbreak in central and western Africa which had been declared a public health emergency of international concern – no cases in UK as yet, but the IPC team were preparing staff and providing PPE training for high consequence infectious disease (HCID), focusing on the high risk areas.

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 October 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Learning from Deaths Update	Y	Y	N	Key headlines were: • HSMR for the period May-23 to Apr-24 is 91.33 **'lower-than-expected'** based on 26,304 super-spells and 811 deaths (crude rate 3.08%). The Trust had now reported four of the last six rolling periods as "lower-than-expected". • Medical Certificate of Cause of Death (to be issued within 72 hours of death): A new process had been introduced by the national team which was more detailed. Colleagues were working to improve performance against the target. • QSC noted that an SI had been declared following a SJR and a second review panel (a conclusion of avoidable death).
2.6 Patient Safety & Quality Update				Key headlines were: **Safety** • 1614 open incidents. 1124 are patient safety incidents and 55% open longer than 30 days. • No new incidents declared in July or August 2024 and the Trust currently has 14 open investigations. Four are SIs and all expected to be completed by end of September. **Legal data**

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 October 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Two new claims received in-month, five claims were closed in the month and five new inquests were notified by HM Coroner with two cases closed in-month. **Clinical Effectiveness** • Conclusion of the migration of data and validation into the InPhase system. • Improvement noted in the participation of National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies. • 962 published procedural documents, 759 in-date and 202 (21%) of these over their review date. Concerns noted around the numbers of open incidents with assurance provided the position is being challenged monthly at the Patient Safety Group.
2.7 Sharing the Learning 4 Monthly Update	Y	Y	N	Learning was shared from incidents from February – May 2024 (12 incidents). Plans were in place to share learning more widely across the organisation including via podcasts.
2.8 Patient Experience Update	Y	Y	N	Key headlines for 23/24 were: • A 33% reduction in complaints. • An increase of 158 cases in PALS. 4411 PALS cases noted in 2023-24.

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 October 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Improving data against key themes; medical care, nursing care and communication.
2.10 QPMO Report	Y	Y	N	Red actions remained unchanged, although trajectories for improvement were in place. Amber actions were progressing. It was pleasing to note however that the previously red action related to training was now rated as red/amber. Work was underway to revamp the QCIG meeting to include more than just CQC actions.
2.11 Quarterly Quality & Transformation Update	Y	Y	N	The paper provided a summary update (status and progress) of quality improvement and transformation projects and programmes at PAHT. Overall the programme was rated as amber with two red actions related to fractured neck of femur (transfer from ED to correct ward) and the application of PIFU.
2.12 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
3.1 M5 IPR	Y	Y	N	All relevant metrics had been discussed during the course of the meeting. It was noted the expectation was the slight

BOARD OF DIRECTORS:	Trust Board (Public) – 3 October 2024			AGENDA ITEM: 4.1
REPORT TO THE BOARD FROM:	Quality and Safety Committee (QSC)			
REPORT FROM:	Oge Austin-Chukwu			
DATE OF COMMITTEE MEETING:	27.09.24			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				increase in pressure ulcers would reverse in coming months.
3.2 Report Against Operating Plan	Y	Y	N	Key headlines included: • Activity levels for August had been over the required 107% compared to 2019. • 62 day cancer performance was improving month-on-month and achieving the trajectory as set out in the 24/25 plan. • Diagnostic performance was above the national standard of 95% for MRI, CT and Gastroscopy for August. • Long waiting elective recovery is continuing to improve and the Trust successfully achieved zero 78+ patients in July and just 1 patient for August. Focus was now on delivering the next national milestone of zero 65+ week patients at the end of September. • Urgent care performance had continued to be challenging but there had been some positive improvements in both the 4 hour standard and the proportion of ambulances being offloaded within 15 minutes.

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 October 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 Briefing Note on Outpatient Improvements	Y	Y	N	QSC noted significant improvements in call waiting times, numbers of PALS/complaints, response to emails, DNA rates and clinic cancellations.
4.1 Horizon Scanning Update	Y	Y	N	Items for the Committee's attention were: • Thirlwall Inquiry • Interim Dash Report • National review of Maternity Services in England 2022 to 2024.
4.2 Medicines Optimisation Annual Report	Y	Y	N	This report provided an annual update on medicine optimisation activities in the Trust including initiatives such as biosimilar switching, administration of Parkinson's medication, the Trust's Medicines Strategy, audits and work around insulin/anticoagulants. QSC noted the Trust was in fifth place nationally for the numbers of discharge summaries sent to community pharmacies (which reduced readmissions).

BOARD OF DIRECTORS:	**Trust Board 03.10.24**			**AGENDA ITEM:**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ralph Coulbeck –Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 September 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Maternity Safety and Support Programme Report	Y	Y	N	Following the exit meeting, it had been agreed that the Trust would remain on the programme for a further 6 months with support from an obstetric MIA to support the sustainability of the exit criteria that had been achieved. An Obstetric lead would be allocated to support a new set of exit criteria related to the Obstetric workforce, leadership and safety culture.
2.2 Monthly Maternity Report and Dashboard	Y	Y	N	The 12 (July) and 7 (August) red flags were highlighted in relation to midwifery staffing. Recent recruitment had been positive; including new consultants. In regards to transformation, the plan to increase the accuracy of fluid balance charts was noted. Highlights from the dashboard included; • Still birth rate below regional and national average at 2.47 per 1000 • Preterm birth rate currently at national KPI/ target of 6% • Outlier with Massive Obstetric Haemorrhage in region – a deep dive would be brought to a future meeting
2.3 Quarterly Maternity Assurance Report	Y	Y	N	The following key points/issues were discussed: • Clinical Guidelines and NICE Assessments requiring review • Large number of SI's/PSII's within the Division • Increase in open and overdue Datix • Vacancies within key roles in governance structure
2.4 Maternity Patient Safety Incidents	Y	N	N	No new maternity incidents declared since the last report for July 2024. There had been no maternity PSII closed since the last report and 6 investigations were ongoing (1 MNSI).

BOARD OF DIRECTORS:	**Trust Board 03.10.24**			**AGENDA ITEM:**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ralph Coulbeck –Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 September 2024**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.5 Maternity & Perinatal Incentive Scheme Update	Y	Y	N	At present 6 out of 10 safety actions would be met. The 3 out of 4 at risks actions had plans in place to ensure they were met within the deadline. Safety Action 1 was a concern and required input from MBRRACE. This was due to submitting a review 4 days after the 2 month deadline due to staff sickness.

Other items noted:

- Maternity and Neonatal Safety Champions report
- Horizon scanning

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

4.2

Agenda item:	2.4
Presented by:	Erin Walters, Head of Maternity Governance and Assurance
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance
Date prepared:	02 September 2024
Subject / title:	Overview of Patient Safety Incidents within maternity services

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

Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. The Trust has transitioned from the Patient Safety Framework to the Patient Safety Incident Response Framework and therefore the service has a combination of Serious Incidents (SI's) and Patient Safety Incident Investigations (PSII's). There have been 0 new maternity PSII declared since the last report for August 2024. There have been 0 maternity PSII closed since the last report (August 2024). Maternity services currently have 6 investigations ongoing. SI's - 3 PSII's - 2 MNSI - 1
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents and Patient Safety Incident Investigations.

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

Previously considered by:	PC.30.09.24
Risk / links with the BAF:	BAF 1.1 Clinical Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden Interim Report that was published in December 2020 with recommendations for maternity services. To also monitor outcomes of those in black and brown ethnicities (known to have poorer outcomes), and vulnerable groups. **Mothers and Babies: Reducing Risk through Audits and Confidential Enquires** MBRRACE Report (October 2023)
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

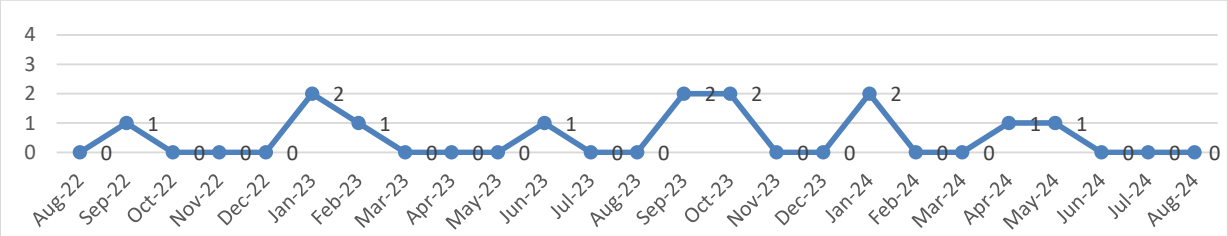
2.0 Background

The Ockenden Interim Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. With the implementation of PSIRF the service will continue this practice by reporting Patient Safety Incident Investigations.

3.0 Analysis

Maternity currently have 6 investigation ongoing, 1 of which is being investigated by Maternity and Neonatal Safety Investigations (MNSI) formally Healthcare Safety Investigation Branch (HSIB). Table 1 details the trend of declared Patient Safety Investigations within the last 24 months to August 2024.

Table 1. Comparison of Patient Safety Investigations reported for Maternity in last 24 months (to August 2024)



There were 0 new Maternity Patient Safety Incident Investigation (PSII) declared in August 2024

Table 2. Serious Incidents declared, submitted and closed for August 2024

Investigations			
Number Declared for August 2024			**0**
Number Submitted for August 2024			**0**
Number Past CCG Deadline as of August 2024 (Not including MNSI/Approved Extensions)			**5**
New Investigations declared in July 2024			
Ref	**Ethnicity**	**Summary**	**Learning Points**
Investigations closed in July 2024			

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to August 2024.

Table 3. Top Themes

Total Number of SI's	Theme	Number
14	Neonatal death	7
	Hypoxic ischaemic encephalopathy (HIE)	3
	Cardiotocograph (CTG) interpretation	3
	Obstetric Haemorrhage	2
	Cross Border Working	2
	Delay in care	2
	Intrauterine death	2
	Retained Object	2
	Escalation	2
	Medical Equipment	2
	Screening Incident	1
	Therapeutic Cooling	1
	Birth Injury	1

5.0 Oversight

All incidents are initially reviewed weekdays by an MDT of senior clinicians. Any that require further information/ investigation are escalated to the twice weekly Trust Incident Management Group (IMG) chaired by the Director of Clinical Quality Governance. This is where management of the incident is decided i.e. SI declared. This is currently in a transition period with the implementation of the Patient Safety Incident Response Framework (PSIRF).

Further management and investigation is undertaken by the division. It is then approved and noted at Divisional Governance Board, then Patient Safety Group, then Quality and Safety Committee. Final oversight once complete is via Patient Safety Incident Assurance Panel, Trust Board, then the Local Maternity and Neonatal System.

Currently, the division is undertaking a review of the governance pathways and reporting structures to strengthen and develop the existing system so that it aligns further with local and national governance objectives.

Further assurance is achieved though triangulation of outcomes from investigations; this includes those from complaints and legal cases. The quality improvement agenda continues and is monitored via the Maternity Improvement Board and all the workstreams are tracked via the PM3 project management tool.

7.0 Recommendation

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

Author: Erin Walters, Head of Maternity Governance and Assurance **Date:** 02 September 2024

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

4.2

Agenda item:	4.1
Presented by:	Linda Machakaire – Director of Midwifery and Gynaecology
Prepared by:	Linda Machakaire – Director of Midwifery and Gynaecology Denise Gray – Deputy Director of Midwifery and Gynaecology Erin Walters – Head of Maternity Governance and Assurance
Date prepared:	17.09.2024
Subject / title:	Maternity Assurance Report – Quarterly review April to June 2024 (Q1)

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

Key issues:	• Clinical Guidelines and NICE Assessments • Large number of SI's/PSII's within the Division • Increase in open and overdue Datix • Vacancies within key roles in governance structure
Recommendation:	To provide assurance to the Board that the maternity and gynaecology services are continually monitoring compliance and learning from complaints and incidents.

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

Previously considered by:	QSCII.27.09.24
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To maintain compliance with the Maternity Incentive Scheme.
Appendices:	n/a

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

This paper is to provide assurance to the Board surrounding Governance within Women's Health Services. This paper will include both local and national data to demonstrate assurance and compliance to the committee.

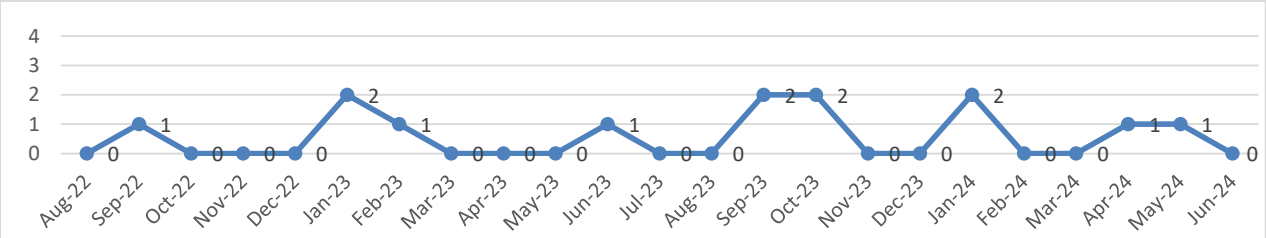
2.0 Background

Within maternity there is an inpatient area which covers 4 wards. Outpatient community services cover a varied demographic area from Harlow to Uttlesford and areas of East Hertfordshire. There is a Maternity Triage which run 24 hours a day to stream service users to the appropriate location based on their needs.

3.0 Analysis

Serious Incidents

Table 1. Comparison of PSII's/SI's reported for Maternity in last 24 months (to June 2024)



Patient Safety Incident Investigations Declared April-June 2024 (Q1)			
Ref	**Ethnicity**	**Summary**	**Learning Points**
	White British	Baby born via forceps due to a prolonged second stage of labour. There was no resuscitation required following birth. On examination the baby was found to have absent reflexes, hypotonic and was subsequently admitted to the neonatal unit. Whilst on the neonatal unit the baby had episodes of apnea and bradycardia so was intubated and ventilated. Cerebral function monitoring was applied and a cranial ultrasound was performed, both of which were abnormal. Baby transferred to a tertiary centre following assessment. Whilst in the tertiary centre and following discussion with the family, a decision was made to redirect care and the baby sadly died.	• Learning shared with all staff regarding appropriate documentation of risks, benefits and alternatives. • Importance of 'Fresh Care' reviews in labour reiterated at handovers and safety huddles. • Escalation to manager on call and senior manager on call discussed at length to ensure support is available when required or in high levels of acuity when oversight of unit activity is required. • **MNSI Investigation**
	White Other	Nasogastric tube inserted incorrectly.	• Ensure that staff have available training to maintain their clinical skills • Clinical guidance should be available to staff and easy to access in cases of unfamiliarity to ensure due process is being followed • Where uncertainty arises with location of feeding tubes, escalation should occur prior to feeding

4.0 Themes

Table 3 details the top themes identified in Maternity SI's within the last 24 months to June 2024. From April 2024 the service moved to Patient Safety Incident Investigations (PSII) as per the national PSIRF Framework.

Table 3. Top Themes

Total Number of SI's	Theme	Number
16	Neonatal death	4
	Cardiotocograph (CTG) interpretation	2
	Obstetric Haemorrhage	2
	Cross Border Working	2
	Delay in care	2
	Intrauterine death	2
	Hypoxic ischaemic encephalopathy	2
	Retained Object	2
	Escalation	2
	Medical Equipment	2
	Screening Incident	1
	Therapeutic Cooling	1

Clinical Incidents

Current Clinical incidents open and closed

The number of open incidents has increased to 50% for incidents reported in quarter 1. Governance processes include daily datix multi-disciplinary review meetings where all incidents over the previous 24 hours are reviewed and responded to in respect of actions and escalation through to Incident Management Group as required. Escalation has occurred within Division to address the backlog. All incidents have had a review with the majority of open incident being no or low harm.

Table 3 – Q1 review of clinical incidents (Datix)

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter (Q1) **Quarter four**	423 422
Number of Incidents Moderate Harm or Above	35 ↓
DoCs Outstanding	None
Number of Open Incidents	248 (11 moderate harm, 1 death)
Number of Incidents Submitted for last financial year April 2023 – March 2024	1874
Percentage of Open Incidents	50% ↑

Table 4. Legal Cases overview April-June 2024 (Q1)

New Claims

2 new claims received in Q1

Closed Claims

No claims closed in Q1

Inquests Opened

No new inquests opened in Q1

Procedural documents (Guidelines)

There are 139 active procedural documents within maternity services, there has been a decrease in expired guidance (26) since the last reporting period (19% outstanding).

Outstanding NICE assessments have also increased since the last report. There are 61 documents in total for maternity services with 36% requiring a review.

An action plan is being developed within Division to tackle this.

Local Document Tracker	New Draft	Due Review	Under Review	Expired	Approved and Published	Total
Maternity	0	6	15	11	107	139

Audit

Audit Schedule 2024-2025 has been agreed, the programme can be shared upon request.

- 5 National Audits
- 27 audits relating to national directives
- 16 local audits
- 1 ongoing spot check audit

Risk Register

Women's health services have 21 risks open on the register. Of these risks 3 score >15

Perinatal Mortality Review Tool Summary

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

PAHT perform a review of cases on a monthly basis which is undertaken as a multidisciplinary panel including midwives, obstetricians, neonatologists and external experts. Table 5 shows the current open cases for PAHT. All cases are within the reportable time frames for MIS Yr 6.

Table 5. Perinatal Mortality Review Tool Open Cases

There were 5 deaths notified to MBRRACE during April to June 2024 Q1.

The PMRT meetings take place on a monthly basis as part of a multidisciplinary panel. There is one consultant neonatologist and one neonatal nurse who routinely attend for all neonatal death reviews as per national requirements. 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.

Current compliance with reporting as of Q1 end was 100%.

MBRRACE-UK Real Time Data Modelling for past 6 months

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

Table 6. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months
reported deaths to MBRRACE which included: Antepartum stillbirths: 5 Intrapartum stillbirth: 0 Neonatal death: 3

External Reviews and External Scrutiny

Table 7. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*
As of June 2024 PAHT, had 1 incident under investigation by MNSI (Maternity and Neonatal Safety Investigations) formerly HSIB.

Staffing

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

Staffing				
Staff feedback from frontline champions and walk-abouts: No significant concerns raised.				
Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)			
Junior Doctor Rota Gaps	Currently recruiting to implement a 2 tier rota (2 registrars per shift).			
Staffing		**Apr-24**	**May-24**	**Jun-24**
	No. of vacancies (WTE)	7.54	9.54	11.53
	Midwives on maternity leave (WTE)	8.43	9.39	9.75
	Bank and Agency usage (WTE)	13.28	14.95	14.76
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)	Current Trust survey complete, action plan being developed within division as part of sustainability plan with maternity services support programme.			
Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	93.75% increase by nearly 10% since 2022.			

Training Compliance

PROMPT, Neonatal Life Support and Fetal Monitoring study days are all multidisciplinary and in person. Mitigations are in place to support attendance and increase study days however releasing the perinatal team from clinical commitments remains a complex challenge.

Migration from Electronic Staff Record (ESR) to This is Me System (TIMS) has been challenging as reporting and data access is limited. The Director of Midwifery has met with the Learning Team Lead to look at possible solutions. The Division is aware that this is a Trust wide issue and not specifically a concern just for Child Health and Women's Services.

MIS Progress

Year 6 was launched in April 2024. The 10 Safety Actions have not changed since last year's scheme however there has been changes within the safety actions for services to implement and the inclusion of further evidence required. This includes working with the Integrated Care Board and the Local Neonatal and Maternity System for assurance. The table below is the projected status of the Safety Actions to NHS Resolution.

Table 10. MIS Progress Yr 6 projection

MIS Progress Yr 6			
SA 1	At Risk	SA 6	Action will be met
SA 2	Potential for risk	SA 7	Action will be met
SA 3	Action will be met	SA 8	Potential for risk
SA 4	Potential for risk	SA 9	Action will be met
SA 5	Action will be met	SA 10	Action will be met

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 final report was released in March 2022.

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

As of March 2024, PAHT maternity services are compliant with 80/89 recommendations of the Ockenden Interim Report (2020). The maternity team are currently working towards compliance with the remaining 8/89 recommendations with related actions.

Out of the 8 open actions, they all remain on target and are due to be completed between March-November 2025. This is reliant on service development, working alongside the maternal medicine

network to provide preconception care for women with pre-existing medical disorders.

Three-year delivery plan for maternity and neonatal services

This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

For the next three years, services are asked to concentrate on four themes:

1. Listening to and working with women and families, with compassion
2. Growing, retaining, and supporting our workforce
3. Developing and sustaining a culture of safety, learning, and support
4. Standards and structures that underpin safer, more personalised, and more equitable care.

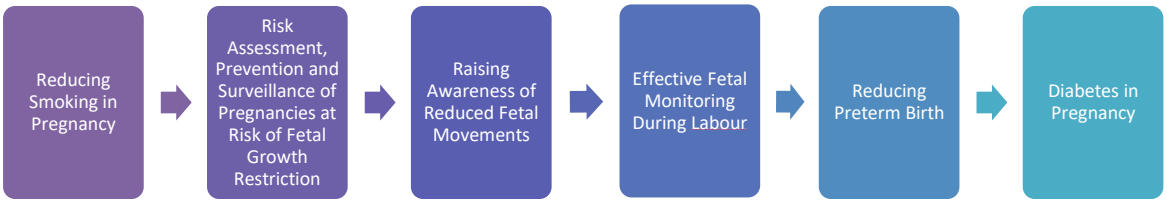
Delivering this plan will continue to require the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women and families and improve care. The plan was published at the end of March 2023.

As of March 2024, PAHT maternity services are compliant with 36/46 recommendations of the Three-Year Delivery Plan. The maternity team are currently working towards compliance with the remaining 10 actions.

Out of the 10 open actions, they all remain on target and are due to be completed by the end of 2026.

Saving Babies Lives Care Bundle v3

'Saving Babies Lives' is a care bundle designed to support providers, commissioners and professionals take action to reduce stillbirths, brain injury and preterm births. 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.



Version 3 of the bundle was published in July 2023, with the introduction of a new element, diabetes. For MIS year 6 an assessment is currently underway to review current compliance with each element. It is predicted that the service will be compliant by the submission date in March 2025. The service have quarterly improvement discussions with the ICB to monitor compliance and support with service improvements.

Maternity Self-Assessment Tool

The National Maternity Self- Assessment Tool provides support to all trusts seeking to improve their maternity service rating from 'requires improvement' to 'good', as well as a supporting tool to support trusts looking to benchmark their services against national standards and best practice guidance.
All actions have been completed.

There is a sustainability plan in place to continue to monitor compliance. This also forms part of the evidence that has been submitted to NHS England as part of the Maternity Services Support Programme exit plan.

Complaints/PALS

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

Complaints	Pals	Compliments
April 1 **May 1** **June 1**	**April 14** **May 13** **June 10**	**April 3** **May 1** **June 1**
Themes		
No change in top themes, communication and attitudes of staff remain top.		
Service User Feedback		
"I gave birth to my beautiful baby boy on your Labour Ward. I was provided with outstanding care, support and attention from the 2 midwives looking after me that day - the lovely Eda and Caitlin. I was exhausted and frightened and their positivity and encouragement ensured my baby was delivered safely into this world. I want them both to know they were with me then, and they will remain with me forever, both in my stories and my heart. Words truly cannot express my feelings of gratitude towards them both. Please thank them from the bottom of my heart for keeping my boyfriend calm, making him laugh, leaving him to take a nap when he was exhausted and letting him take his shoes off when his feet were hurting. We are so grateful to have had them share this special time in our lives and we will never forget the magical moment of welcoming our baby into the world. I would really love for you to pass on my comments as they are both amazing people and outstanding midwives and they deserve the recognition."		

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.

The service are continuing to work towards the requirements of MIS yr. 6, SBLCBv3, Three Year Delivery Plan for Maternity and Neonatal Services 2023 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur.

Work is ongoing to strengthen the Governance and Assurance Processes within Division. There are some key roles within the structure that are awaiting appointments:

Patient Safety and Quality Midwife on maternity leave as of May 2024 – Maternity cover role currently going through the recruitment process.

Quality and Compliance Midwife going on maternity leave October 2024 – Maternity cover role currently going through the recruitment process.

Governance Consultant has stepped down from the role. Awaiting a replacement.

5.0 Recommendation

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

Author: Linda Machakaire – Director of Midwifery and Gynaecology
Erin Walters – Head of Maternity Governance and Assurance 17.09.24

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board (Public) – 3 October 2024

Agenda item:	4.3
Presented by:	Giuseppe Labriola, Chief Nurse (interim)
Prepared by:	Giuseppe Labriola, Chief Nurse (interim)
Date prepared:	21st May 2024
Subject / title:	Mid-year nursing and midwifery establishment review

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

Key issues:	A mid-year establishment review was undertaken in March 2024 in line with national recommendations utilising the new methodology which detailed that a 14.80 WTE increase in the establishment is required. No changes to an establishment should take place until there are two consecutive reviews. The full year establishment review is due to be completed in September 2024 and reporting to Board in January 2025. There are no recommended changes to the establishment at this time – all nursing and quality indicators have been reviewed and there are no concerns identified. There continues to be a robust process for reviewing Trust wide staffing three times a day and redeploying staff where necessary. A full review of midwifery staffing will be completed by Birthrate Plus in Autumn 2024
Recommendation:	The Board is asked to note the information within this report and support the outcome and recommendations

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

Previously considered by:	SMT PAF.26.09.24 PC.30.09.24
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 There are no ED&I implications identified from this report
Appendices:	Appendix 1 Regulatory requirements and best practice guidance Appendix 2: Nurse sensitive indicators March 2023 Appendix 3: Full SCNT results compared to September 2022 full review Appendix 4: Current ward establishment versus proposed Appendix 5: Average daily number of Level 4 enhanced care patients March 2022 / March 2023 Appendix 6: Refreshed SNCT levels and descriptors

Key headlines:

Nursing

- The nationally approved and endorsed SNCT tool was updated in 2024 to adopt new multipliers, enhanced care and ward layout are now taken into consideration and two additional levels of care are now within the tool. The refreshed tool considers the ageing population's impact on inpatient acuity and dependency, single room ward design, Care hours per patient day (CHPPD) and proportion across days and nights; and supporting inpatients with increasing care requirements due to risk of falls, confusion and mental health needs (enhanced care)

- The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness) which has been incorporated within the reviews, it should be noted that the Royal College of Nursing (RCN) recommends 25%. This headroom allowance is insufficient, particularly for specialist areas such as critical care, the emergency department and maternity services, which have greater training requirements for staff which will inflate the headroom required. A piece of work will commence this year to identify what headroom should be recommended for nursing and midwifery staff, including headroom requirements for our specialist areas. The Ward Manager role is fully supervisory.

- This mid-year review has applied both the previous and the revised SNCT multipliers. It is recognised that trend data is required before there are any recommended changes to an establishment. Therefore, the outcome of the new multipliers have not been used to inform any recommendations in this review.

- The mid-year review does not recommend any changes to the nursing establishments. However, it should be noted the indicative changes to establishments that are emerging from applying the new multipliers are predominately within medicine (Tye Green Ward, Winter Ward and Kingsmoor Ward)

- The next review is September 2024, and will report into board in January 2025.

Maternity

- Birthrate Plus is the evidenced based tool used to inform midwifery establishments with a recommendation to be undertaken every three years. The last full Birthrate Plus review was undertaken in autumn 2021 and will be undertaken again in Autumn of this year.

- Birthrate plus recommends that the service should be funded to a midwife to birth ration of 1:23. The mid-year establishment review supports that the service has the required staffing to meet the acuity and activity and no additional funding is required.

1.0 Background and National Context

The National Quality Board (NQB) in their publication 'Developing workforce safeguards' (2018), clearly sets out a requirement for the Board of Directors to receive a report outlining the assessment or resetting of the nursing establishment and skill mix by ward or service area twice a year.

This report details the results of the mid-year review, which was undertaken in March 2024 in line with regulatory requirements and provides assurance that the review was undertaken in line with regulatory requirements.

The NQB guidance (2014, 2018) and NICE (2014) set out clear expectations for boards in relation to staffing:

"Boards are required to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards are required to ensure there are robust systems in place to assure themselves that there is sufficient capacity and capability to provide high quality care to patients on all wards, departments, services or environments day or night, every day of the week".

This was reiterated in the RCN Nursing Workforce Standards (Supporting a safe and effective nursing workforce) 2021 Standard 1**:** Executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision

Further information and references are in **Appendix 1.**

2.0 Process and methodology

A full establishment review was conducted in September 2023, gaining Board approval in January 2024.

The data collection for this establishment review was undertaken during a period of 30 days between the 4th March 2024 and 2nd April 2024 for the Adult inpatient wards, Adult Assessment Unit, Opal ward and Dolphin Ward utilising approved acuity and dependency tools. Henry Moore Ward collected data from the 4th March to the 13th March, and then from the 24th March to 12th April. This was due to an internal critical incident with the ward being used for critical care patients. Data for the Emergency Departments were collected over 12 days, with both the Adult ED and Paediatric ED collecting data between 18th March and 30th March 2024

Adult Inpatient Wards	Safer Nursing Care Tool Adult Inpatient Wards in Acute Hospitals and Adult Acute Assessment Units
Adult Assessment Unit (AAU) and Older Person's Assessment and Liaison Service (OPAL)	Safer Nursing Care Tool Adult Inpatient Wards in Acute Hospitals and Adult Acute Assessment Units
Dolphin Ward	Safer Nursing Care Tool Children's & Young People's Inpatient Wards

Emergency Department – Adults and Paediatrics	Emergency Department Safer Nursing Care Tool

The data collection for the inpatient wards, consisted of collecting patient dependency/acuity data at 15:00hrs (scoring the patient at the predominant level they have been in the past 24 hours) for 30 days to determine each ward's average acuity and dependency mix. Data is collected by senior nursing staff who have undertaken and passed the Trust's SNCT training and assessment.

The Emergency Department Safer Nursing Care Tool data collection is twice per day over 12 days at intervals of 12 hours, that allows capture of 24 hours over the 12 days (scoring the patients at their current level of acuity). Patients who were in the department for more than 12 hours were counted at only one data point

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness) which has been incorporated within the reviews, it should be noted that the Royal College of Nursing (RCN) recommends 25%. This headroom allowance is insufficient, particularly for specialist areas such as critical care, the emergency department and maternity services, which have greater training requirements for staff which will inflate the headroom required. A piece of work will commence this year to identify what headroom should be recommended for nursing and midwifery staff, including headroom requirements for our specialist areas. The Ward Manager role is fully supervisory.

Whilst the establishment reviews focus on the acuity/dependency results, these were not reviewed in isolation. Experience and best practice identify that a wider suite of quality indicators must be considered to allow more informed approaches in respect of assuring the Trust that staff are in place to provide high quality, safe and compassionate care. Therefore, in addition to the acuity/dependency results, the number of patients requiring enhanced care, professional judgement, peer group validation, review of e-roster data, ward layout and nurse sensitive indicators were incorporated into the review process.

A full breakdown of the nurse sensitive indicators that were reviewed when considering the SNCT results are available in **Appendix 2**.

All reviews will align to the agreed methodology within the approved PAHT Policy *The Nursing Establishment Setting Policy*.

This staffing establishment review has aligned with the new Safer Nursing Care Tool (SNCT) guidance which was released in October 2023. Within the new refreshed SNCT tool, the levels of care for patient classification, detailing staffing required for the level of care required by the patients have been adjusted. Enhanced care and ward layout are now taken into consideration and two additional levels of care are now within the tool. The new multiplier values reflect the WTE nurse staffing required to provide care for patients assessed at the appropriate SNCT levels. The refreshed tool considers the ageing population's impact on inpatient acuity and dependency, single room ward design, Care hours per patient day (CHPPD) and proportion across days and nights; and supporting inpatients with increasing care requirements due to risk of falls, confusion and mental health needs (enhanced care). The detail is provided in **Appendix 3**.

3.0 Data quality

To ensure accuracy of the acuity data the matrons should complete a twice weekly audit. If there is a discrepancy found SNCT should be corrected. To ensure accuracy of SNCT, a total of 8 audits per ward should be undertaken over the 30-day census period. 10 wards managed to achieve 7 or more audits, with no wards not having any audits undertaken. Overall there was a significant increase in compliance in March 2024 (108) compared with September 2023 (68).

For this review we are confident that the SNCT data collected is accurate as all of the staff that gathered the data have been trained, assessed and passed their PAHT interrater reliability assessment for SNCT. To strengthen this, for the next establishment review the Trust is on track to have a minimum of 3 trained staff on each ward, which removes the reliance on matrons inputting patient acuity. Therefore, allowing them the time to independently validate the data which will strengthen our confidence. This is in line with the SNCT recommendations.

4.0 Findings

The results of the establishment review need to be considered in context with the new methodology for SNCT which now includes additional metrics to support inpatients needs with increasing care requirements due to risk of falls, confusion and mental health needs, known as enhanced care. The additional metrics (**Appendix 3**) known as 1c and 1d requires **73.46 WTE** staff to provide enhanced care which is generally concentrated in the medicine division. This would be expected given the acuity and cohort of patients. The tool now allows this enhanced care requirement to be allocated to the ward establishment or to be assigned centrally to the Enhanced Care Team. The new tool also considers empty beds. There has been no change to the tool for paediatric inpatients or the Emergency Departments.

No changes to an establishment should take place until there are two consecutive reviews demonstrating an increasing or decreasing trend in nursing and midwifery staffing. In addition, this should be triangulated with patient and staff outcomes and professional judgment of the senior nursing and midwifery team.

The full data is available below.

Columns B and **Column C** provide the recommended establishment required utilising the SNCT 2018 workforce methodology tool which the organisation has used pre-2024.

Column D is our recommended establishment required if we continued to follow the SNCT 2018 workforce methodology tool

Column E is our recommended establishment including the revised indicators for enhanced care patients attributed across all wards using the new SNCT 2024 methodology

Column F is our recommended establishment excluding enhanced care and using the new SNCT 2024 methodology. This would recommend a central enhanced care team of **73.46 WTE**.

A	B	C	D	E	F
Ward	Mar-23 SNCT Data WTE	Sep-23 SNCT Data WTE	Mar-24 SNCT Data WTE	Mar-24 including enhanced care SNCT Data WTE	Mar-24 excluding enhanced car SNCT Data WTE
AAU	47.2	45.3	35	52.48	48.78
Charnley	35.6	35.6	32.6	38.33	33.19
Dolphin	32.5	29.1	29.1		
Fleming	31.1	32	30.2	30.93	30.93
Harold	42.6	46.4	44.7	52.76	49.04
Harvey	24.9	26.7	25.4	27.72	27.08
Henry Moore	15.9	18	25.6	31.56	31.24
John Snow	11.3	10.8	10.7	15.79	15.15
Kingsmoor	39.9	38.6	43.9	59.94	42.49
Lister	40.9	41.4	38.4	46.87	40.77
Locke	34.5	42.6	40.1	45.95	42.09
Nightingale	19.9		22.2	24.72	24.4
OPAL Beds only	15.7	15.6	16.8	21.37	19.45
Penn	38.3	38	37.9	42.36	39.47
Ray	37.7	35.2	37.1	43.24	40.03
Saunders	33.1	33.5	33.1	37.89	35
Tye Green	45.4	46.8	46.8	62.89	48.98
Winter	38.4	39.5	41.1	49.25	42.5
	584.9	575.1	590.7	684.05	610.59

In addition, both the emergency departments for adults and paediatrics do not require additional staffing and have sufficient registered and unregistered staff based upon their activity. What has been identified during the establishment review are rostering changes are needed to shift patterns over the 24-hour period to reflect activity.

A full breakdown of the findings from the establishment review can be found in **Appendix 4** which provides a breakdown of SNCT data providing a comparison including enhanced care and excluding enhanced care.

5.0 Going forward

As this is the first review with the new SNCT methodology and based upon professional nursing judgement, it is not recommended that there are increases in establishments at this current time, rather to review alongside subsequent establishment reviews. The Trust has an established enhanced care team in place following board approval in September 2021. The team are now fully established. In addition, a Lead Nurse for Mental Health commenced within the organisation from January 2024. This postholder will be working with the Enhanced Care Lead regarding the level of support the wards require for registered mental health nurses.

Inclusion of other areas not included within this paper, including the methodology applied, will be included in the establishment reviews moving forward in 2024/2025. The areas which have not been formally reviewed and reported since Covid 19, include theatres, cardiac catheter laboratories, outpatients and chemotherapy day unit in line with safe practice and demand and capacity for services.

The SNCT calculation is based upon a funded headroom allowance of 22% and this has been incorporated within the reviews. This headroom allowance is insufficient, particularly for specialist areas such as critical care, the emergency department and maternity services, which have greater training requirements for staff which will inflate the headroom required. A

piece of work will take place this year to identify what headroom should be recommended for nursing and midwifery staff, including headroom requirements for our specialist areas.

6.0 Maternity services

Midwifery staffing is evidenced by application of the Birthrate Plus methodology, with a recommended cycle of a full review using this methodology every 3 years. The maternity service undertook a workforce review in the autumn of 2021 using Birthrate Plus casemix methodology (Midwifery workforce tool recommended by NICE). Casemix is categorised into five categories (1-V) 1 being a woman with a low risk pregnancy and straightforward birth with V being a woman with a complex pregnancy +/or birth. The acuity within the population denotes the WTE required to safely run a maternity service as it takes into consideration activity and acuity, as well as specialist midwifery services and managerial responsibilities. Birthrate Plus recommends that the maternity service should be funded to a midwife to birth ratio of 1:23.

Midwifery and Support Staff

The current midwifery establishment is based on the workforce review completed in November 2021. The table below demonstrates the position as at Month 2 (May) 2024.

May 2024 Midwifery establishment (including specialists)

Banding	Funded	In post	Variance
Band 5	0.00	25.48	-25.48
Band 6	121.95	88.88	33.07
Band 7	38.98	37.03	1.95
TOTAL	**160.93**	**151.39**	**9.54**

Midwifery staffing has stable in the last six months with a vacancy rate of less than 5%. There are currently 9.54 WTE vacancies with no new starters anticipated until the qualification of 3rd year midwifery students in September 2024 with their professional registrations expected in October. The recruitment of students will help with further reducing our vacancies.

May 2024 Support Worker establishment

Banding	Funded	In post		Variance
Band 2	35.05	31.28		3.77
Band 3	19.18	13.37		5.81
Band 4	7.25	4.29		2.96
	61.59	**48.94**		**12.65**

The vacancy rate for support workers is currently 25.8% with ongoing recruitment plans. Maternity have supported their first two support workers to start a Midwifery Degree Apprentice in September 2024.

The use of Bank and Agency staff within the midwifery and support worker workforce is closely monitored. The midwifery leadership team have established twice weekly meetings to review staffing and ensure levels are kept safe, requests for temporary staffing are made on time, and that they are justified. These meetings are in addition to ensuring that roster management is within Trust guidance and complies with appropriate annual leave allocation and that this is managed well throughout the year.

Daily, staffing is monitored and any potential red flags highlighted in advance.
Safety huddles are held to discuss any potential challenges in maternity and neonatal services. There is a monthly report that is reviewed at the Quality Safety Committee Part II which details the current vacancies and recruitment plans. The Professional Midwifery Advocate (PMA) service continues to provide clinical supervision for staff and well-being support. The PMA to midwife ratio remains 1:20 which is within the national recommendation.

The establishment review has detailed that the maternity service has the required funded establishment for the level of acuity and activity within the service, and that no additional funding is requested. The service meets the Birthrate Plus recommendation of midwife to birth ratio of 1:23. Birthrate Plus will be commissioned in autumn 2024 to provide a full review of midwifery staffing

7.0 Recommendations

The committee are asked to note the context and recommendations of this report including the revised methodology for SNCT. It is recommended that there are no changes to the establishment and there will be a further review of the workforce which is scheduled to commence in September 2024. Nursing and quality indicators have been reviewed and there are no concerns identified. There continues to be a robust process in place to review Trust-wide nursing and midwifery staffing three times a day

Appendix 1: Regulatory requirements and best practice guidance

Post publication of the Francis Report 2013 and Safe Staffing in adult inpatient wards in acute hospital (NICE, 2014) the National Quality Board (NQB July 2016) has defined a framework and set of expectations (July 2016) to achieve the “right staff, with the right skills, in the right place at the right time”, including the responsibilities of Trust Boards.

The fundamental aims of each of the safe nurse staffing guidance are set out as three main principles, right care, minimising avoidable harm and maximising the value of available resources.

NHS organisations have a responsibility to undertake an annual comprehensive nursing and midwifery skill mix review to ensure that there are safe staffing levels and to provide assurance to the Board and stakeholders. The yearly skill mix review should be “followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate” (NQB 2016).

Lord Carter’s report, ‘Operational Productivity and Performance in English Acute Hospitals: Unwarranted variations’ (revised February 2016), identified efficiency opportunities and the requirement for organisations to meet the challenges of maintaining and improving quality, operational performance, finance and efficiency. The latest CQC Consultation document outlines how effectively a provider uses its resources is one of the factors that determines the quality and responsiveness of its care.

The principles set out by the NQB are further supplemented by a suite of nationally driven guidance documents, and speciality specific recommendations, which further inform the governance required to demonstrate the application and delivery of safe staffing in practice.

Appendix 2: Nurse sensitive indicators March 2024

	PALS	New Complaints	Compliments	Pressure ulcers	Falls	SI	Staffing levels	Medication errors
A&E	15	3	*	1	6	0	7	4
AAU	2	0	*	2	8	0	0	4
Charnley	3	0	*	1	5	0	1	2
Dolphin	1	0	*	0	1	0	1	1
Fleming	0	0	*	3	2	0	0	2
Harold	2	0	*	8	6	0	1	2
Harvey	2	0	*	1	3	0	0	0
Henry Moore	2	0	*	2	0	0	0	3
John Snow	0	0	*	0	1	0	0	1
Kingsmoor	6	0	*	5	9	0	1	1
Lister	4	2	*	5	8	0	0	2
Locke	8	0	*	6	6	0	0	3
Nightingale	3	0	*	1	2	0	0	2
OPAL	1	0	*	8	5	0	0	1
Paeds A&E	7	0	*	0	0	0	4	1
Penn	0	0	*	2	3	0	1	0
Ray	3	1	*	6	8	0	0	3
Saunders	7	0	*	1	2	0	2	2
Tye Green	0	2	*	17	7	0	2	3
Winter	1	0	*	2	8	0	0	0

**Due to capacity in the Patient Experience Team no complements were recorded during this period*

Appendix 3: Refreshed SNCT Care Levels and descriptors

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	- Underlying medical condition requiring on-going treatment. - Post-operative / post-procedure care – observations recorded as per local policy. - National Early Warning Score (NEWS) is within normal threshold. - Patients requiring oxygen therapy. - Patients not requiring enhanced therapeutic observations (according to local policy). - Patients requiring assistance of one with some activities of daily living.

Level 1a
Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
	- Step down from Level 2 care.
	- Requiring continual observation / invasive monitoring/physiological assessment.
	- NEWS local trigger point reached and requiring intervention/action/review.
	- Pre-operative optimisation/post-operative care for complex surgery.
	- Requiring additional monitoring/clinical interventions/clinical input including:
	  - Patients at risk of a compromised airway
	  - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis
	  - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains
	  - Severe infection or sepsis
	  - New spinal injury/cord compression

Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	- Complex wound management requiring more than one nurse or takes more than one hour to complete. - Patients with stable Spinal/Spinal Cord Injury. - Patients who consistently require the assistance of two or more people with mobility or repositioning. - Requires assistance with most or all care needs. - Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/ administration/post-administration care). - Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. - Patients requiring intermittent or within eyesight observations according to local policy. - Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	- Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	- Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.

Level 2
Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.
	- Deteriorating / compromised single organ system.
	- Step down from Level 3 care or step up from Level 1a.
	- Post-operative optimisation/ extended post-op care.
	- Cardiovascular, renal or respiratory optimization requiring invasive monitoring.
	- Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure.
	- First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction.
	- CNS depression of airway and protective reflexes.
	- Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes.
	- Requires a range of therapeutic interventions which may include:
	  - Greater than 50% oxygen continuously
	  - Requiring close observation due to acute deterioration and needing advanced organ support
	  - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium
	  - CNS depression of airway and protective reflexes
	  - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains

Level 3 Patients needing advanced respiratory support and/or therapeutic support of multiple organs.	- Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. - Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. - Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection.

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The Princess Alexandra Hospital
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Appendix 4: Full SCNT results compared to March and September 2023 full review and March 2024 interim review (comparing the 2018 tool and the October 2023 tool, including or excluding the Enhanced Care patients 1c, 1d)

									Using 2018 multipliers and descritpors				SNCT Data WTE inc Enhanced				SNCT Data WTE excluding Enhanced Care				
Ward	Mar-23				Sep-23				Mar-24				Mar-24								
	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	1c & 1d Requirement WTE
AAU	47.2	80	37.8	9.4	45.3	80	36.2	9.1	35	80	28.0	7.0	52.48	80	42.0	10.5	48.78	80	39.0	9.8	3.7
Charnley	35.6	70	24.9	10.7	35.6	70	24.9	10.7	32.6	70	22.8	9.8	38.33	70	26.8	11.5	33.19	70	23.2	10.0	5.14
Dolphin	32.5	60	19.5	13.0	29.1	60	17.5	11.6	29.1	60	17.5	11.6		60	0.0	0.0		60	0.0	0.0	0
Fleming	31.1	70	21.8	9.3	32	70	22.4	9.6	30.2	70	21.1	9.1	30.93	70	21.7	9.3	30.93	70	21.7	9.3	0
Harold	42.6	75	32.0	10.7	46.4	75	34.8	11.6	44.7	75	33.5	11.2	52.76	75	39.6	13.2	49.04	75	36.8	12.3	3.72
Harvey	24.9	60	14.9	10.0	26.7	60	16.0	10.7	25.4	60	15.2	10.2	27.72	60	16.6	11.1	27.08	60	16.2	10.8	0.64
Henry Moore	15.9	60	9.5	6.4	18	60	10.8	7.2	25.6	60	15.4	10.2	31.56	60	18.9	12.6	31.24	60	18.7	12.5	0.32
John Snow	11.3	60	6.8	4.5	10.8	60	6.5	4.3	10.7	60	6.4	4.3	15.79	60	9.5	6.3	15.15	60	9.1	6.1	0.64
Kingsmoor	39.9	60	23.9	16.0	38.6	60	23.2	15.4	43.9	60	26.3	17.6	59.94	60	36.0	24.0	42.49	60	25.5	17.0	17.45
Lister	40.9	60	24.5	16.4	41.4	60	24.8	16.6	38.4	60	23.0	15.4	46.87	60	28.1	18.7	40.77	60	24.5	16.3	6.1
Locke	34.5	60	20.7	13.8	42.6	60	25.6	17.0	40.1	60	24.1	16.0	45.95	60	27.6	18.4	42.09	60	25.3	16.8	3.86
Nightingale	19.9	60	11.9	8.0		60	0.0	0.0	22.2	60	13.3	8.9	24.72	60	14.8	9.9	24.4	60	14.6	9.8	0.32
OPAL Beds only	15.7	60	9.4	6.3	15.6	60	9.4	6.2	16.8	60	10.1	6.7	21.37	60	12.8	8.5	19.45	60	11.7	7.8	1.92
Penn	38.3	60	23.0	15.3	38	60	22.8	15.2	37.9	60	22.7	15.2	42.36	60	25.4	16.9	39.47	60	23.7	15.8	2.89
Ray	37.7	60	22.6	15.1	35.2	60	21.1	14.1	37.1	60	22.3	14.8	43.24	60	25.9	17.3	40.03	60	24.0	16.0	3.21
Saunders	33.1	60	19.9	13.2	33.5	60	20.1	13.4	33.1	60	19.9	13.2	37.89	60	22.7	15.2	35	60	21.0	14.0	2.89
Tye Green	45.4	60	27.2	18.2	46.8	60	28.1	18.7	46.8	60	28.1	18.7	62.89	60	37.7	25.2	48.98	60	29.4	19.6	13.91
Winter	38.4	60	23.0	15.4	39.5	60	23.7	15.8	41.1	60	24.7	16.4	49.25	60	29.6	19.7	42.5	60	25.5	17.0	6.75
	584.9		373.4	211.5	575.1		367.84	207.26	590.7		374.4	216.3	684.05		435.8	248.3	610.59		389.9	220.7	73.46
					Nightingale Ward Closed no data collected								No change to the C&YP tool								

Trust Board (Public) – 3 October 2024

Agenda item:	4.4
Presented by:	Giuseppe Labriola –Interim Chief Nurse
Prepared by:	David Dellow – Safe Staffing Lead and Jo Ward – Deputy Chief Nurse
Date prepared:	16.9 2024
Subject / title:	Report on Nursing and Midwifery staff levels for August 2024.

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The overall fill rate remains stable. No ward reported average fill rates below 75% for RN's against the standard planned template during the reporting period.							
Recommendation:	The Board is asked to note the information within this report.							

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

Previously considered by:	PC.30.09.24
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:** Ward and divisional fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2**: Ward and divisional CHPPD data **Appendix 3:** Nursing Red Flags (NICE 2014) **Appendix 4:** Occasions when registered staffing fell below 75% trend **Appendix 5:** Substantive staff redeployment trend **Appendix 6:** Falls SPC charts **Appendix 7:** Pressure Ulcers SPC charts **Appendix 8:** Complaints, PALS and Compliments Trend

1.0 Introduction

This paper illustrates how PAHT's nursing and midwifery staffing has been deployed for the month of August 2024. It evidences how planned staffing has been successfully achieved and how this is supported by nursing and midwifery recruitment and deployment.

2.0 Background

The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in August 2024. The following sections identify the processes in place to demonstrate that the Trust proactively manages nursing and midwifery staffing to support patient safety.

3.0 Inpatient wards fill rate

The Trust's safer staffing submission has been submitted to NHS Digital for August 2024 within the data submission deadline. Table 1 shows the summary of the overall fill rate for this month. Appendix 1 illustrates a ward-by-ward breakdown for this period. Table 2 shows a summary of overall fill rate percentages for a rolling 12-month period.

Due to the continuing fluctuating capacity John Snow Ward has not consistently been sending 1 of the 2 day HCA shifts to NHSP. This continues to impact on the number of HCA shifts being redeployed from the ward during August, both of these factors continue to impact on the HCA fill rate for day and night.

Maternity continue to robustly review staffing through twice weekly staffing reviews and use of Birthrate Plus. Safety is maintained by daily staffing huddles and staff deployment according to acuity, while support is provided by specialist practitioners and Matrons being redeployed as required.

The impact of staffing requirements for patients requiring enhanced care is shown in the number of wards which continue to have greater than 100% fillrate, this is especially demonstrated in wards such as Nightingale, Ray and Harvey night fillrate for HCAs. The fillrate is based against the standard ward template.

Greater than 100% fill rate for RN shifts is attributable to RMN 1:1 requirements or supporting the induction of newly qualified/registered RNs.

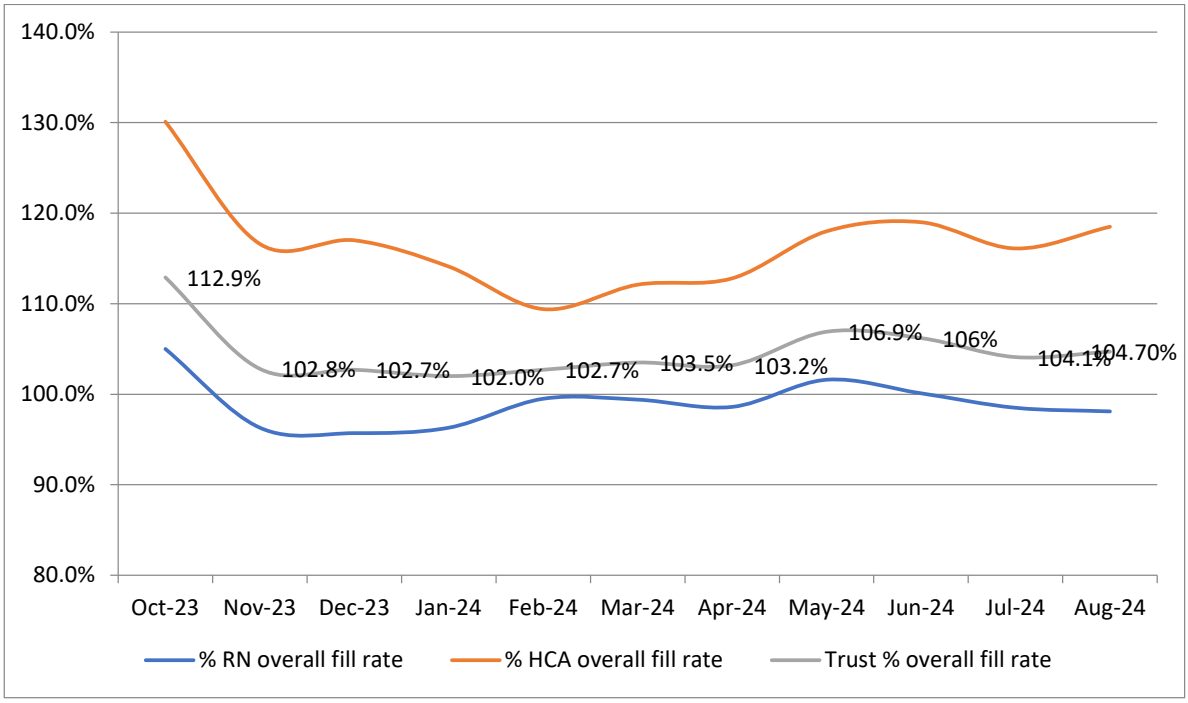
We continue to utilise NHS Professionals (NHSP) and agency to mitigate vacant shifts, though continue to reduce our temporary staffing pools. New control measures have been put in place regarding the creation of additional duties. In addition, our senior nurses and midwives are also supporting individual areas if required. SafeCare data continues to be collected three times a day to improve staffing governance across the organisation.

Table 1. Overall fill rate

Average day fill rate - registered nurses/midwives	Average day fill rate - care staff	Average night fill rate - registered nurses/midwives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate

95.2%	113.6%	101.8%	124.4%	98.1%	118.5%	104.7%

Table 2. Inpatient fill rate including Maternity Wards Trend



4.0 Care Hours Per Patient Day (CHPPD)

CHPPD allows comparison of a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. It can be used to look at variation between similar wards to ensure the right staff are being used in the right way and in the right numbers.

The hours worked during day and night shifts by registered nurses and midwives and healthcare assistants are added together. This figure is then divided by the number of patients at midnight, this then gives the total CHPPD. The number of registered and unregistered hours can be divided by the number of patients to understand the registered and unregistered CHPPD.

By itself the 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.

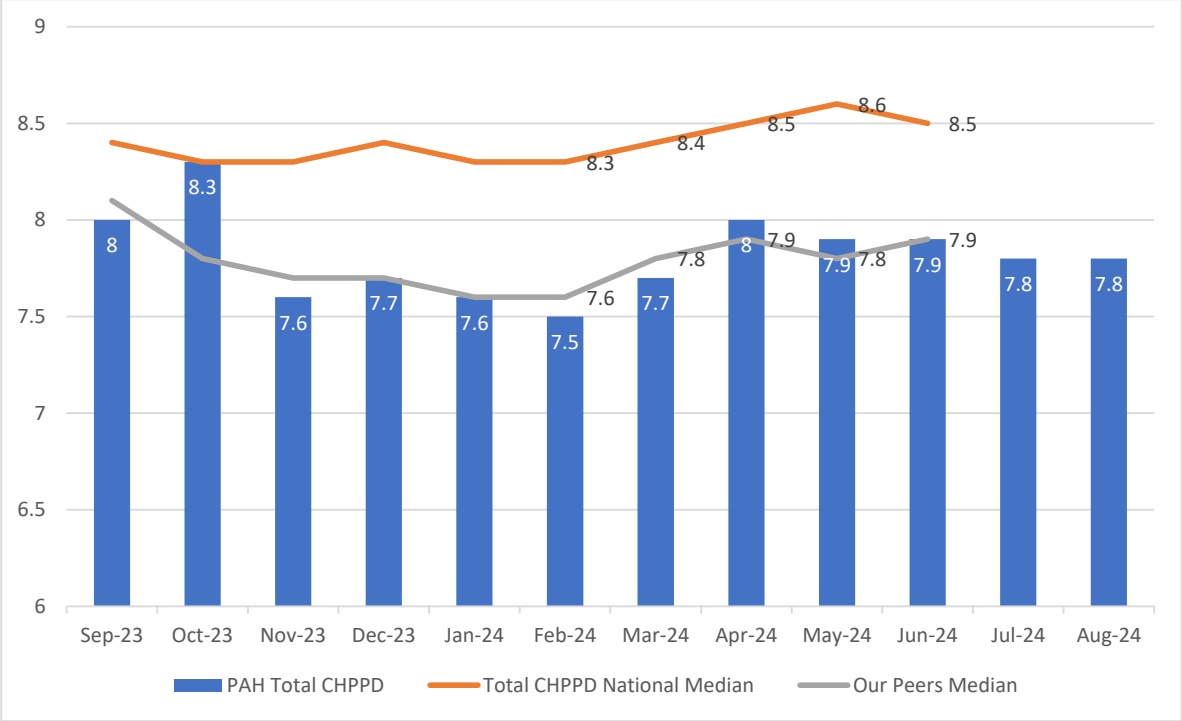
Table 3. Overall Care Hours Per Patient Day (CHPPD) August 2024

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.0	2.9	7.8

The Model Hospital data for June 2024 shows the Trust with a CHPPD of 7.9 against the national median of 8.5**.** Table 4 also now shows the Trusts total CHPPD against our peers (East and North Hertfordshire NHS Trust and West Hertfordshire Teaching Hospitals NHS Trust)

Appendix 2 shows the individual ward and divisional CHPPD for August 2024

Table 4. CHPPD Trend



5.0 Quality Indicators

5.1 Nursing Red Flags

Nursing red flags prompt an immediate response by the registered nurse in charge of the ward. The response may include allocating additional nursing staff to the ward or other appropriate responses. Appendix 3 details the NICE (2014) definition of Nursing Red Flags. Currently this information cannot be monitored for all nursing red flags on the DATIX incident reporting system. Following a meeting on the 4th September chaired by the Deputy Chief Nurse (Interim) to discuss capturing Red Flags going forward it was decided that, due to the current configuration of SafeCare and the implementation of Alex Health we will delay introducing a new process to support additional oversight of Red Flags until Alex Health has been implemented.

In the interim a trial of using SafeCare to capture Red Flags will take place on Winter Ward to support an informed decision about how the process will work following the launch of Alex Health.

This report already captures staffing of less than 75% and less than 2 RNs on a shift.

The Trust has a robust Red Flag three times daily staffing review process where issues are raised, discussed and escalated.

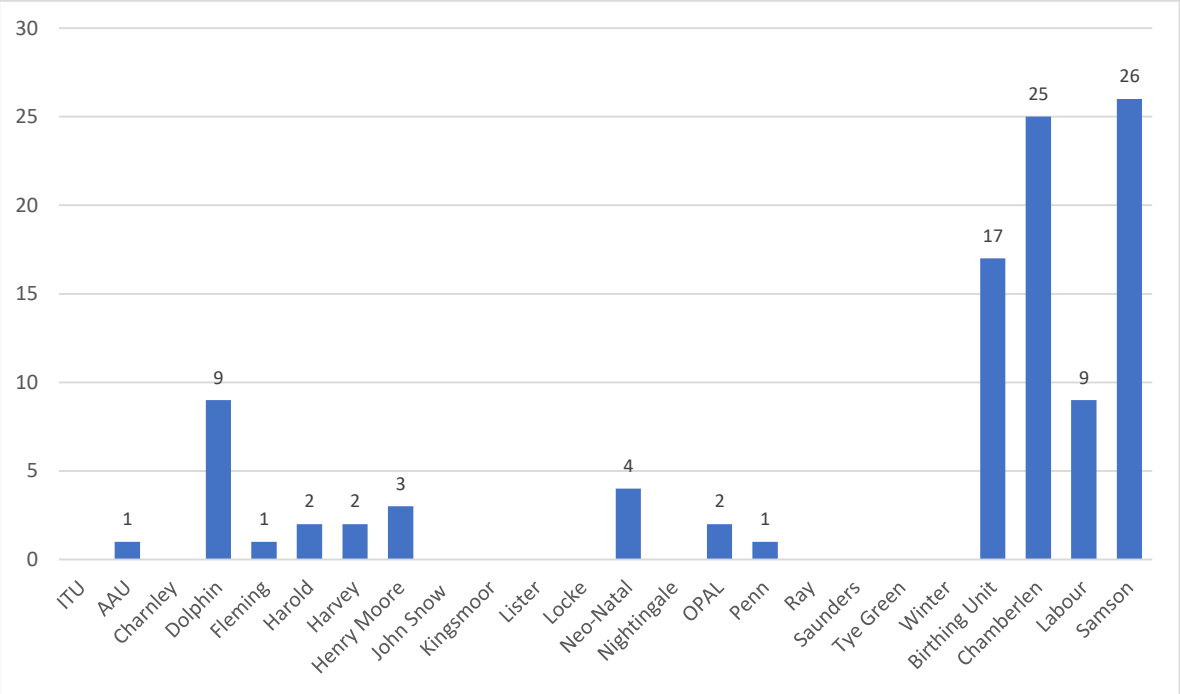
Staff are still utilising Datix to raise staffing concerns and the number of staffing Datix relating to “lack of suitably trained / skilled staff” is being reinstated into this report. Table 5.5 shows the number of Datix relating to “lack of suitably trained / skilled staff” in August.

A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available, compared with the actual requirement for the shift is a nursing red flag.

The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards is available in Table 5. This increased by 23 occasions in August to 102. The majority of this was in Maternity which rose from 44 in July to 77 in August.

Appendix 4 details the staffing red flags trend.

Table 5. Occasions when registered staffing fell below 75% of standard template



5.2 Falls

Table 6. Number of falls, unwitnessed falls and falls with harm in August, with the top 3 wards being highlighted

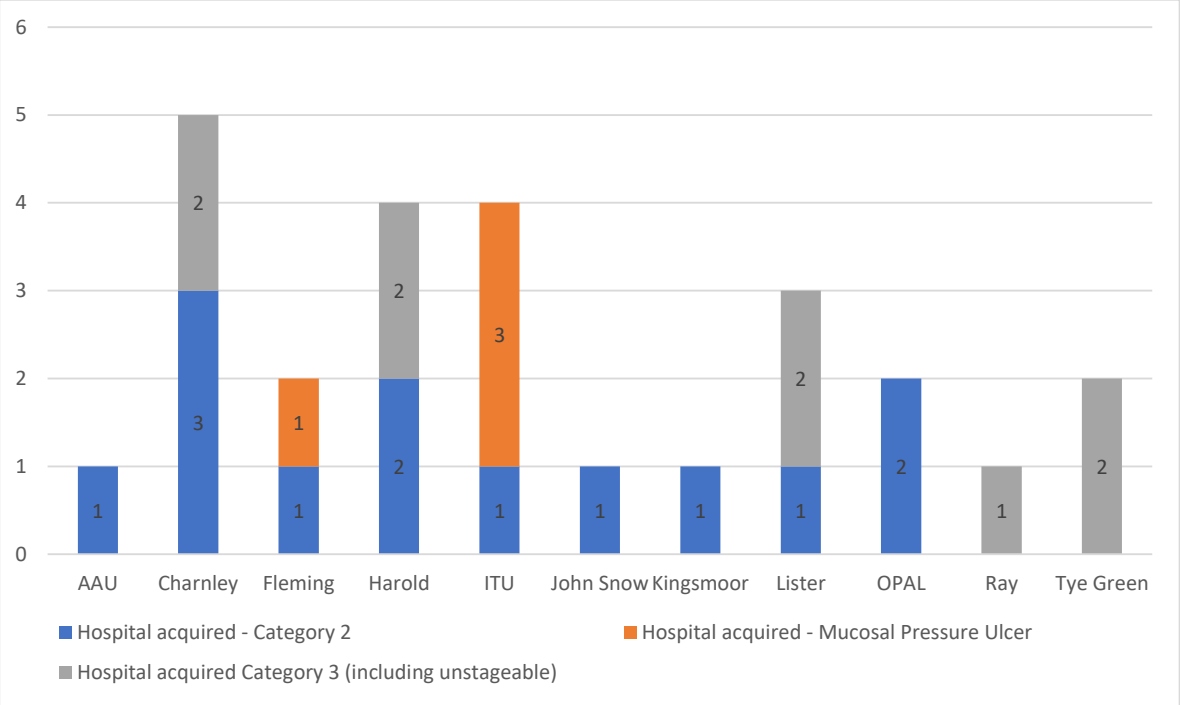
	Total falls in month	Top 3 wards		
Total falls	68	Lister 10	AAU 8	Charnley 7
Unwitnessed falls	57	Lister 8	AAU 8	Charnley, Harold, Kingsmoor and Locke 5
Falls with harm *	11	Lister 2	AAU 2	

**subject to change following review at Falls Incident Oversight Group*

The Trust falls reduction strategy and workplan (2024/2025) remains in place and mandatory falls training has increased to 92%.

5.3 Pressure Ulcers

Table 7. Number of Hospital Acquired Pressure Ulcers (HAPU) Cat 2 and Cat 3 Pressure Ulcers (including unstageable)



In August there were 25 HAPU's compared to 34 last month. However, the number of category 3 and mucosal HAPUs have increased this month.
This month, the highest number of HAPUs developed on Charnley (5) followed by Harold and ITU with 4 each. Charnley and ITU are due to present their quality improvement action plan for pressure ulcers this month at the Pressure Ulcer Oversight Group

Tye Green reduced their number of HAPUs (2 from 4 last month), so they are on a downward trajectory. This month Locke ward and Winter ward have achieved zero HAPUs compared to 5 and 6

The tissue viability's main focus continues to be around teaching staff about the new pressure ulcer risk assessment tool 'Purpose T' which will be implemented with AlexHealth and continuing to highlight the importance of pressure ulcer prevention.

5.4 Complaints, PALS and Compliments

Table 8. Number of new Complaints, PALS and Compliments in August with top three wards highlighted

	Total in month	Top 3 wards		
New complaints	12	Harvey 2	Penn 2	8 wards with 1 each
PALs	47	A&E 8	Ray 5	Saunders 4

Compliments	0			

The 3 main PALS themes for August were:

- Delay – 35.25%, Communication – 23.04%, Appointments 13.09%

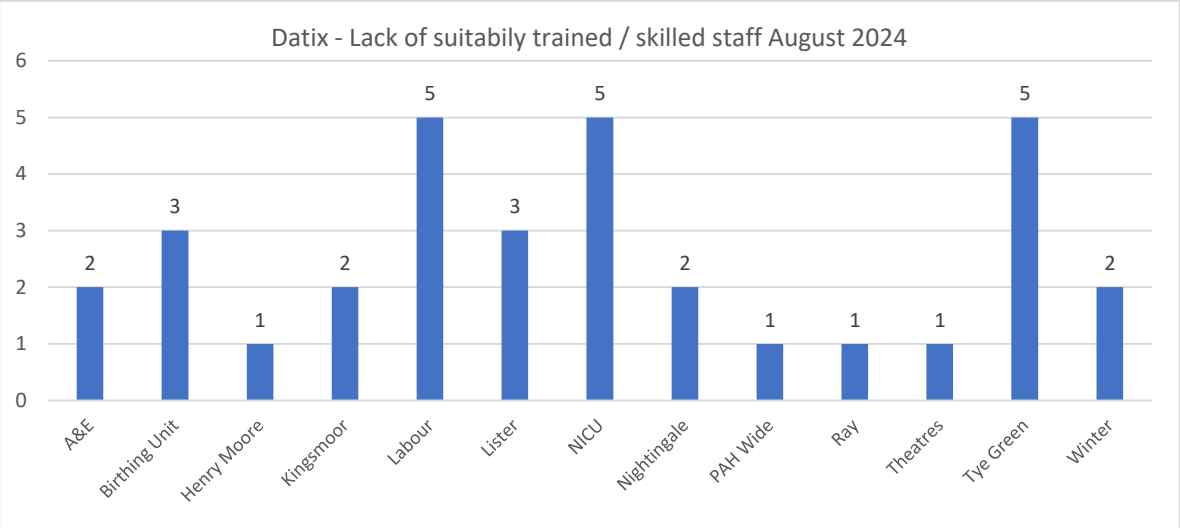
Complaints themes for August were as follows

- Communication 20.18%, Medical Care 19.27% Nursing Care – 18.35%

Appendix 8 shows the trend for complaints, PALs and compliments.

5.5 Datix – Lack of suitably trained / skilled staff

Table 9. Number of Datix raised for lack of suitably trained / skilled staff in August



Datix reports in relation to lack of suitability trained / skilled staff was 33 for August, with Labour Ward, Tye Green and Neo National Intensive Care raising 5 each.

6.0 Redeployment

Redeployment of staff continues to be undertaken to support safe staffing as part of the daily staffing huddles. Table 9 details the trend in August with OPAL redeploying the highest number of substantive staff with Tye Green being the next highest. The highest net receiver of staff remains Nightingale ward alongside Henry Moore and OPAL wards. Appendix 5 demonstrates the number of substantive staff redeployments per month trend.

Table 10. Hours of substantive staff redeployed August 2024

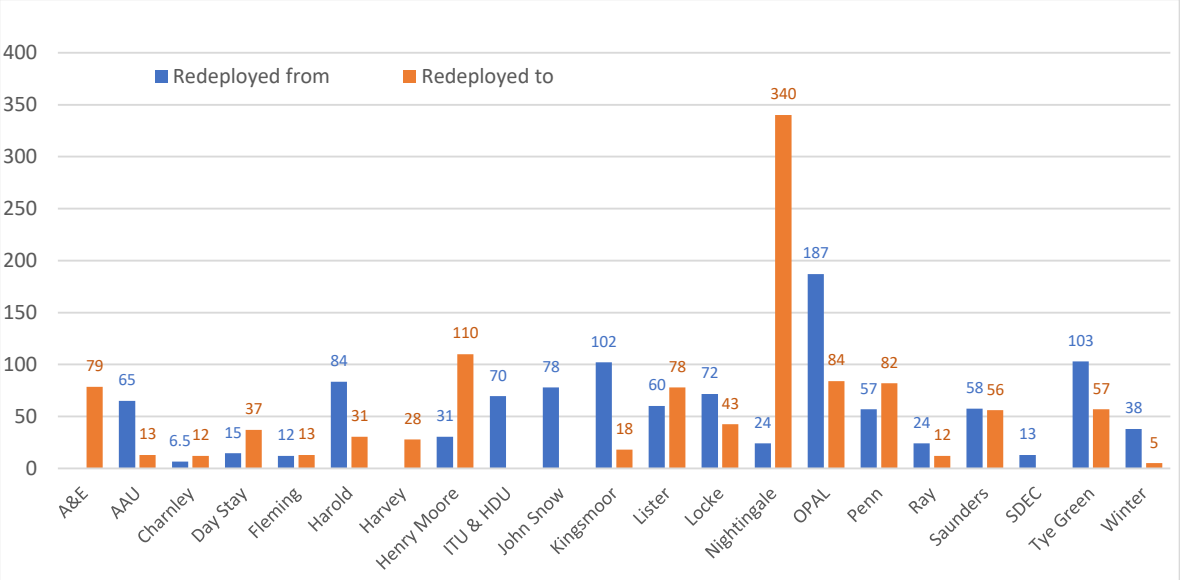


Table 11 shows the hours of substantive staff moved as a percentage of total hours worked.

Table 12 shows the hours of all staff including bank and agency, excluding the Enhanced Care Team, Bank Pool and Rapid Response Pool staff.

Table 11. % of substantive staff redeployed as % of total hours worked

Substantive staff hours redeployed	Total hours worked (inc bank and agency)	% of total hours worked / substantive staff redeployed
1096	136986	0.8%

Table 12. % of staff redeployed as % of total hours worked

All staff hours redeployed (including bank and agency but excluding Enhanced Care Team, Bank Pool and Rapid Response Pool)	Total hours worked (inc bank and agency)	% of total hours worked / staff redeployed (including bank and agency but excluding Enhanced Care Team, Bank Pool and Rapid Response Pool)
2740	136986	2.0%

The data detailing nurse redeployment indicates that the numbers of staff reassigned are minimal and not a cause of concern. The redeployment process is efficiently managed with improved governance and oversight.

7.0 Conclusion

This paper will evolve in the future to include the impact of staffing including additional nursing and midwifery sensitive indicators such as compliance with nationally mandated staffing such as CNST provision in midwifery. The paper will also demonstrate initiatives underway to review staffing establishments and activities to ensure nursing and midwifery workforce is deployed in the most cost-efficient way.

8.0 Recommendation

The Board is asked to note the information in this report to provide assurance on the daily mitigation of nursing and midwifery staffing.

Appendix 1: Ward level data: fill rates August 2024. *(Adjusted Standard Planned Ward Demand)*

>100%	95 – 100%	75-95%	<75%

	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 (%)**	**% Registered overall fill rate**	**% HCSW overall fill rate**	**% Overall fill rate**
Harvey	82.1%	177.9%	102.2%	180.1%	90.3%	179.0%	122.4%
Henry Moore	105.6%	126.9%	142.0%	121.0%	120.2%	124.1%	121.9%
ITU & HDU	102.7%	106.7%	105.5%	128.3%	104.1%	117.5%	105.3%
John Snow	105.0%	59.6%	100.0%	45.2%	102.6%	55.0%	82.1%
Penn	93.3%	117.4%	104.0%	147.8%	97.9%	128.9%	109.0%
Saunders	93.7%	113.4%	123.3%	131.5%	104.8%	120.3%	110.6%
Surgery Total	***97.1%***	***117.6%***	***110.0%***	***133.4%***	***102.8%***	***124.1%***	***109.2%***
Fleming	86.9%	107.9%	100.0%	115.8%	92.4%	111.6%	98.3%
Harold	91.1%	97.2%	101.1%	111.3%	95.5%	103.9%	98.2%
Kingsmoor	102.2%	115.4%	122.5%	137.2%	109.9%	125.8%	115.8%
Lister	94.6%	128.1%	100.8%	117.6%	97.2%	123.1%	107.5%
Locke	97.3%	113.6%	100.1%	121.9%	98.5%	117.6%	106.1%
Nightingale	120.2%	84.0%	106.5%	199.3%	113.6%	120.3%	116.5%
Opal	99.7%	116.5%	100.0%	114.0%	99.9%	115.3%	106.0%
Ray	100.8%	119.2%	105.8%	190.9%	102.9%	146.4%	118.5%
Tye Green	94.2%	106.0%	100.0%	122.0%	96.7%	112.5%	102.8%
Winter	110.1%	138.7%	121.2%	116.0%	114.8%	127.8%	120.0%
Medicine Total	***98.0%***	***113.5%***	***105.5%***	***128.8%***	***101.2%***	***120.3%***	***108.4%***
AAU	91.8%	140.0%	102.4%	139.7%	96.5%	139.9%	105.6%
Charnley	101.9%	148.1%	102.8%	153.0%	102.4%	150.5%	116.1%
UEC Total	***95.7%***	***144.1%***	***102.6%***	***146.4%***	***98.8%***	***145.2%***	***110.0%***
Birthing	96.5%	100.4%	70.7%	96.8%	84.2%	98.7%	89.0%
Chamberlen	85.0%	83.9%	79.2%	97.1%	82.2%	90.2%	84.2%
Dolphin	77.2%	67.1%	89.4%	91.3%	82.6%	75.2%	80.8%
Labour	94.3%	87.9%	90.6%	80.8%	92.6%	84.5%	90.8%
Neo-Natal Unit	88.2%	96.8%	91.0%	93.5%	89.6%	95.2%	90.5%
Samson	79.4%	124.3%	87.2%	98.9%	83.1%	112.2%	97.7%
CHAWS Total	***87.0%***	***96.6%***	***87.0%***	***93.0%***	***87.0%***	***95.0%***	***89.2%***
Total	**95.2%**	**113.6%**	**101.8%**	**124.4%**	**98.1%**	**118.5%**	**104.7%**

Appendix 2: Ward level data: CHPPD August 2024.

Care Hours Per Patient Day (CHPPD)			
Ward	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total			
Harvey Ward	3.7	4.2	7.9
Henry Moore Ward	4.4	3.5	7.9
ITU & HDU	28.0	3.2	31.2
John Snow Ward	6.8	2.8	9.5
Penn Ward	3.9	2.9	6.8
Saunders Unit	3.9	2.7	6.5
Surgery Total	**6.1**	**3.2**	**9.3**
Fleming Ward	3.7	2.0	5.7
Harold Ward	4.6	2.3	6.9
Kingsmoor General	4.1	2.8	6.8
Lister Ward	3.7	3.1	6.8
Locke Ward	3.7	2.9	6.6
Nightingale Ward	3.3	2.6	5.9
Opal Unit	4.5	3.5	8.0
Ray Ward	3.9	3.1	7.0
Tye Green Ward	4.3	3.2	7.4
Winter Ward	4.3	3.2	7.5
Medicine Total	**4.0**	**2.8**	**6.9**
AAU	6.5	2.5	9.0
Charnley Ward	4.6	2.7	7.3
UEC Total	**5.5**	**2.6**	**8.1**
Birthing Unit	17.2	10.1	27.2
Chamberlen Ward	4.9	1.8	6.7
Dolphin Ward	8.9	2.7	11.6
Labour Ward	12.8	3.3	16.1
Neo-Natal Unit	7.5	1.6	9.2
Samson Ward	1.9	2.5	4.4
CHAWS Total	**6.2**	**2.6**	**8.8**

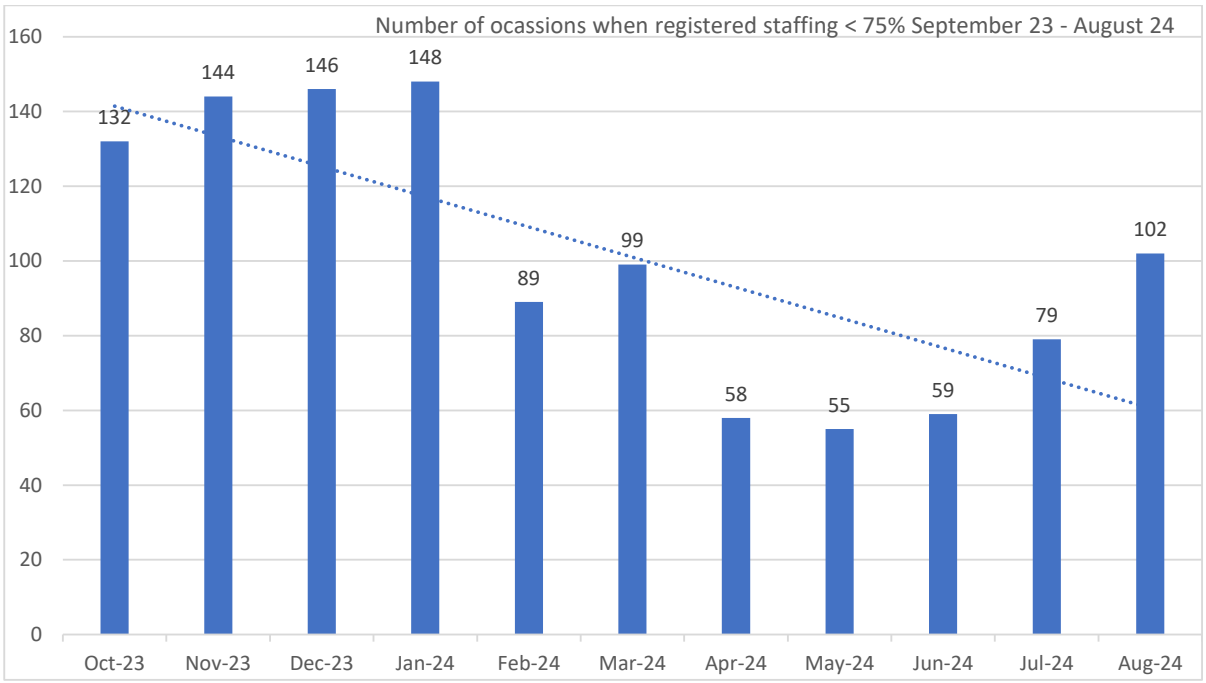
Appendix 3. Nursing Red Flags (NICE 2014)

Box 2: 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.
- A shortfall of more than 8 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 (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

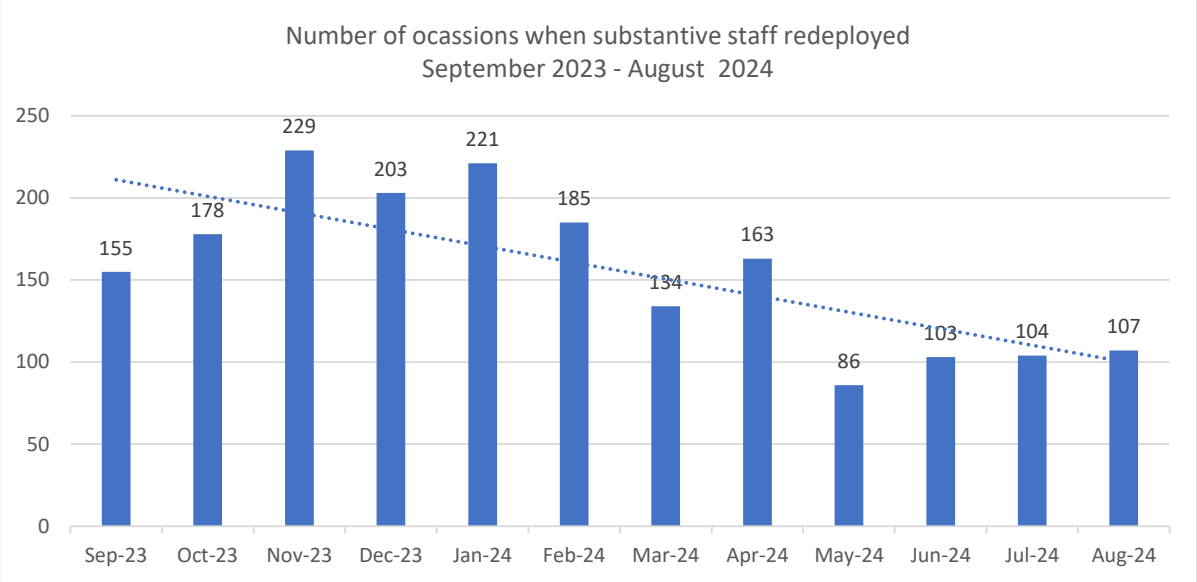
Note: other red flag events may be agreed locally.

Appendix 4: Staffing Red Flags Trend Data

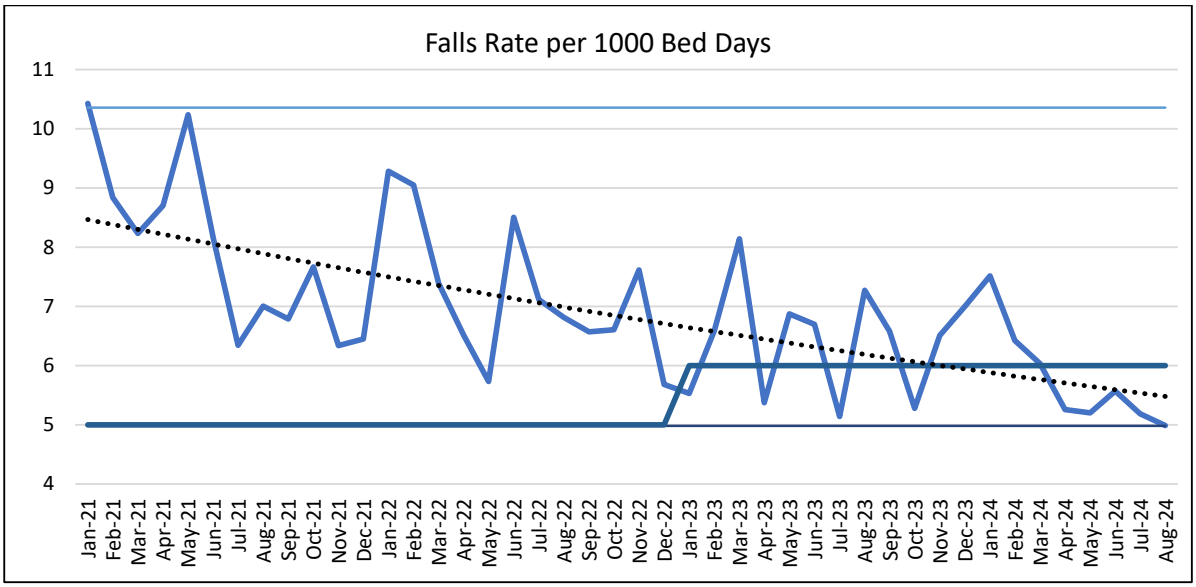


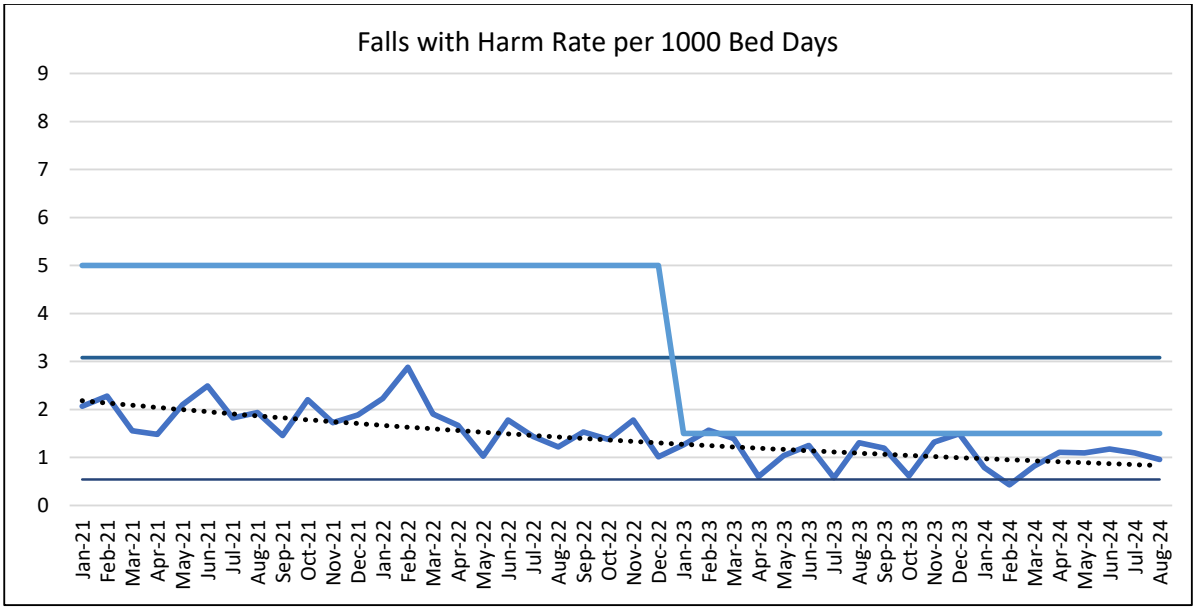
Appendix 5: Substantive staff redeployment trend

This reports looks at the number of shifts substantive staff working a shift are redployed, it does not include the shifts when agency, bank or multi post holders are redeployed.



Appendix 6: Falls Rate per 1000 bed days

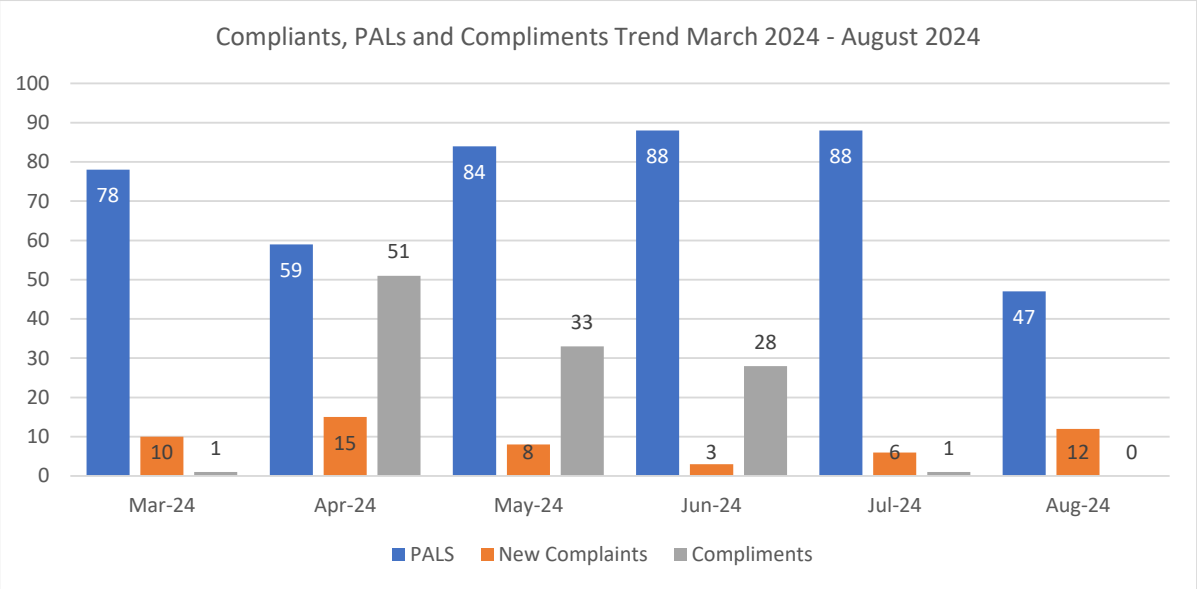




Appendix 7: Total Pressure Ulcer Rate per 1000 bed days and Moderate Harm Pressure Ulcer Rate per 1000 bed days trend.

These reports were not available at the time of this report

Appendix 8: Complaints, PALS and Compliments Trend Data



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

4.5

Agenda item:	4.5
Presented by:	Giuseppe Labriola, Interim Chief Nurse
Prepared by:	Shahid Sardar, Associate Director Patient Engagement and Experience
Date prepared:	September 2024
Subject / title:	National Adult Inpatient Survey Results 2023 Improvement Programme

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	In November 2023, 506 Trust patients responded to the national inpatient survey with a response rate of 43.6%. We are mid-point in a two-year national inpatient survey improvement programme, with evidence of improvement over one year, with 19 questions rated the same as the national average. Improvements in privacy, dignity and being asked to give views on quality. 26 questions are rated worse, 17 of these relate to admission, discharge and transfer. Improvement programmes are underway led by patient experience, divisional leaders and Quality First.
Recommendations:	A working group is in place to review the actions from the previous inpatient survey, and bring in the intelligence from this year's survey. There is good Trust wide and divisional representation, and this is being chaired by the chief nurse. The task and finish group will reconvene in October with full background details of the 2023 adult inpatient survey, explanation of the results and provide details of dissemination with an improvement plan

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

Previously considered by:	Quality and Safety Committee 27.09.24
Risk / links with the BAF:	BAF 1.1 and BAF 1.3
Legislation, regulatory, equality, diversity and dignity implications:	The Equality Act 2010 The Local Authority Social Services and NHS Complaints (England) Regulations 2009
Appendices:	Appendix 1: Table of results rated 'about the same', 'somewhat worse', 'worse' and 'much worse'. *Diligent Resources: Adult Inpatient Survey 2022 – PAHT Management Report*

The Princess Alexandra Hospital NHS Trust

1. Purpose

This report is intended to the give the board an overview of the results of the benchmarked PAHT National Inpatient Survey 2023 which was published on 21st August 2024, based on fieldwork in the month of November 2023. 506 patients responded to the survey with a response rate of 43.6%.

2. National Adult Inpatient Survey 2023

2.1 Overall

Benchmarking our 2023 performance against 2022 and against other organisations is shown in two pie charts below. The first pie chart (on the left) shows improvement year on year so we have significantly improved on 3 questions and stayed the same on 36 questions.

The second pie chart (on the right) compares PAH with other Trusts in England and shows we are the same on 19 questions and significantly worse on 26 questions.

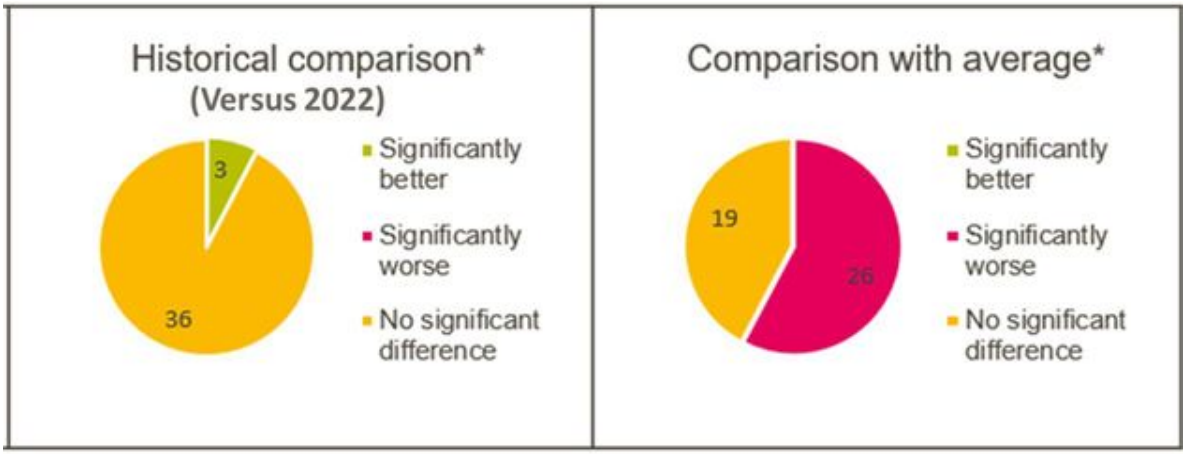


Figure 1: Comparison with 2022 (historical) and England cohort (average)

Another way of visualising the improvement is a more detailed scale “somewhat worse, worse and much worse”. This demonstrates the shift more clearly, so ‘about the same’ went from 36% to 47% and worse from 51% to 27%. (Tabulated at Appendix 1.)

Figure 2: Using a more detailed scale reveals the pace of the improvement

The Princess Alexandra Hospital NHS Trust

2.2 Triangulating or cross checking this evidence

To help triangulate this evidence of improvement, the narrative of the inpatient survey is supported by evidence from our Friends and Family Test data which has been trending upward for the last 6 months and now shows more than 80% of patients rate care as good or very good.

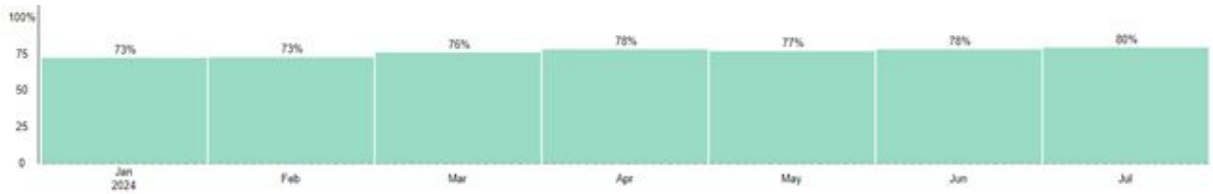


Figure 3: Friends and Family Test for all areas PAHT Jan 2024 to July 2024

In addition, the National Cancer Patient Survey 2023 just reported, now has 7 areas rated above the expected range, as follows:

	Case mix adjusted scores			National score
	2023 score	Lower expected range	Upper expected range	
Q13. Patient was definitely told sensitively that they had cancer	**88%**	62%	87%	**74%**
Q14. Cancer diagnosis explained in a way the patient could completely understand	**90%**	65%	89%	**77%**
Q15. Patient was definitely told about their diagnosis in an appropriate place	**97%**	75%	96%	**86%**
Q17. Patient had a main point of contact within the care team	**100%**	83%	100%	**91%**
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	**89%**	63%	89%	**76%**
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	**95%**	66%	93%	**79%**
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	**100%**	76%	98%	**87%**

Figure 4: National Cancer Patient Survey 2023 reported July 2024

2.3 Specific areas of improvement

The areas which have improved (in a statistically significant way):

1. Given enough privacy when being examined or treated
2. Treated with respect and dignity overall
3. Asked to give views on quality of care during stay

Areas which have improved (without statistical significance) include:

Admission and ward experience

4. Did not mind waiting as long as did for admission
5. Staff explained reasons for changing wards at night
6. Room or ward very or fairly clean
7. Able to take own medication when needed to
8. Offered food that met dietary requirements
9. Got enough to drink
10. Staff helped control pain
11. Staff helped when needed attention

Leaving Hospital

12. Understood information about what they should or should not do after leaving hospital
13. Treated with respect and dignity overall

2.4 Areas of worse performance than the national average (26 questions)

The themes areas of worse performance versus the national average

The Princess Alexandra Hospital NHS Trust

Admission and ward experience examples (5 questions)

Questions related to waiting too long to get to a bed on a ward, help to wash or keep clean and hospital food.

Doctors and Nurses (5 questions)

Questions related to doctors and nurses answering questions in a way patient could understand and having confidence and trust in nurses and doctors

Care and Treatment (4 questions)

Questions related to staff contradicting each other about care and treatment, being involved in decisions and being given information on the condition or treatment.

Leaving Hospital (12 questions)

This is the area with the greatest number of questions and included themes such as information about treatment on a virtual ward. The predominant concerns related to involvement in decision making about discharge from hospital, involving family or carers, being given enough notice about discharge, what to do after leaving, understanding medication and what would happen next with care, such as social care involvement after discharge.

2.5 Actions being taken

Action being taken to improve can be summarised as follows:

- the Trust has a two-year long inpatient experience improvement programme, focussed on the national inpatient survey which has seen improvements in communication, food and drink and overall care experiences. We are now mid-programme.
- SAGE and THYME (a three hour, nationally accredited communication model) and clinical simulations of communication in distressed patients have each reached 1035 and 40 staff respectively with an advanced skills course being planned.
- Launching a ‘noise at night’ improvement project, bringing innovations from children’s services to adults wards (noise meters and data on noise) and other trusts (a sleep charter) to our wards.
- Quality First team has been working with patient experience, gathering data on leaving hospital processes from four wards using and spending a week on wards observing Board rounds and conducting a Red2Green Audit. Tests of change begin on 16 September, if effective and sustainable, these are to be rolled out beyond our model ward environment.
- A MADE event (multi-agency discharge event) earlier this year demonstrated that volunteers can have an impact on 58% of reasons for delays in discharge and work is being done to develop this impact in a long-term way.
- Working with the complex discharge support team, Essex Social Services and HealthWatch Essex (HWE) is ongoing to develop a wider range of stakeholders working to improve the discharge process.

3. Recommendations

A working group is in place to review the actions from the previous inpatient survey, and bring in the intelligence from this year’s survey. There is good Trust wide and divisional representation, and this is being chaired by the chief nurse. The task and finish group will reconvene in October with full background details of the 2023 adult inpatient survey, explanation of the results and provide details of dissemination with an improvement plan

The Princess Alexandra Hospital NHS Trust

Appendix 1

Table of results rated ‘about the same’, ‘somewhat worse’, ‘worse’ and ‘much worse’.

Tabulated

Year	About the same	Somewhat worse	Worse	Much worse
2023	23	10	13	3
2022	16	4	23	2
2021	19	9	29	0

2023

Worse

Your trust’s results were much worse than most trusts for **3** questions.
Your trust’s results were worse than most trusts for **13** questions.
Your trust’s results were somewhat worse than most trusts for **10** questions.

Same

Your trust’s results were about the same as other trusts for **23** questions.

2022

Worse

Your trust’s results were much worse than most trusts for **2** questions.
Your trust’s results were worse than most trusts for **23** questions.
Your trust’s results were somewhat worse than most trusts for **4** questions.

Same

Your trust’s results were about the same as other trusts for **16** questions.

2021

Worse

Your trust’s results were much worse than most trusts for **0** questions.
Your trust’s results were worse than most trusts for **19** questions.
Your trust’s results were somewhat worse than most trusts for **9** questions.

Same

Your trust’s results were about the same as other trusts for **19** questions.

Trust Board (Private) – 3 October 2024

Agenda item:	4.6
Presented by:	Giuseppe Labriola, interim chief nurse
Prepared by:	Giuseppe Labriola, interim chief nurse
Date prepared:	26th September 2024
Subject / title:	Nursing, Midwifery and Allied Health Professionals strategy 2024-2027

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

Key issues:	The Nursing, Midwifery and Allied Health Professionals strategy has been developed with the professions. The vision and values of nursing, midwifery and allied health professionals are represented by the four strategic priorities. 1. Our greatest asset: our nursing, midwifery and AHP workforce 2. Deliver outstanding care: person centred practice and outcomes 3. Digital: drive forward to digitise, connect and transform 4. Our commitment to system partnership working and leading innovative opportunities for all Aligned to the national priorities, a tactical work plan will be developed to deliver the strategy and delivery will be overseen by the Nursing, Midwifery and Allied Health Professionals Senior Leadership Group, This will also report into the People Committee.
Recommendation:	The board are asked to note the nursing, midwifery and allied health professional's strategy and the approach to deliver the strategic priorities via the tactical workplan

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:	Nursing, Midwifery and Allied Health Professionals Senior Leadership Group EMT May 2024 People Committee May 2024
Risk / links with the BAF:	BAF Risk 1.1 (Clinical Outcomes) BAF Risk 2.3 (Workforce)
Legislation, regulatory, equality, diversity and dignity implications:	The strategy was developed with EDI at its core and represented within the key priorities.
Appendices:	Appendix 1: Nursing, Midwifery and Allied Health Professionals Strategy 2024-2027

Nursing, Midwifery and Allied Health Professionals

The Princess Alexandra Hospital NHS Trust

Strategy 2024-2027

First published 11/09/2024

Introduction from Sharon McNally, Chief Nurse

It is with professional and personal pride that I am delighted to present our second nursing, midwifery, and allied health professional (AHP) strategy. In the four years since we launched our first strategy, we have seen and worked with significant change across healthcare. Over this period, we have worked and lived through a global pandemic that has had a lasting legacy to us all both personally and professionally. I would like to thank each and every member of our nursing, midwifery and AHP teams for their courage, dedication, skill, and sacrifice.

Thank you for your engagement in the development and the delivery of our four priorities. The priorities are aligned with national strategies; significantly those of our national professional leads. Two additional strategies support our collective vision to lead the delivery of compassionate healthcare to achieve outstanding person-centred outcomes, and I am proud to launch our first adjunct strategy specifically for our AHPs, alongside our first ever research strategy.

At some point in all of our personal lives we shall come into contact with nurses, midwives and AHP's and the confidence of the public and their perception of our professions are crucial. Likewise, as we continue to address the workforce challenges, our professions need to be seen as high value career opportunities.

Sharon McNally

Chief nurse and deputy chief executive

Collectively, these strategies will support you in the vital work that you do, support you as an individual to reach your potential and enjoyment in your work and for us to further develop our collective voice and strength.

This is an exciting time to be a nurse, midwife or AHP at our organisation. I am committed to leading us though the change this strategy will drive; further enhancing our professional identify and our voice, creating opportunities for career growth and focusing on developing great leadership, digitalising the way in which we work and the way we use data to drive improvement, and striving to be at the forefront of evidence based, compassionate, outstanding care.

I am immensely proud of our nursing, midwifery and AHP workforce because of the professionalism, the skill, care, and compassion given to those that we serve, our communities and to each other; and significantly, your wonderful, consistent desire for learning and continuous improvement.

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

Goals

To achieve our vision, the following three goals have been developed based upon the three PAHT 2030 overarching goals to be outstanding, integrated and modern:

Modern

We will be innovative and adaptive to create a dynamic environment where research and technology enhances patient outcomes

Integrated

We will provide the right staff, with the right skills to deliver the right care in the right place

Outstanding

We will strive to deliver excellence through evidence based practice demonstrating our positive contribution to patient outcomes

Trust Values

patient at heart • everyday excellence • creative collaboration

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

Alignment with the national framework

Chief Nurse and NHS LTP Priorities

Renew the reputation of our profession for the future

Stereotypes around the profession need to be removed and the profile of their integral role within healthcare need to be raised. The workforce is highly skilled and works in a breadth of roles, something which is not widely understood. These extraordinarily skilled people and leaders need to be recognised for their ability.

A collective voice that is powerful and heard

It is vital that the workforce knows to speak with confidence, understand their value and know the importance of their contribution. A collective voice enables collective leadership and ensures the professions are heard and valued in all decision-making conversations.

Workforce fit for the future

There is a national shortage of nurses, midwives and AHPs which need to be tackled. Steps to be taken include building a workplace which is rewarding and full of opportunity, developing the quality of management and leadership skills, breaking down inequality barriers and creating an infrastructure for volunteers to provide more support to front-line staff.

PAHT Nursing, Midwifery & AHP 2025 Vision

To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes

PAHT Nursing, Midwifery & AHP Objectives aligned to 5Ps

PAHT Nursing, Midwifery & AHP Courageous Goals

Outstanding

we will strive to deliver excellence through evidence based practice demonstrating our positive contribution to patient outcomes

Integrated

we will provide the right staff, with the right skills to deliver the right care in the right place

Modern

we will be innovative and adaptive to create a dynamic environment where research and technology enhances patient outcomes

What do these goals mean to our patients, people, performance, places and pounds?

Outstanding we will strive to deliver excellence through evidence based practice demonstrating our positive contribution to patient outcomes	Integrated we will provide the right staff, with the right skills to deliver the right care in the right place	Modern we will be innovative and adaptive to create a dynamic environment where research and technology enhances patient outcomes
Throughout their healthcare journey, our patients will have a person centred experience and achieve positive outcomes	Patients will receive a consistent level of high quality care across all teams and based on the patients needs	Our patients will have access to devices which aid self-management while improving access to nursing, midwifery or AHP teams
Our people will have the skills and competences to lead the delivery of evidenced based practice. We will provide compassionate leadership and promote equality and diversity	Accountability of care through co-designed pathways will be shared across teams. Our staff will have clear career pathways with opportunity and support for progression. We will support their health and wellbeing needs	Our people will have improved communication between healthcare professionals and will be able to access research while being supported to translate into practice
Acknowledged and recognised as a centre of excellence for quality	We will strive to meet the national quality outcomes while reducing variations in care	Our performance will measure nursing, midwifery and AHP outcomes and demonstrate the impact of our professions
We will actively inform and advise the future environment to enable outstanding care	We will provide integrated services from GP practices, Community Hospitals and peoples homes, based on the patients need	We will offer services in places which suit the patients needs, in or outside of the hospital setting
We will understand our contribution to the delivery of efficient and effective care pathways	We will work within our digital strategy to deliver sustainability and increase our productivity	We will make informed investment decisions based upon patient outcomes, best practice evidence and research

5

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

What needs to change and how will it be different?

Drivers for change	Future ways of working
Impact of the workforce on patient care is not clearly defined	Use of nursing sensitive indicators and ward accreditation programme
KPIs and outcome measures used can sometimes lose the focus on patient, their	Measures established which take into account the difference and improvement to patient care
Training and development opportunities are not always available to all	Regular easy access to opportunities for training and development
There is a shortage of nurses, midwives and AHPs across the local healthcare system, and at a national level	Flexibility of the workforce to have the right staff in the right place to deliver patient care
To identify the opportunity for nurses, midwives and AHP's in an integrated system: working across pathways	Clear roles for the workforce within an integrated healthcare system
The collective voice of nurses, midwives and AHP's has opportunity to be strengthened	For the voice of the workforce to be collective and informing of organisational decisions
Benefits of digital transformation have not always been focused on our Nurses, Midwives and Allied Health Professionals	Workforce that's understands the benefits of digital technologies to improve patient safety and care
The CNO for England 7P framework; Purpose, Professionalism, Personalisation, Proactivity, Partnership, Prevention, and Productivity	Incorporating the 7 P's to support the creation of a dynamic and responsive workforce

6

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

Highlight achievements from 2020-2024

We have re-established and promoted networks within and across teams and departments to enable professionals to re connect, re-engage and strengthen our collective voice

We have used evidence based, best practice tools to invest in our nursing and midwifery establishments and additionally reduced our vacancy rate to 8% (March 2024)

We can demonstrate our commitment to successfully delivering excellence through evidence based practice, providing the right staff for the right care, and fostered innovation for enhanced patient outcomes.

We have been actively involved and engaged in development of the new EHR and are prepared for EHR and digitalisation. We have strengthened our commitment to being at the forefront of digitalisation through the appointment of our Chief Nursing Information Officer

We have launched our shared governance framework, strengthened our commitment and are ready to embed this over the coming year

We have achieved bronze-level accreditation for all wards and raised awareness about the accreditation scheme's principles, and have standardised adult inpatient wards to evidence-based criteria aligned with CQC KLOE's, NMC standards, and Trust priorities.

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

We have Delivered a comprehensive outline plan for nursing and midwifery research by implementing a strategic approach consisting of 10 key steps. These steps have enhanced the capacity and capability for nursing research at PAHT, fostering a culture of innovation and advancement

We have successfully delivered our first CNO fellowship programme, providing leadership development and improvement methodology to our fellows. We are now ready to embed this as a formal annual programme

We have strengthened the voice and organisational profile of our midwives and our AHPs though investing in leadership: appointing an Associate Director of AHPs and a Director of Midwifery.

We have modernised our workforce strategy and strengthened our advanced practice for our workforce; demonstrable though appointment of consultant roles; advanced practitioners and career mapping

1. Our greatest asset: our nursing, midwifery and AHP workforce

Our people and workforce are our enabler to delivering outstanding care. Through our focus on developing our community of practice and strengthening leadership across our workforce, we will raise the profile and identity of our NMAHP community, and make PAHT a centre of excellence, building our attraction to other great people to join our team. Through shared governance, our people will feel empowered and able to influence change.

We will do this through a focus on leadership:

- We will focus on developing our leadership capability and collective compassionate leadership
- We will support and harness the talent across our professional community
- We will strengthen the roles and responsibilities across our professions
- We will adopt coaching and mentorship models to enable effective role modelling and professional challenge
- We will focus on equity through continuing to build trust and ensure that everyone's voice is heard and valued; strengthening our collective professional culture

We will do this through a focus on our workforce development:

- We will optimise having the right staff, with the right skills, in the right place along our patients pathways
- We will drive effective retention and recruitment strategies; attracting great people to work with us, to stay with us and to build their careers with us
- We will have effective preceptorship programmes to support our staff and optimise their contribution to our teams; and we will have clear career mapping to enable our staff to reach their potential
- Our workforce will be valued and supported to have rewarding careers, optimising development opportunities, maximising the scope of professional roles, and enabling our workforce to thrive in the learning environment

And celebrate our success and our future

2. Deliver outstanding care: person centred practice and outcomes

Through our NMAHP community, our shared values, priorities and vision, we will understand our unique contribution to the delivery of outstanding person-centred care and improve outcomes for our patients. We will understand our shared professional contribution to the prevention agenda and the wider determinants of health – recognising our role in health promotion and holistic care in all that we do.

We will do this through:

- We will promote the delivery outstanding care utilising evidence-based practice; we will foster our professional pride through our research strategy delivering person centred, clinically driven best practice.
- We will use feedback and data in an intelligent way, which alongside our research and innovation, will drive forward improvements in our care and outcomes
- We will embed our Princess Alexandra Clinically Excellent accreditation programme (PACE) as a vehicle to ensure a collective sense of purpose, and further develop and improve our practice
- We will embed shared governance across our professions: supporting our leadership priority, provide local ownership of improvement, influence care delivery and inform our strategic priorities
- Focus on resetting and enhancing delivery of care and team working through the delivery of a Fundamentals of Care Programme

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

3. Digital: drive forward to digitalise, connect and transform

By 2027, our NMAHP colleagues will have aided the development, launch and optimisation of our new EHR system. We will use digital information to understand opportunities for improvement and to celebrate success.

Through digitalisation, connecting and transforming, our NMAHP community will harness and strengthen digital opportunities and enablers to both strengthen our community of practice and improve care.

We will do this through:

- While using digital as a platform to impact on better and safer care, we will continue to deliver this to our patients with compassion and humanity
- Digital clinical safety is everyone's responsibility. Through our skills and knowledge we will recognise and escalate any risks and issues to clinical safety from the use of technology
- We will share the importance of digital, showcase the benefits that can be achieved, sustain excitement and opportunity for maximising digital as a key enabler to strengthen our unique contribution to healthcare
- We will strive to support our patients to become active participants in their health and care though accessing data platforms
- We will use data to inform nursing practice, expanding our focus to learn more about population health, inequalities and driving equitable access through our service development plans.
- Our professionals will be informed by data and have the skills and confidence to utilise this to make decisions that improve care and identify areas of good practice for sharing

4. Our commitment to system partnership working and leading innovative opportunities for all

Through being proactive system partners, we aim to understand our local population in greater detail using accurate information from across the system. We will understand at a comprehensive level who are service users are and how we can best support them. We aim to understand the current service provision across the HCP and what gaps and overlaps exist in care needs and service delivery. We will understand the roles and responsibilities of our people working across the system in an inclusive way to promote a collaborative approach to reviewing opportunities for establishing a seamless service with excellent patient outcomes. We will work as a HCP to provide continuity of care both in and out of hospital, and in the most ecological and sustainable way.

Will do that through:

- Working with our system partners; sharing data, being active participants and having our voice heard in shared clinical forums, leading and informing pathway redesign and system learning.
- Our nurses, midwives and AHPs to be actively involved and engaged in delivering the priorities within PAHT 2030 and the clinical pathways for the new hospital
- Continue to focus on maximising opportunities and promote the contribution nurses, midwives and AHP's can make to population health; ensuring we prepare professionals for new career pathways both in and out of hospital to support person-centred pathways across the HCP.
- Championing and leading on opportunities for effective and engaging system partnerships

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

4.7

Agenda item:	4.7							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team Fay Gilder | Medical Director							
Date prepared:	17th September 2024							
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 QSC
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.*
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.7

1.0 Purpose/issue

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

2.0 Background

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

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

3.1 Background

Telstra provided an in-hospital mortality report, for all inpatient admissions for the 12 month time period May 2023 - Apr 2024.

3.2 Analysis

Figure 1 – HSMR Monthly Trend
HSMR (May-23 to Apr-24)

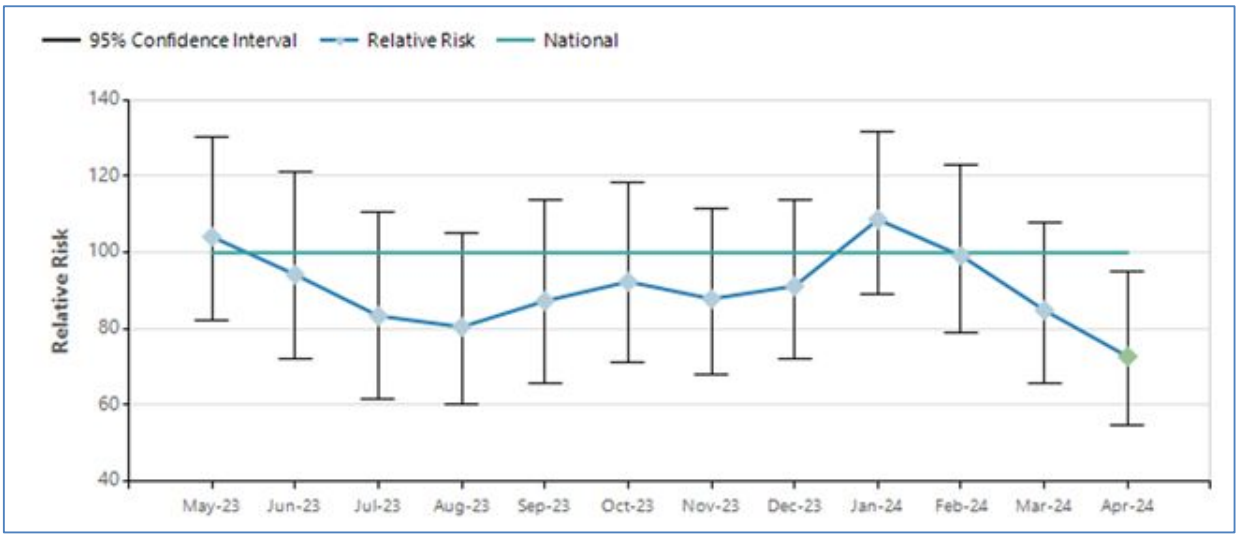


Figure 2 – Expected V's Observed Deaths (May-23 to Apr-24)

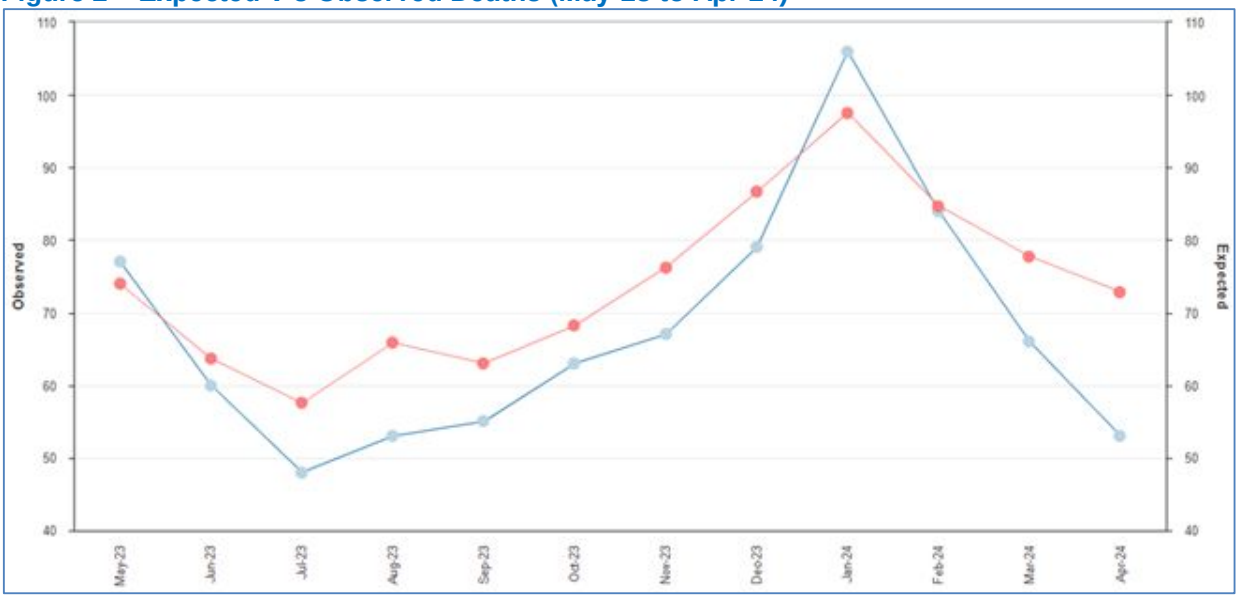


Figure 3 - HSMR 11 Month Peer Comparison: National

(PAH = blue; National acute non-specialists = brown)

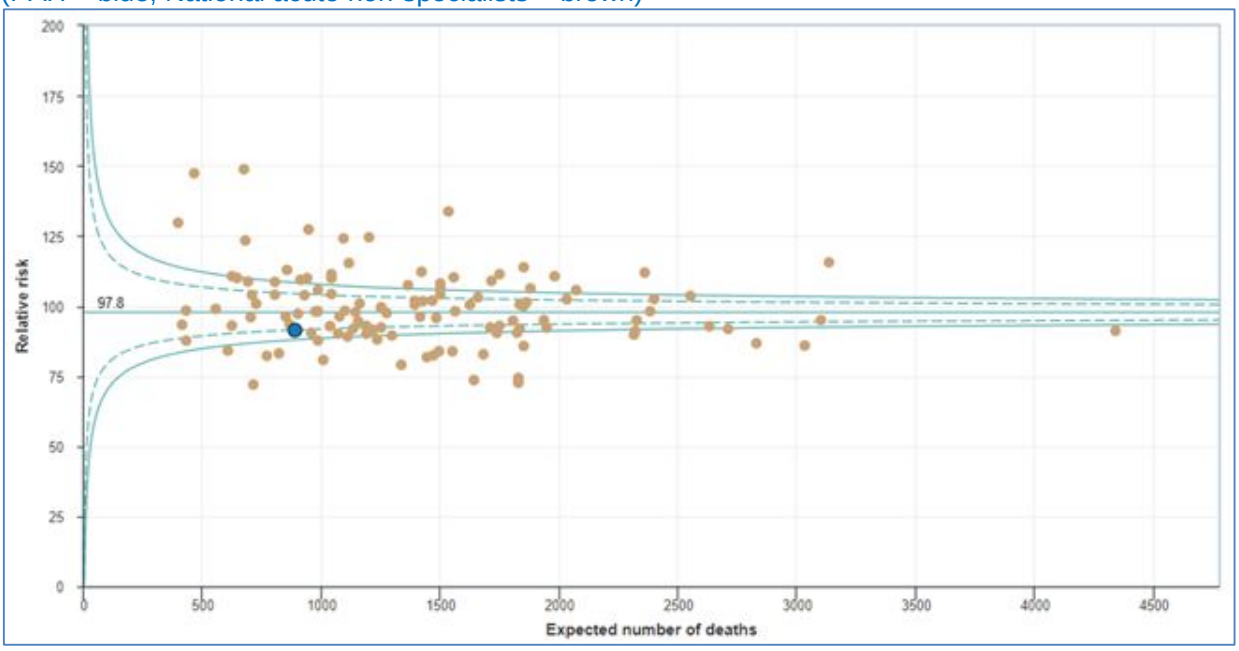


Figure 4 - Outliers and alerts

Title	CUSUM	Vol	Obs
All Diagnoses	1 2	**65600**	**981**
HSMR (56 diagnosis groups)	5	26304	811
Cardiac arrest and ventricular fibrillation	2	13	11
Other liver diseases	1	245	14

Standardised Mortality Ratio Overview

HSMR for the period May-23 to Apr-24 is 91.33 **'lower-than-expected'** based on 26,304 superspells and 811 deaths (crude rate 3.08%).
The Trust have now reported four of the last six rolling periods as "lower-than-expected".

3.3 Summary

Figure 1 shows that HSMR has reported as "within expected" in every month for the past financial year (May 2023 to April 2024), which is extremely good news.

Figure 2 details the HSMR observed deaths (blue) vs. expected deaths (red) shows a very similar pattern over the last year; with expected frequently higher than observed deaths.

Figure 3 highlights the national HSMR for FY23/24 which is 98.8 and "lower-than-expected". PAH are just inside the 95% control limit indicating no significant difference to acute, non-specialist peers nationally.

Figure 4 lists the diagnostic outlier and alerts. All CUSUM alerts continue to be audited and presented at the Learning from Deaths Group.

4.0 Mortality Programme Updates

Femoral Fracture Update

Meetings are due to take place in September 2024 between Urgent and Emergency Care and Medicine Division to review time from diagnosis to correct ward and look at improvements. Updates will be provided at the SLFDG.

Level 2 M&M Appraisal

An appraisal proposal regarding the excessive backlog of level 2 mortality reviews was presented and agreed by SLFDG September 2024
It was agreed by the Divisional Directors and the SLFDG to review only the last 6 months of level 2 reviews.
This option reduces the number of pending Level 2 reviews, with the exception of those related to investigations/Datix, but leaves a smaller margin (6 months) for the review of recurring topics that may have a learning value and that will be included in the programming of the specialty and ward Mortality and Morbidity meetings.
Each proposed level 2 review will be cross referenced with datix prior to elimination from the backlog to identify if an incident has been raised and left open for review should the case require this.
Any concerns in relation to patient care and treatment should still be highlighted via SJR's, incidents, coroner's inquests etc.
The paper will be taken to Trust Policy Group as an amendment to the learning from deaths policy for approval.

5.0 Learning from deaths process update

5.1 Mortality Narrative

- There were 81 deaths in August 2024.
- 18 cases referred for SJR's
- There are 122 outstanding SJRs (over 6 weeks of the patients' death.) The divisional directors receive a monthly report with the breakdown of outstanding SJR's
- Medicine and UEC have made significant improvement. Surgery and critical care have not and this is being taken up with the division.

Progress with SJRs is monitored through the divisional review meetings with the executive team.

5.2 Deaths Investigated Under the Patient Safety Incident Response Framework
Figure 5 – Avoidable Deaths (June 2024)

Surgical Division:

- Nil

Medical Division:

- One case for second review panel concluded avoidable death. The investigation undertaken by Medical Division with action plan. An SI has been declared.

6.0 Medical Examiner (ME) Headlines

6.1 Scrutiny Update

100% of deaths scrutinised between 8 Medical Examiners.
20 cases were referred to the Coroner:

National MCCDs issued within 72 hours: (National Target)

- A new process has been introduced by the national team which is more detailed. The ME team are working with the Trust to improve performance on the target as the new process is understood by all divisions.
- This resulted in 75.4% of MCCDs being issued within 72 hours in August 2024. This falls below the National target of 95%.

6.2 Ongoing Developments

- SMART training provided for new junior doctors across many specialities
- SMART – ongoing work with the team to develop:
  - Dashboard to pull off issues raised for Nurse review
  - An 'actions' section to be included in Administrative form for M&M meetings
- New working group started with Quality First to make better use of data collated in SMART since launch at the trust.

7.0 Risks

There were no changes made to the Learning from Deaths risk register.

8.0 Recommendation

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

The Princess Alexandra Hospital NHS Trust

Public Trust Board – 3 October 2024

Agenda item:	4.8
Presented by:	Phil Holland – CIO and Alex Health SRO
Prepared by:	Phil Holland – CIO and Alex Health SRO
Date prepared:	27 September 2024
Subject / title:	Alex Health (AH) Programme Update

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	X
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This paper provides the monthly update on the programme with specific reference to progress through full dress rehearsal, and the preparations for go live in early November							
Recommendation:	For information and assurance.							

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:	1.2 EPR and 1.4 EHR
Legislation, regulatory, equality, diversity and dignity implications:	The programme is ensuring that all personal data is protected and processed in accordance with relevant data protection, security, and privacy laws, such as the UK General Data Protection Regulation (UKGDPR) and the Data Protection Act 2018. It will also ensure that patient rights to privacy are respected, and their personal data is used in accordance with their wishes. We are also ensuring that all staff members are treated fairly and equally regardless of their race, gender, religion, disability, or any other protected characteristic. We continue to ensure that the implementation allows for appropriate access for all individuals and ensures necessary dignity and diversity implications are factored into the programme, such as enabling all access through the new patient portal and providing specific training to enable access to our new digital system.
Appendices:	None

Introduction

This paper will outline progress over the last 4 weeks, and plans for the period up to go live. It will also articulate current risks we are managing and mitigations, and review of our critical path.

Programme Progress

Since the last board meeting significant progress has continued as we to track to our go live weekend of 2 and 3 November. This has been due to the delivery of the following

- Completion of data delete in the testing environments to prepare for beginning of technical full dress rehearsal
- Successful completion of technical full dress rehearsal to enable commencing of operational full dress rehearsal on 24 September
- Opening of our Alex Health simulation suite for role play clinical training

Plans for the next period

The following key activities will be completed over the next 4 – 6 weeks:

- Completion of operational full dress rehearsal
- Completion of work off plans for reporting, data migration and pathology
- Completion of end user training
- Commencement of cutover from 31 October
- Go live weekend of 2nd 3rd and 4th November

Current Risks and Issues

The top risks being tracked regarding programme delivery are:

- Data migration trial load 3 outputs.
- Statutory reporting adherence post go live
- Completion of integration testing for pathology.
- Ensuring we meet the 80% of colleagues trained prior to go live

Key risks are continuing to be managed by the team though the Implementation Board, which are being monitored weekly and mitigation plans constantly revised and updated. The Implementation Board is also constantly evaluating the project scope regarding both technical and operational readiness, and the scopes impact on the critical path timeline.

We have seen a significant increase in engagement across the organisation through full dress rehearsal, and has provided significant learning for our final cutover planning.

Critical path timeline review

The key dates up to cutover, go live and early life support are as follows:

- Full dress rehearsal operational – 23 Sept – 4 October
- NHS England assurance gateway – week ending 4 October
- Activate Gateway – w/c 28 October
- Go live weekend – 2 and 3 November

Programme Assurance

We continue to receive assurance support from NHS Frontline Digitisation and our assurance partner across all areas of the programme, but in particular overall programme assurance, but also device integration, cutover, and stabilisation.

Conclusion

The Trust Board is asked to review and consider the contents of this report

Phil Holland

Chief Information Officer and Alex Health SRO

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

5.2

Agenda item:	5.2
Presented by:	Denise Amoss – Associate Director of Learning & OD
Prepared by:	Arleen Brown – Head of EDI & Nathaniel Williams People Information & System Lead
Date prepared:	18 September 2024
Subject:	Workforce Race Equality Standard (WRES) Annual Report 2024

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	The WRES shows that there are disparities in the experience of BME staff compared to white staff across most indicators. Each indicator highlights the areas of difference and the WRES action Plan seeks to address the outcome to improve the experience of BME staff in the workforce.
Recommendation:	That this report is discussed and the WRES Actions agreed.

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:	This report will be simultaneously shared with SMT and the Equality Steering Group for information only. PC.30.09.24
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	The Trust has a number of statutory duties arising from the Equality Act 2010.
Appendices:	None

1.0 Introduction

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 receive fair treatment in the workplace. The Workforce Race Equality Standard (WRES) is a data collection framework which measures elements of race equality in NHS organisations. Implementing the WRES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WRES is designed around nine indicators, or measures, which compare Black and Minority Ethnic (BME) colleagues and their White counterparts. We acknowledge and respect that not everyone is comfortable with the term “BME” and prefer other terms instead, however in line with the WRES terminology we shall use BME for consistency purposes.

We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group, however on the same lines as above mentioned, we are following national guidelines and for the purposes of this report and data we will only compare the data for the generic two groups.

Five indicators of the WRES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for BME and White staff.

This includes;
Indicator 1: the distribution of staff in each pay band,
Indicator 2: likelihood of being appointed following shortlisting
Indicator 3: likelihood of entering a formal disciplinary process
Indicator 4: access to training and development
Indicator 5: BME Board membership

The remaining four indicators are populated with comparative data from the NHS National Staff Survey for three years from 2021 to 2023. The data covers, experiences of bullying and harassment, abuse; discrimination, and perceptions of fairness in career progression

The data is to enable the Trust to adopt a ‘learning organisation’ approach and produce an action plan to build cultures of continuous improvement. These are essential steps in helping to bring about a workplace that is free from discrimination and bias.

As a public service, our Trust is bound by the Equality Act - Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation.
- Advancing equality of opportunity between people from different protected characteristics
- Fostering good relations between people from different protected characteristics

2.0 Context

The data in this report is comparing 2022 - 2023 to 2023 2024. When reviewing the information, it is useful to understand the overall numbers of BME and white staff in the workforce. As at 31 March 2024 the ethnic profile of staff represents 43% for BME staff, 54% for White staff and 3% Not stated (staff who prefer not to declare their ethnicity).

Ethnicity	Headcount - 31 March 2024
BME	1794
Not stated	140
White	2232
Grand Total	4166

3.0 Indicators 1 to 9

Indicator 1: Percentage of staff in each of the AFC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce:

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

Non-Clinical	Apr22-Mar23						Apr23-Mar24					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
Band 1	11	69%	2	13%	3	19%	10	71%	2	14%	2	14%
Band 2	369	80%	71	15%	24	5%	340	72%	109	23%	21	4%
Band 3	114	86%	12	9%	6	5%	153	85%	21	12%	6	3%
Band 4	175	91%	14	7%	4	2%	174	88%	20	10%	4	2%
Band 5	62	82%	10	13%	4	5%	63	81%	11	14%	4	5%
Band 6	53	70%	20	26%	3	4%	57	72%	20	25%	2	3%
Band 7	59	86%	9	13%	1	1%	73	78%	18	19%	2	2%
Band 8a	37	88%	4	10%	1	2%	40	80%	10	20%	0	0%
Band 8b	20	71%	7	25%	1	4%	23	72%	8	25%	1	3%
Band 8c	9	64%	5	36%	0	0%	9	82%	2	18%	0	0%
Band 8d	8	73%	3	27%	0	0%	8	80%	2	20%	0	0%
Band 9	7	100%	0	0%	0	0%	7	88%	1	13%	0	0%
VSM	8	89%	1	11%	0	0%	7	88%	1	13%	0	0%
NEDS	7	70%	0	20%	0	0%	5	56%	3	33%	0	0%

The workforce profile of BME Staff employed within the Trust has increased from 39% in 2022- 2023 to 43% in 2023 - 2024. A big drive up seems to come from the fact we have recruited a great number of our staff through international recruitment.

For BME staff in Band 7, the numbers have increased last year from 13% (9 staff), compared to 19% (18 staff). Similarly, progression has been made in Band 8a for BME staff, representing 20% (10 staff) compared to last year 10% (4 staff). This increase can be tracked down to the drive of having 'Equality Ambassadors' sitting on recruitment panels to support recruiting managers on removing bias from their decision making progress.

At the most senior levels of the Trust BME staff collectively continue to be underrepresented with similar numbers to last year. Collectively in Bands 8c and above staff held 9 posts compared to white staff at 32. It is an improvement from the 2023 - 2024 data but we do recognise there is still some work to be done to address the under representation.

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

Clinical	Apr22-Mar23						Apr23-Mar24					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
Band 2	258	64%	135	33%	10	2%	247	61%	150	37%	9	2%
Band 3	102	78%	23	18%	2	2%	102	78%	26	20%	3	2%
Band 4	70	61%	52	45%	3	3%	66	57%	48	42%	1	1%
Band 5	152	22%	454	67%	23	3%	136	20%	532	78%	14	2%
Band 6	257	53%	197	41%	15	3%	244	51%	220	46%	17	4%
Band 7	196	62%	97	31%	13	4%	197	62%	108	34%	12	4%
Band 8a	71	50%	39	27%	7	5%	90	63%	47	33%	5	4%
Band 8b	19	70%	6	22%	2	7%	17	63%	7	26%	3	11%
Band 8c	9	69%	4	31%	1	8%	9	69%	3	23%	1	8%
Band 8d	7	88%	2	25%	0	0%	7	88%	1	13%	0	0%
Band 9	1	100%	0	0%	0	0%	0	0%	1	100%	0	0%
Medical & Dental	146	24%	370	62%	31	5%	152	25%	422	71%	24	4%

Comparing the data from last and present years the staff profile has shown little change from Band 5 to Band 8a. The majority of BME staff are at Band 5 equalling 532 staff, representing 78% of Band 5 employees.

In a similar picture to the non-clinical staff, the very senior AfC colleagues, bands 8C and above are under represented and on the same vein we understand there are still work to be done to address this disparity.

The data regarding to colleagues on the M&D terms and conditions, show a very different picture where the imbalance is with only having 25% of white staff. This is a representation of our diverse culture and international recruitment campaigns.

Indicator 2: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME:

Indicators	2023						2024					
Relative likelihood of white staff being appointed from Shortlisting compared to BME staff across all posts	1.44						2.14					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	655	51%	501	39%	125	10%	690	42%	529	32%	412	25%

We acknowledge that our indicator 2 has unfortunately worsened in the past year. This may be a reflection of our recruitment process whereby our international recruitment does not fall part of this data.

We have committed to implemented the NHS De-bias recruitment programme to assist us in improving this outcome and will also be doing spot checks and deep dives to realise an action plan to support the indicator to be as close to 1 as possible.

Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

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)	2023						2024					
	0.30						0.54					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	19	83%	4	17%	0	0%	23	70%	10	30%	0	0%

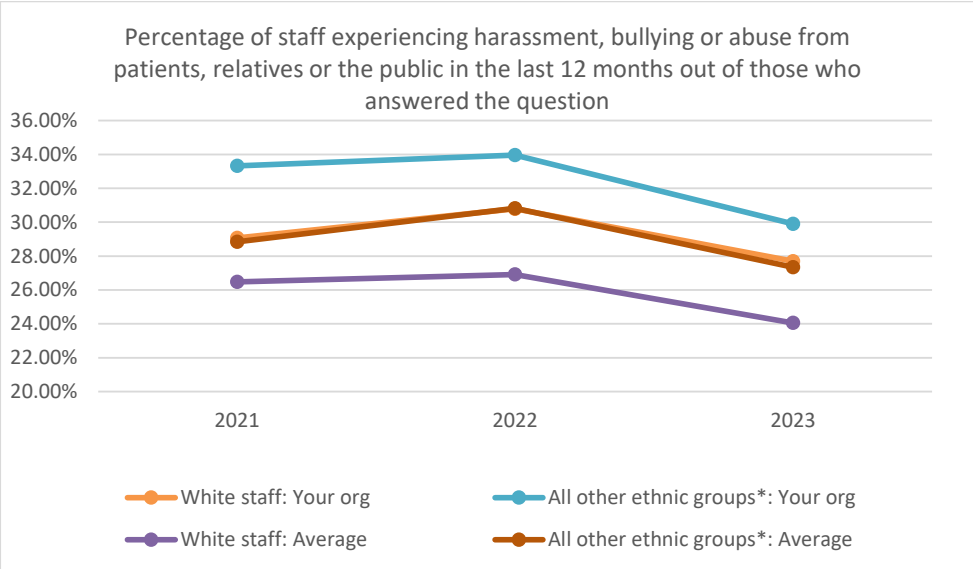
Although we should be happy that for the past 2 years this indicator demonstrates that white staff is much more likely to enter a disciplinary process we also need to be mindful that the dial on this indicator does not promotes an unbalance. As an employer we should always strive for fairness and equity across the board.

Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	2023						2024					
	0.99						0.87					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	528	58%	369	40%	21	2%	321	53%	296	44%	19	3%

The likelihood of White staff accessing non-mandatory training and has dropped from last year. A value of “1.0” for the likelihood ratio means that white and BME staff are equally likely to access non-mandatory training or CPD. We will be reviewing applications for training to understand the decline and address the outcome for next year so the balance and equity on this indicator is restored.

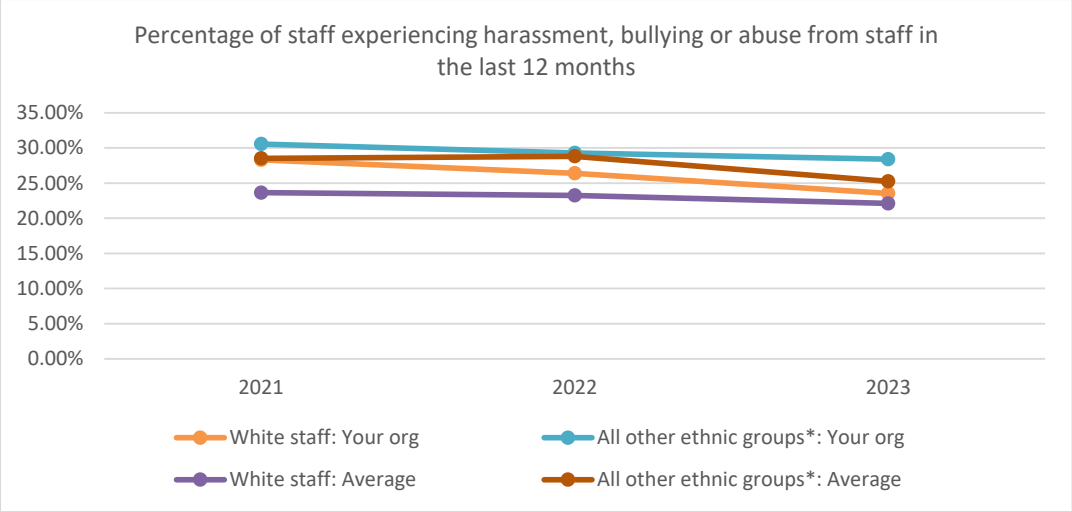
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



We are happy with the downward shift for all our colleagues both locally and nationally. However we will have to still acknowledge that the rate of perception from our staff is not within acceptable numbers, with our BME colleagues still feeling more affected than our white colleagues.

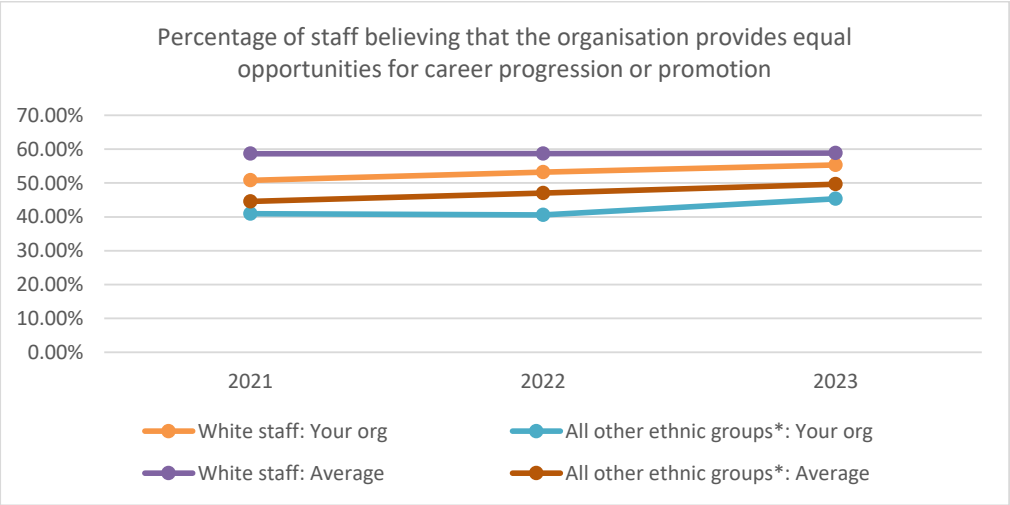
Our REACH (Race Equality and Cultural Heritage) network is being proactive on supporting the Trust to create a communications campaign to address behaviours from patients and relatives (and staff). Our aim is to fully support the network and also look into further initiatives to address these issues.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



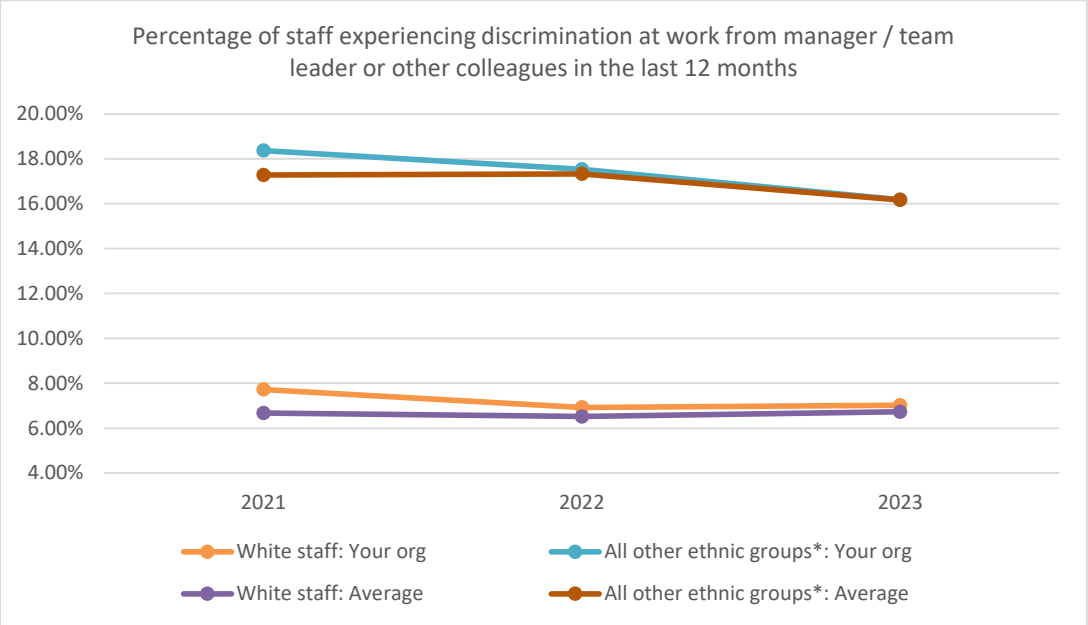
This table also represents a very similar picture as the indicator 5. We will be addressing both indicators simultaneously with the addition of a further strengthening om our established 'just culture' programme on our policies and practices.

Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



In the past year we have been working on supporting a change in culture in regards to career progression and promotion, which has been identified on the slight increase from our BME staff's perception.
However it is very clear that overall our staff do not believe that our organisation provides equal opportunity for career progression and promotion.
We have appointed a new Head of Organisational Development at the beginning for this financial year and he is working to develop a further framework that will support development and learning across the organisation. We may not see this indicator increasing drastically on the next report due to when the survey is released, but we are confident that in 2 years' time, when the work we are currently developing is actually in place, our data will show an improvement.

Indicator 8: Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months



The table above indicates that our staff perceptions and experiences are in line with our national average. This indicator also tells us there is much work to do to tackle discrimination and perceptions of discrimination in the work place. We will be reviewing and implementing appropriate actions from the EOE (East of England - Region) Anti-racism Strategy, to assist us in tackling race discrimination and perceptions of discrimination within the Trust.

Indicator 9: BME board membership – Executive and Non-Executive Directors:

Total Board Members by ethnicity	2023				2024			
	White		BME		White		BME	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	15	79%	3	16%	13	72%	4	22%

BME representation at board level is 22% when compared to 16% last year. The national indicative at senior level positions is 19%.
We are always striving for a better representation on our Board but these numbers are encouraging for the leadership and progression of diverse leadership in the Trust, and we will continue to encourage diversity on our Board.

4.0 Actions for 2024 to 2025

It is important that we sign up to the recommended actions below and agree the timescales.

Ref	Indicator	Actions	Lead	Timescale
1	1,2,9	Debias recruitment NHS programme to be implemented in line with the NHS EDI High impact actions – attraction, recruitment and retention.	**Head of People - Recruitment and Retention**	**March 2025**
2	1,2,9	Review the role of recruitment inclusion specialist. To ensure they are effectively able to challenge and report on bias recruitment processes.	**Head of People - Recruitment and Retention**	**March 2025**
4	3,6,8	Review all People policies as they come up for renewal to strengthen the just culture approach.	**Head of People - Business Partnering**	**Ongoing 2025**
5	5,6,8	Within our culture change initiatives set standards of behaviour to tackle bullying and harassment. – support network initiatives	**Head of ODL & Head of EDI**	**March 2025**
6	4,5,6,8	Consider bystander training - Select existing EDI champions, Freedom to Speak up Guardians, and Inclusion Specialist for the Active Bystander Train-the-Trainer programme - to roll out across the Trust.	**Head of EDI**	**March 2025**
7	5,6	Implement the EOE Anti- racism Strategy and Action plan – to ensure we appropriately challenge racism within PAHT.	**Head of EDI**	**March 2025**
8	4,7	Deep dive and spot checks on non-mandatory training and CPD process and policy	**Head of OD**	**Ongoing 2025**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

5.3

Agenda item:	5.3
Presented by:	Denise Amoss – Associate Director of Learning & OD
Prepared by:	Arleen Brown Head of EDI & Nathaniel Williams – People information System Lead
Date prepared:	18 September 2024
Subject:	Workforce Disability Equality Standard (WDES) Annual Report 2024

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	The WDES report shows that there are disparities in the experience of disabled staff compared to non-disabled staff across most indicators. The main area of concern is the lack of information on ESR where staff have not completed their disability status. Each indicator highlights the areas of difference and the WDES action Plan seeks to address the outcome to improve the experience of disabled staff in the workforce.
Recommendation:	That this report is discussed and the WDES actions agreed.

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:	This is the first group to view this report as the Equality, diversity and Inclusion steering group could not meet the timeframe to view this report. PC.30.09.24
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 was introduced in April 2019 and it is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
Appendices:	

The Princess Alexandra Hospital NHS Trust

5.3

1.0 Introduction

The Workforce Disability Equality Standard (WDES) is a data collection framework which measures elements of disability equality in NHS organisations. Implementing the WDES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract. This is our 2024 PAHT data report of the Workforce Disability Equality Standard (WDES) indicators.

The WDES is designed around ten indicators, or measures, which compare disabled colleagues and their non-disabled counterparts. In PAHT 3% of our total workforce declared as disabled. The data on ESR relating to our disabled staff is incomplete and we will be making a concerted effort to encourage staff to update their information.

Four indicators of the WDES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for disabled and non-disabled staff. This includes the distribution of staff in each pay band, likelihood of being appointed following shortlisting, likelihood of entering a formal capability process, and representation in very senior leadership.

A further five indicators are populated with comparative data from the NHS National Staff Survey showing comparisons from 2021 to 2023 and includes: experiences of bullying, harassment, and abuse; discrimination, feeling pressure to come into work while unwell, and perceptions of fairness in career progression. The remaining metric refers to whether the voices of disabled staff are heard within the organisation. This will enable the Trust to adopt a 'learning organisation' approach and produce an action plan to build cultures of continuous improvement. This will be essential steps in helping to bring about a workplace that is free from discrimination and bias.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation.
- Advancing equality of opportunity between people from different protected characteristics
- Fostering good relations between people from different protected characteristics

2:0 Context

The data in the report is comparing 2022 - 2023 to 2023 2024. When reviewing the data, it is useful to understand the overall numbers of disabled staff and non-disabled staff in the workforce. As at 31 March 2024 disability profile of staff: disabled staff 3%; non-disabled staff 71%; not declared 10.6%; prefer not to answer 0.4%; and unspecified 15%.

Disability	Headcount – 31 March 2024
No	2959
Not declared	427
Prefer not to answer	18
Unspecified	632
Yes	130
Grand Total	4166

3.0 The Indicators

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. This data is provided in clusters by grouping Bands, due to the small numbers of staff declaring a disability.

Table 1 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	40	5%	9	4%	6	7%	0	0	2	22%
Non-Disabled	563	65%	164	66%	54	65%	30	83%	7	78%
Unknown	259	30%	77	31%	23	28%	6	17%	0	0%

Bands 1 to 8b and the Non- Executives show an over-representation of disabled staff in comparison to our 3% overall data. However, the percentages of unknown are high across Bands 1 to 8b. This indicates that we do not have a true picture of the number of disabled staff, across the non-clinical workforce.

Table 2 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	13	2%	42	3%	7	4%	1	4%
Non-Disabled	501	77%	1078	73%	108	64%	18	82%
Unknown	138	21%	360	24%	54	32%	3	14%

From Bands 5 to VSM disabled staff are represented in proportion. However, the percentages of unknown in Bands 1 to 8B are high, which means we may not have a true picture of the number of disabled staff, across the clinical workforce.

Table 3 identified the headcount and percentage of medical staff who are disabled and non- disabled

Medical staff	M&D consultants		M&D career grade		M&D trainee grade	
Disabled	2	1%	0	0%	8	4%
Non-Disabled	122	57%	135	80%	179	81%
Unknown	91	42%	34	20%	35	16%

The data on medical staff indicates that there is underrepresentation in M&D consultants and career grade. However disabled staff are represented in M&D Trainee Grade.

As with the previous analysis of the workforce in Table 1 & 2, the percentages of unknown are high. To show a true picture of the number of disabled staffs in the workforce, we need to focus on encouraging staff to complete their equality profiles in ESR by updating their personal data.

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.

Indicator	Disabled	non-Disabled	Unknown
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.	64	1273	415

Relative likelihood is 1.18 compared to last year (1.23). A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting. This indicator shows that we are improving in our efforts to employ disabled staff.

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.

Indicator	Disabled	non-Disabled	Unknown
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	2	3	4

Disabled staff are more likely to enter a formal capability process compared to non-disabled staff. However, as the numbers of unknown staff represent the largest number we need to view this with caution.

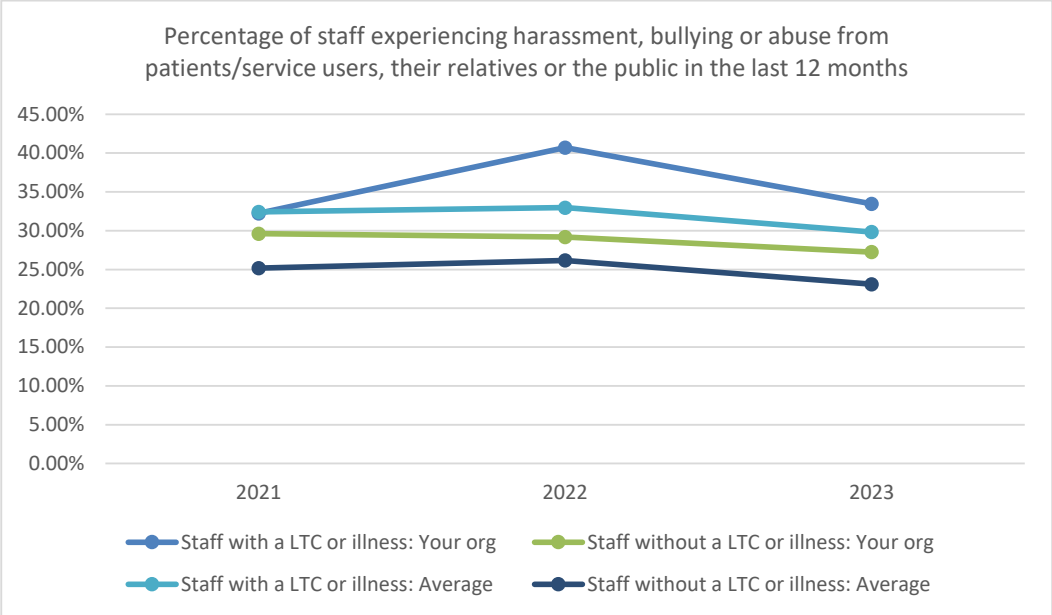
The introduction of robust monitoring would help us to understand why disabled staff are entering the formal capability, and also ensure that we are paying due regard to the Equality Duty. There is a requirement for us to ensure that all reasonable adjustments are considered when for staff who have a disability. In particular, where staff may have hidden disabilities or not declared long-term health conditions. We are confident that we are following all requirements dutifully.

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	9	82%	6	67%
Unknown	1	9%	3	33%

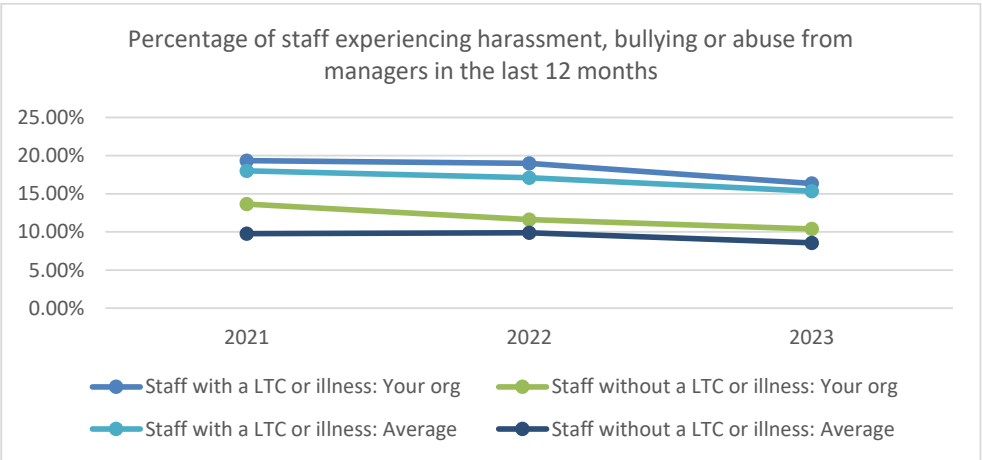
The data shows that disabled staff are represented by voting Board Membership. However, there is no representation at Executive Membership, but this could change once the unknown numbers have been declared. We will be encouraging our colleagues to complete their disability status.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months



The percentage of staff declaring a long-term condition (LTC) is the highest marker. However, it has fallen in 2022 from 40.71% compared to 2023 to 33.47%. There is a communications campaign being developed by our REACH (Race Equality and Cultural Heritage) network that will address all forms of verbal abuse to our staff. And although not directly linked with disabilities, it will support this work on improving the lives of all our staff.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

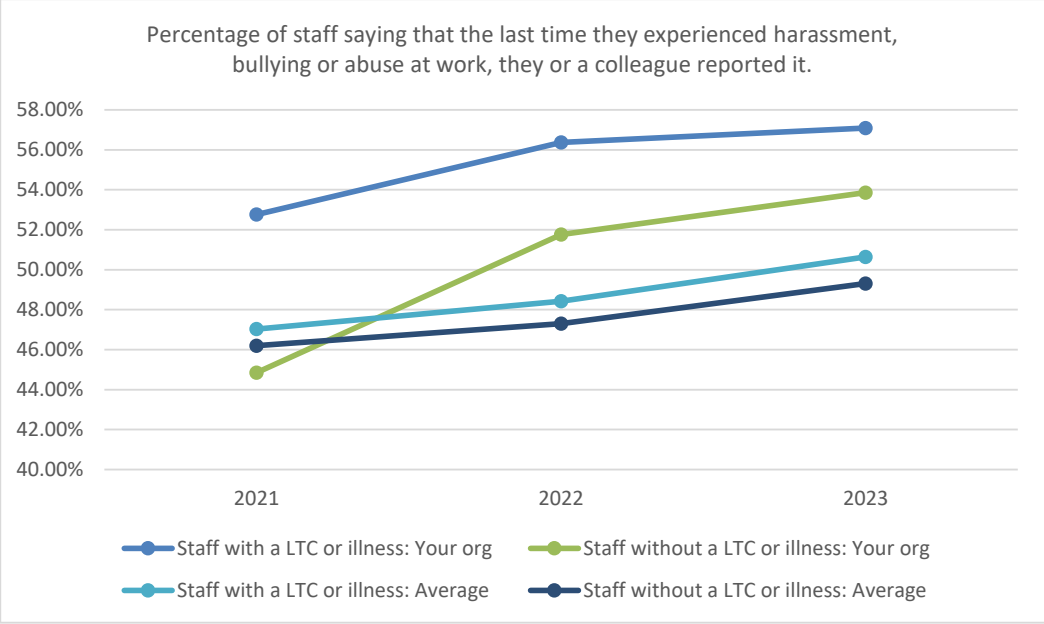


Indicator 7: Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

Both Indicators 6 & 7 show staff with a long-term condition (LTC) or illness compared to those without, disproportionately experience harassment, bullying or abuse from managers and colleagues in the Trust. This trend is consistently high over the 3 years, and we have been consistently higher than the national averages.

We will be taking effective measures to address the current situation to ensure all forms of abuse from managers and colleagues are addressed appropriately. We will review our policies and processes to support this work and offer appropriate training for line managers across the Trust in line with our legal duties to comply with the Equality Act 2010. We will also be reviewing and implementing appropriate actions from the EOE (East of England - Region) Anti-racism Strategy, to assist us in tackling all discriminatory behaviours based on this strategy framework.

Indicator 8: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



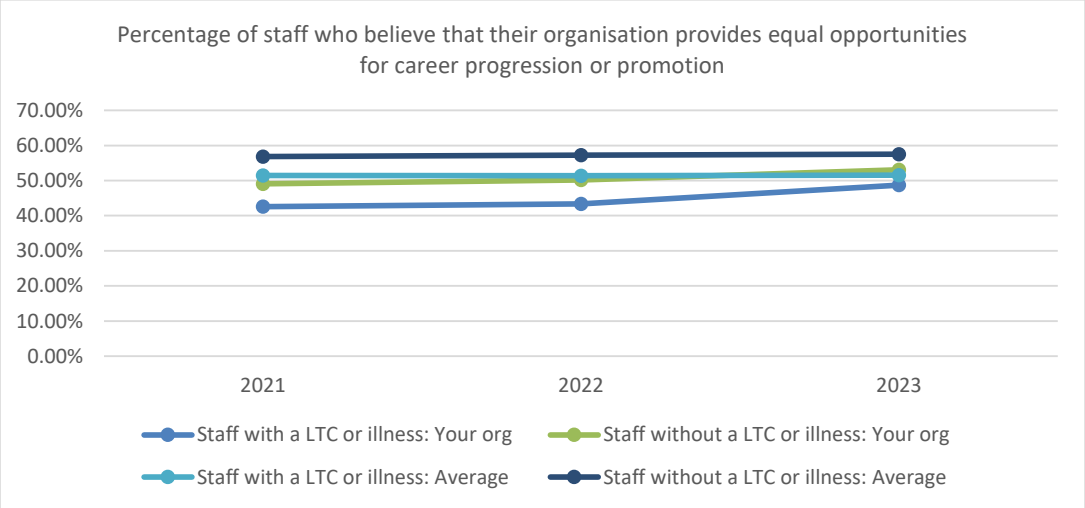
The percentage of staff with long-term condition (LTC) or illness reporting incidents of their experience, has been significantly higher in 2021. Although the gap between the two groups within our Trust have reduced in 2022 and 2023, the overall data for our Trust remains higher than national averages for both groups.

Further analysis of the data in the Staff Survey 2023 shows the following:

Staff Reporting incidents	2021	2022	2023
Staff who have an LTC	127	163	204
Staff who do not have an LTC	347	466	512

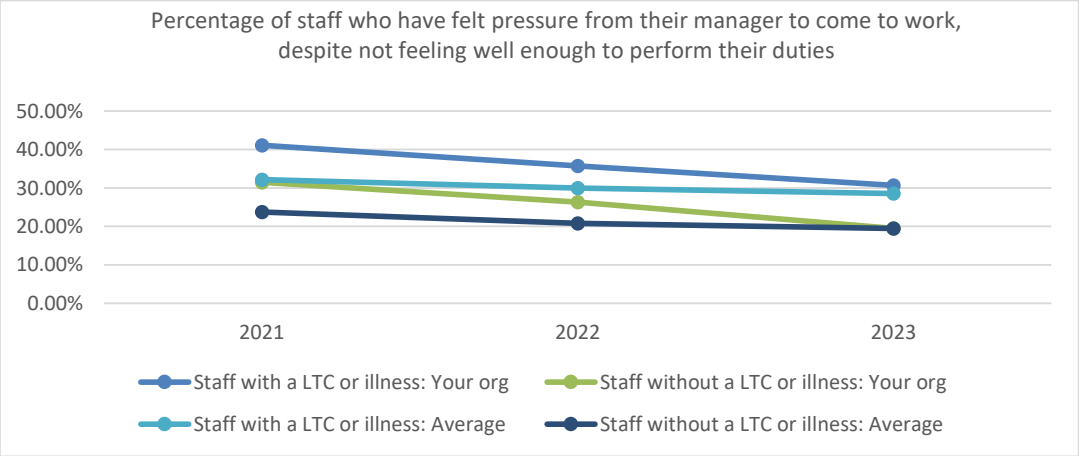
With the volume of incidents being reported we need to review the evidence and action taken to address staff concerns and their experience.

Indicator 9: Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.



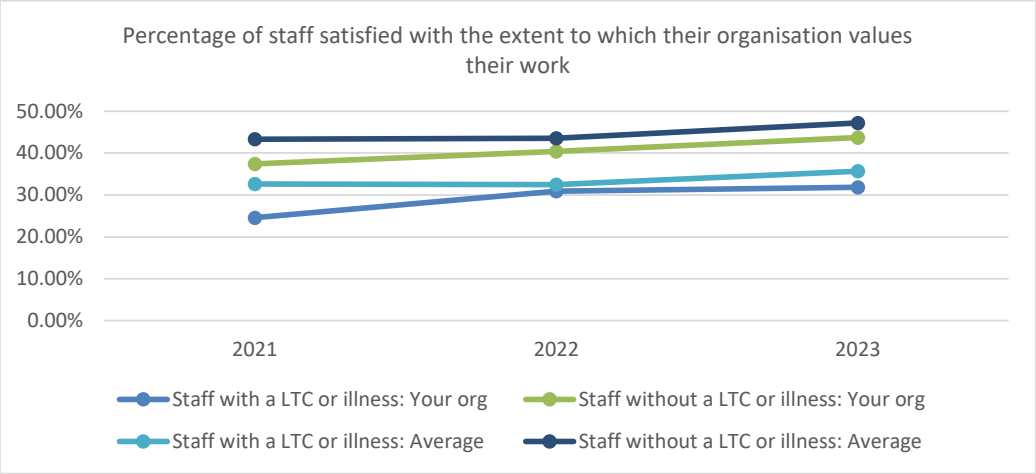
The percentage of staff within the Trust with an LTC or illness, is significantly lower than those without an LTC and the national average. This is a positive outcome for the Trust.

Indicator 10: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



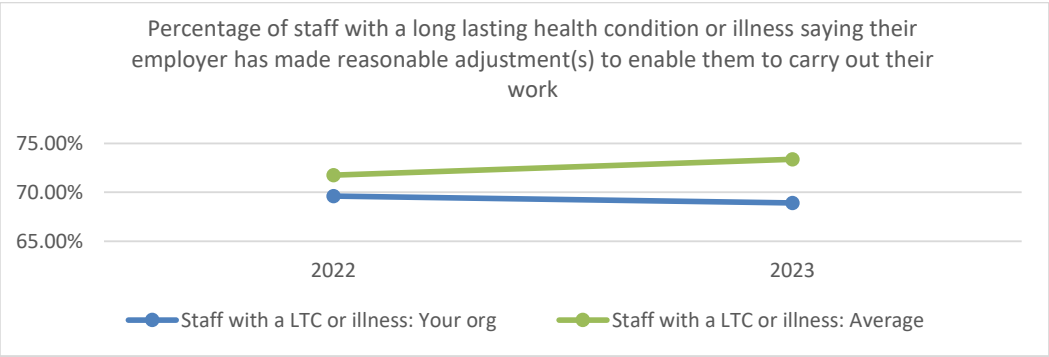
There has been a continued reduction for staff with an LTC. This is a positive outcome for staff with an LTC in our Trust. WE believe a big contributor to this fact is the comprehensive support the Trust has in terms of Occupational Health support and Here4You (psychological support).

Indicator 11: Percentage of staff satisfied with the extent to which their organisation values their work.



In relation to staff with LTC, whilst there is a slight increase in their satisfaction in the last year, their responses have been consistently below the national and Trust average.

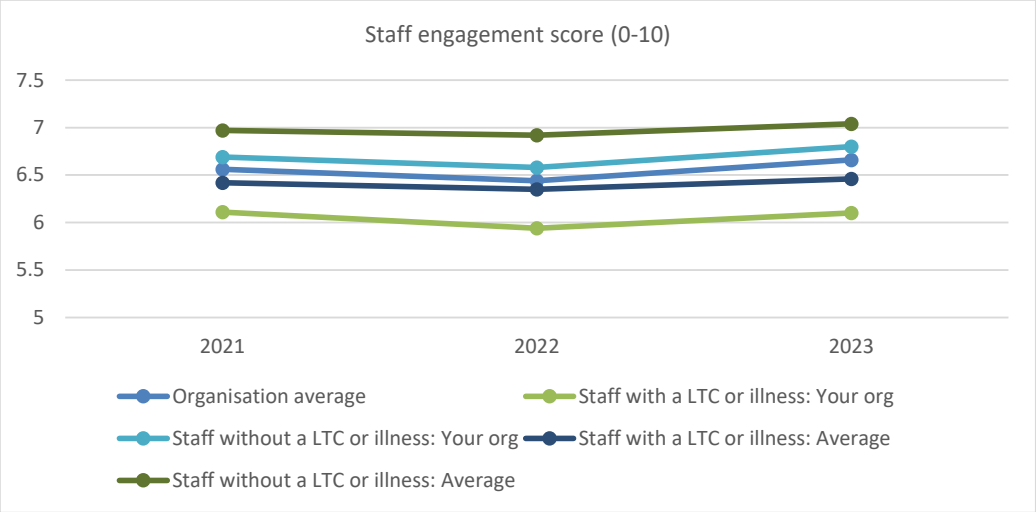
Indicator 12: Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



In 2022 the data shows that 69.6% of staff with a long-lasting health condition felt their employer made reasonable adjustments compared with the average of 71.66%. In 2023 this reduced to 68.92 whilst the national average went up to 73.38. We will need to continue to review on how we are promoting our legal responsibility to make reasonable adjustments and understand the reasons on why either manager are not acting on it or staff have the perceptions that this is not being done.

The Princess Alexandra Hospital NHS Trust

Indicator 13: Staff engagement score (0-10)



The data clearly shows that for all our staff we are below the national average. And for our disable staff we are even lower. We are gong back to the drawing board as we know engagement encompasses everything, from recruitment, to day-to-day up to the point of exit. We are developing a new People Strategy and one of the main point son that is to do everything with Equality, diversity and inclusion on the centre of it. This policy will be finalised in 2024 and we will be making a concerted effort to support this indicator to improve.

4:0 Actions for 2024/25:

It is important that we sign up to the recommended actions below and agree the timescales.

Ref	Indicator	Actions	Lead	Timescale
1	1,2,4,13	Debias recruitment NHS programme to be implemented in line with the NHS EDI High impact actions – attraction, recruitment and retention.	**Head of People – Recruitment and Retention**	**February 2025**
2	2,3,9,10, 12,13	EDI training covering disability awareness and our responsibilities in implementing reasonable adjustments in line with the Equality act, to be rolled out across the Trust.	**Head of EDI**	**September 2025**
3	5,6,7,8, 13	Review existing measures and strengthen our policies in regards to tackling bullying and harassment.	**Head of EDI & Head People - Business Partners**	**December 2024**
4	6,8,13	Set up a system for the annual monitoring and recording of all bullying, harassment and abuse incidents and complaints (staff on staff) with a record of outcomes.	**Head of People – Business Partners & Head of EDI**	**February 2025**
5	10,11,12, 13	Review the sickness policy to ensure it sufficiently supports staff and addresses reasonable adjustments	**Head of People – Business Partners**	**December 2024**
6	13	Through our membership with Business Disability Forum conduct an audit of policies, practices and processes to measure the impact and make improvements for staff with disabilities in the workplace	**Head of EDI**	**March 2025**
7	9	Deep dive and spot checks on non-mandatory training and CPD process and policy	**Head of OD & Head of EDI**	**Ongoing 2025**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

5.4

Agenda item:	5.2
Presented by:	Fay Gilder, Medical Director
Prepared by:	Jane Bryan, Medical Professional Standards Manager
Date prepared:	18/9/24
Subject / title:	Professional Standards Assurance

Purpose:	**Approval**	x	**Decision**		**Information**		**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The responsible officer in each designated body has a duty under the regulations to assure and improve their professional standards function for doctors with whom they hold a prescribed connection. The report gives a summary of Appraisal & Revalidation metrics and processes relating to 1st April 2023- 31st March 2024 for quality assurance This is revised framework and more detailed version of the previous AOA							
Recommendation:	This paper is presented 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		

Previously considered by:	PC.30.09.24
Risk / links with the BAF:	BAF Risk 1.1 (Clinical Outcomes)
Legislation, regulatory, equality, diversity and dignity implications:	In accordance with national guidance and GMC regulations, promoting good practice
Appendices:	Appraisal & Revalidation metrics and processes relating to 1st April 2023- 31st March 2024 for quality assurance

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board of Princess Alexandra Hospital Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None
Comments:	An appropriately trained licensed medical practitioner is a appointed as a responsible officer, which is the Medical Director Fay Gilder
Action for next year:	N/A

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.
Action for next year:	N/A

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	We continue to monitor and maintain accurate records of all practitioners with a prescribed connection as part of our appraisal and revalidation processes. Monthly Reports are received from the People Information team listing all starters and leavers and are actioned as appropriate
Action for next year:	N/A

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Review of medical appraisal policy to take place
Comments:	This policy has been reviewed, incorporating the new good medical practice guidance. The final version will go the next JLNC for comments and then sign off by Trust Policy group.
Action for next year:	N/A

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	N/A
Comments:	The last peer review was carried out with mid Essex hospitals in 2016 The last Higher Level Responsible Officer visit was carried out on 2018. The report from the HLRO visit was very positive, this confirmed that PAHT continued to deliver good practice in relation to Appraisal & Revalidation processes. A further peer review meeting is arranged for October 2024 partnering with West Herts Hospitals Trust
Action for next year:	To be confirmed - any actions that may arise following the peer review

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	N/A
Comments:	Robust processes are in place to support all fixed term/locum doctors in the same way as substantive doctors. Each new doctor joining the trust with a prescribed connection is invited to a 1-1 introduction meeting with the Medical Professional Standards team and progress is monitored and on- going support provided
Action for next year	N/A

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	N/A

Comments:	All doctors have an annual appraisal covering the whole scope of practice. They are required to complete sections to include complaints and information regarding significant events, clinical outcomes
Action for next year:	N/A

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	N/A
Comments:	N/A
Action for next year:	N/A

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	To review the policy and to incorporate the new good medical practice guidance in to policy and related processes
Comments:	Policy has been reviewed and updated in line with new good medical practice guide, and will be submitted to the JLNC for sign off
Action for next year:	N/A

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	N/A

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners with a prescribed connection We continue to monitor the number of required appraisees to ensure that there are sufficient numbers and equal distribution amongst appraisers have an equal amount, usually an average of 10 per annum but these are spread throughout the year
Action for next year:	N/A

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	N/A
Comments:	Medical Appraisers attend annual refresher training, internal bi- monthly appraisal forums, where they are briefed on changes to guidance developments and this gives an opportunity to raise queries, have open discussions, also they attend network events, development events, and webinars as appropriate. Last appraiser refresher training was held on 11th September 2024
Action for next year:	N/A

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	N/A
Comments:	We have a quality assurance process in place, this has been reviewed and detailed in our policy and reports to the People Committee
Action for next year:	To review the approach to quality assurance of the appraisals carried out by individual appraisers in order to support high quality appraisals.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	N/A
Comments:	The deputy RO completes a quality assurance form prior to confirm recommendation to the GMC. There is a quality assurance process in place for appraisal and revalidation recommendations The Deputy RO quality assures the last five appraisals of all doctors undergoing revalidation each year (approximately 20%) of the appraisees. Any themes are raised with appraisers at meetings. The Clarity system ensures that the minimum standard of quality assurance is met as the appraisals cannot be 'completed' otherwise. Anonymous feedback forms are completed by appraisee as part of the Trust process for individual appraisers and the processes carried out within the organisation. This is discussed at the Appraisers forums and reviewed where necessary
Action for next year:	N/A

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	N/A
Comments:	There are weekly meetings held with the Deputy R.O regarding doctors under notice. Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, in a timely manner There is a system in place to ensure that Revalidation recommendations made to the GMC are communicated to the doctor reasons. Ig a deferral is necessary or non-engagement, this is discussed with the doctor before the recommendation is submitted. In cases of deferral an action plan will be shared with the doctor clarifying timescales for completion of missing requirements

Action for next year:	N/A

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	N/A
Comments:	Clinical governance processes are in place in line with policies and national guidance There is a clinical effectiveness meeting bi –monthly that is chaired by the medical director and follows an annual work plan A half day each month is designated protected time for audit/clinical effectiveness/learning and are led by the Associate medical director for risk and quality Clinical effectiveness policies are in place relating to audit, the implementation of NICE guidance and new interventional procedures. These are available on the intranet and are currently in the process of being updated. There is a quality governance structure in place Trustwide audit meetings will be held quarterly (had been on hold) commencing October 2024 There is a divisional patient safety and quality board meeting that is held within each division and led by the divisional patient safety and quality lead
Action for next year:	Clinical audit process has been audited by PAH internal auditors (September 2024). The Trust will be implementing recommendations once agreed by Audit Committee within 12 months of the final report.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	N/A
	Effective systems are in place in line with national guidance and policies

	A grievance policy is in place An MHPS policy is in place with framework for dealing with conduct and concerns A complaints policy is in place A quarterly meeting is held with the GMC Employment Liaison advisor to monitor and discuss concerns, cases and outcomes
Action for next year:	N/A

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	N/A
Comments:	Relevant information is provided for doctors to include in their appraisals they have access to their mandatory training records via internal system, complaints data via Datix. Mandatory training records are available to each doctor via the Trust TIMS system
Action for next year:	To ensure that where any doctor is named in a Datix a discussion is held with an appropriate supervising individual (clinical lead or educational supervisor) and that discussion reflected upon in the annual appraisal

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	N/A
Comments:	Responding to concerns policy and processes are in place, in line with the national framework guidelines - NHS England The Trust has an MHPS policy which is used in these circumstances
Action for next year:	N/A

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as

aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	N/A
Comments:	The workforce committee is provided with data relating to any formal cases, which includes doctors. The Board is provided with statistical analysis annually included formal cases with analysis including protected characteristics
Action for next year:	N/A

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	N/A
Comments:	There is a robust process in place which includes sharing concerns and information effectively between Responsible Officers and timely completion and request of Medical Practitioner Information Transfer (MPIT) forms with other organisations
Action for next year:	N/A

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	N/A
Comments:	Safeguards are in place, processes for responding to concerns are carried out in line with the NHS England framework , There is a current responding to concerns policy as well as MHPS policy
Action for next year:	N/A

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	N/A
Comments:	Trust compliance with national reviews, reports and enquiries is reported to at the clinical compliance and clinical effectiveness committees. These are chaired by the Medical Director and all divisional leads in attendance. This committee reports to the Trust Quality and Safety committee. With the introduction of PSIRF – there are plans to host patient safety learning events to ensure all teams learn from incidents, inquests, complaints and claims
Action for next year:	

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	N/A
Comments:	We have policies in place that are applied consistently The HR team are involved in discussions where concerns are raised regarding professional standards for all health care staff
Action for next year:	N/A

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	N/A
Comments:	On-boarding of fixed term locums or substantively appointment follow all recruitment processes and cannot start until all checks are cleared. This includes obtaining references and police checks from previous host organisations and countries. Agency locums obtained via an agency as temporary staff can only be booked/appointed if their CV has been

	reviewed by a clinician and must include references, statutory training, DBS and qualification history
Action for next year:	N/A

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	N/A
Comments:	Leadership and Management competence is included in the appraisal for all people managers and a rating required. Executive team members must have an objective related to EDI in their annual appraisal The NHS Staff Survey results feed into an annual 'Feedback to Action' plan to address the People Promise elements which include EDI data. All new starters attend a forum to meet the Executives and Non-Executive Directors where culture is discussed and promoted as well as avenues for feedback such as Freedom to Speak up Guardians, raising risks, People team and support through Here for You. New consultants attend a Consultant development programme
Action for next year:	N/A

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	The PAHT Equality, Diversity and Inclusion Strategy 2023 -2030 was created last year.
Comments:	Our starting point is that everyone has the right to be treated fairly and equitability. This is true whether they are members of PAHT staff, those from partner organisations that we work with, community groups we seek to engage, or the patients, carers and families who our work is ultimately for. • We aim to maintain and promote a zero-tolerance approach to discrimination in any form, and we are committed to planned and consistent action to reduce and eliminate all practices that allow the continuation of discriminatory behaviours, policies or practices.

	• We value both visible and non-visible difference as a key part of a healthy organisation. We will strive to harness people's differences to create an environment in which people feel valued, staff talents are fully utilised, and we deliver against our strategy. • We know that celebrating individual difference, and bringing diverse teams together with disparate styles and talent, will foster innovation and continuous improvement for patients, service users, their families, carers and our people. • We recognise that equality and diversity are most effective and sustainable if we are inclusive, and all of our people are welcome, valued and able to contribute. • We want to build a reputation of being a values-based organisation that focuses on ensuring that all care delivered to patients by our people has a truly person-centred focus. • We are in no doubt that equality, diversity and inclusion is a collective responsibility, and the Trust Board has a duty to ensure this work is at the heart of our business. • We are asking all our people to adopt and embrace this strategy within their individual roles and workplaces. Our core goals and objectives are: 1. To Put EDI at the heart of our organisation 2. Recruit, retain develop and support a diverse workforce. 3. Improve patient experience and outcomes for people with protected characteristics and other communities who experience marginalisation. 4. Engage our diverse communities across our services and pathways.
Action for next year:	To implement our EDI strategy, we have developed our EDI Delivery Plan 2024 to 2026. This provides the details of the projects and activity we aim to achieve in our EDI strategy, the Equality Act 2010 and the NHS Standard contract

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	All staff are encouraged to speak up, this has been particularly encouraged with our medical staff over the past year. The Trust has a freedom to speak up guardian who is a doctor along with some resident

	doctors who are FTSU ambassadors. Listening events have been held for Dr's. Issues are listened to at both JLNC and RDC and acted upon and shared in order to improve processes
Action for next year:	N/A

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	All cases are discussed with PPAS/NHS Resolutions as well as the GMC ELA to ensure that staff are treated fairly. Each case is dealt with in line with Trust policies to ensure consistency.
Action for next year:	N/A

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and N/A disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	All doctors are treated equally in line with concerns and disciplinary policy- the level of parity is not assessed but process applied equally to all
Action for next year:	N/A

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	N/A
Comments:	Participating in peer reviews with partnering organisations Engaging with higher level responsible officer reviews with NHSE Attending RO Training network meetings GMC updates Accessing Responsible Officer hub –GMC website
Action for next year:	N/A

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 363	

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed 342	
Total number of appraisals approved missed 21	
Total number of unapproved missed 0	

fixed term doctors who left the organisation prior to appraisal due date 17	

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made 56	
Total number of late recommendations 0	
Total number of positive recommendations 37	
Total number of deferrals made 19	
Total number of non-engagement referrals 0	
Total number of doctors who did not revalidate 0	

2D – Governance

Total number of trained case investigators Approximately 15	
Total number of trained case managers Approximately 15	
Total number of new concerns registered	

9 MHPS	
Total number of concerns processes completed 5	
Longest duration of concerns process of those open on 31 March 24 months	
Median duration of concerns processes closed 2.6 months	
Total number of doctors excluded/suspended 1	
Total number of doctors referred to GMC 0	

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation 102 connected doctors	
Number of new employment checks completed before commencement of employment 102 connected doctors	

2F Organisational culture

Total number claims made to employment tribunals by doctors 0	
Number of these claims upheld 0	
Total number of appeals against the designated body's professional standards processes made by doctors 1 (appeal against a conduct sanction)	
Number of these appeals upheld 0	

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
All of last year's actions have been completed. With the new peer review process, a key action to review the quality assurance of the work done by appraisers has been identified and will be addressed by December 2024.
Actions still outstanding • To finalise and sign off the Appraisal and revalidation policy

Current issues
To review any policies require review and update, then seek ratification A review is required for quality assurance process for the work of the appraisers Upcoming peer review with Partnering Trust in October
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• To review the Responding to concerns policy • To implement the quality assurance process for Appraisers • To implement our EDI strategy, in relation to development our EDI Delivery Plan 2024 to 2026 • Any action that may arise following the peer group review in October
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Appraisal completion rates increased to 94 % MHPS training recently undertaken within organisation in September Inaugural New Consultant development programme held this year. It is an annual programme with the next commencing to held in September 2024 To implement our EDI strategy, we have developed our EDI Delivery Plan 2024 to 2026

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Princess Alexandra NHS Hospital Trust

Name:	
Role:	
Signed:	
Date:	

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**	**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26.09.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M5 Integrated Performance Report (IPR) 2.2 Report Against Operating Plan	Y	Y	N	Key M5 headlines were: **Ambulance Handover:** A positive improvement in ambulance handover within 15 minutes had been seen, the best for three years. **Non-admitted performance:** A gradual increase in performance was now being seen despite dips over the summer. This remained in common cause variation but was steadily improving. **Urgent Care:** Whilst performance remained behind trajectory, there were continued signs of improved experience for patients, supported by current HSMR/SHMI data. **Elective Care:** 65 week waits continued to reduce with 78 week waits now at zero and in line with the target. **Cancer:** Steady performance against the 28 and 62 day standards with current positions as expected.
2.3 BAF Risk 4.1 (Seasonal Pressures)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.
2.4 BAF Risk 1.3 (Recovery Programme)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**	**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26.09.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.5 BAF Risk 4.2 (ED 4 Hour Standard)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
2.6 BAF Risk 4.3 (Industrial Action)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
3.1 M5 Finance Update	Y	Y	N	In M5 the Trust had a plan of £2.3m deficit with delivery at £2.1m deficit. This was £0.2m favourable to the submitted plan for M5. Year to date (YTD) the plan was £9.2m deficit with an actual deficit of £10.6m hence £1.4m adverse to plan YTD. The closing cash balance at the end of August was £8.4m. There had been an expectation that cash support would be required during 2024/25, but the Trust was working with the ICB to ensure cash advances for pay awards were received. The Trust's 2024/25 financial plan would change through receipt of an additional £12.706m of non-recurrent system support funding.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**			**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.2 Productivity Review/Lord Darzi Report	Y	Y	N	The Healthcare Finance Management Association (HFMA) had recently hosted a conference looking at financial productivity and efficiency which included an analysis of the drivers behind the perceived drop in productivity within the NHS after the pandemic. Additionally, the Darzi report had been published which overlapped with many of those themes and considered how to develop thinking into the future. A comparison of the two analyses was provided along with a summary of the Darzi themes and how those related to PAHT.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**	**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26.09.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.3 Capital Update	Y	Y	N	The Trust's total funding for 24/25 was £39.9m and included within that was £25.6m of external funding for specific projects (i.e. New Hospital, CDC and EHR). Total capital expenditure for the year to date was £13.9m made up of £8.6m of actuals and £5.3m of committed expenditure. This included £0.9m for the EHR Training Centre. EHR forecasts for both revenue and capital were underway and given the scale of the project there remained a high risk of overspend. A review of forecasts for October would identify any expected slippage. PAF was asked to note the capital risk and whilst this was always present, with the risks around IFRS16 funding, EHR, CDC etc. the current risk to capital was high.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**			**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.4 Quarterly Procurement Update	Y	Y	N	Key headlines were: • Savings forecast for FY24/25 (£926k) above baseline target. • Overall operational performance continued to be strong. • Inventory Management System progressing well with opportunity for new Inventory Management System at ENHT. • Buying Team Transformation Programme Phase II commenced. • Continue to support the East of England Ambulance Service. • Enhanced partnership with NHS Supply Chain. • New Contract Management resource starting 1st October. • Staff Survey Action Plan initiated. • New Procurement Act February 2025 – significant changes impacting not just the Procurement Service with associated risks which are being mitigated by the central team.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**	**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26.09.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.5 PQP Report	Y	Y	N	Against a straight-line target, the PQP programme remained behind target by £2.3m YTD. However, in comparison to last year, delivery remained significantly higher (£5.39m in month 5 of 2024/25 compared to £4.14m in month 5 of 2023/24). In month 5, a total of £1.31m was delivered, with £5.39m delivered year to date, of which £721k has been delivered recurrently (13.4%). PAF noted the proportion of schemes that are non-recurrent. PWC have issued a draft report which will be shared with PAF on completion of the factual accuracy process.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**			**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26.09.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.6 Mid Year Establishment Review	Y	Y	N	A mid-year establishment review had been undertaken in March 2024 in line with national recommendations utilising the new methodology which detailed that a 14.80 WTE increase in the establishment was required. No changes to an establishment should take place until there were two consecutive reviews. The full year establishment review was due to be completed in September 2024, reporting to Board in January 2025. There were currently no recommended changes to the establishment. All nursing and quality indicators had been reviewed and there were no concerns identified. There continued to be a robust process for reviewing Trust wide staffing three times a day and redeploying staff where necessary. A full review of midwifery staffing would be completed by Birthrate Plus in Autumn 2024.
3.7 BAF Risk 5.1 (Finance – Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.

BOARD OF DIRECTORS:	**Trust Board (Private) – 3 October 2024**	**AGENDA ITEM:6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26.09.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.1 Community Diagnostic Centre (CDC)	Y	Y	N	An options appraisal for the CDC provider was discussed in detail. After careful consideration of the risks, costs and benefits for patients, PAF endorsed for Trust Board approval the option to move forward with a new provider, a direction of travel that was recommended by NHSE. Further assurance will be sought before the Board meeting on 3 October 2024.
4.2 Summary Report from Health & Safety Committee 4.3 Quarterly Health & Safety Update	Y	Y	N	A key focus of the papers was the work underway to comply with fire safety regulations in the hospital's basement. It was agreed a more detailed paper would be provided to the Committee detailing staff compliance with fire safety training. The good news that an Associate Director of Estates & Facilities had been appointed was noted and welcomed.
4.4 BAF Risk 3.1 (Estate & Infrastructure)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
5.1 EPRR Annual Report	Y	Y	N	PAF: • Considered and approved the core standards submission. • Was assured that the Business Continuity Programme/ BCMS was now a work in progress. • Provided full support to the MCMS, Major Incident Preparedness including testing, training and equipment.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

Agenda item:	6.2
Presented by:	Tom Burton, DoF
Prepared by:	Beth Potton, DDoF
Date prepared:	17 September 2024
Subject / title:	Month 5 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	In M5 the Trust had a plan of £2.3m deficit with delivery at £2.1m deficit. This is £0.2m favourable to the submitted plan for M5. Year to date (YTD) the plan was £9.2m deficit with an actual deficit of £10.6m hence £1.4m adverse to plan YTD. The closing cash balance at the end of August is £8.4m. There is an expectation that cash support will be required during 2024/25, but the Trust are working with the ICB to ensure cash advances for pay awards are received.								
Recommendation:	The Board is asked to note the month 5 financial results and the high-level forecast outturn position.								
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:	Paper to EMT, Paper to LMT, Paper to PAF
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

- In M5 the Trust had a plan of £2.3m deficit with delivery at £2.1m deficit. This is £0.2m favourable to the submitted plan for M5 of 2024/25. Year to date (YTD) the plan was £9.2m deficit with an actual deficit of £10.6m hence £1.4m adverse to plan YTD. See table 1 below.

Table 1: M5 24/25 position

	FY Budget	Aug-24			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS & non-NHS Income	369.3	30.5	31.7	1.2	151.3	155.9	4.6
Income Total	369.3	30.5	31.7	1.2	151.3	155.9	4.6
Pay							
Substantive	(241.9)	(20.3)	(18.6)	1.7	(101.6)	(92.0)	9.6
Bank	(7.9)	(1.0)	(3.3)	(2.3)	(3.3)	(13.3)	(10.0)
Agency	(6.9)	(0.9)	(0.7)	0.2	(2.9)	(4.6)	(1.7)
Pay Total	(256.7)	(22.2)	(22.5)	(0.4)	(107.9)	(109.9)	(2.1)
Non-Pay							
Drugs & Medical Gases	(29.7)	(2.4)	(2.4)	0.0	(12.2)	(12.7)	(0.5)
Supplies & Services - Clinical	(8.9)	(0.7)	(1.2)	(0.5)	(3.7)	(5.1)	(1.5)
Supplies & Services - General	(4.9)	(0.4)	(0.5)	(0.0)	(2.0)	(2.3)	(0.2)
All other non pay costs	(65.5)	(5.3)	(5.5)	(0.3)	(25.8)	(28.4)	(2.5)
Non-Pay Total	(108.9)	(8.9)	(9.6)	(0.8)	(43.8)	(48.5)	(4.7)
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.3)	0.1	(6.8)	(6.3)	0.5
PDC & Interest	(5.2)	(0.4)	(0.4)	0.0	(2.1)	(1.8)	0.3
Financing & Depn Total	(21.7)	(1.8)	(1.7)	0.1	(9.0)	(8.2)	0.8
Total	(18.0)	(2.3)	(2.1)	0.2	(9.3)	(10.7)	(1.4)
Technical Adjustment	0.3	0.0	0.0	0.0	0.1	0.1	0.0
Grand Total	(17.7)	(2.3)	(2.1)	0.2	(9.2)	(10.6)	(1.4)

- Temporary staffing continues to be a key driver of the year-to-date expenditure position with costs exceeding vacancies by £2.1m YTD. However, there has been a significant improvement in the agency expenditure with M5 bringing the agency expenditure as a percentage of the total pay bill to 3.0% in month which is below the NHSE target of 3.2% (excluding EHR training costs).

- Temporary staffing remains a key focus area and forms a significant element of the PQP requirement for 2024/25. The implementation of Triple Lock, work to reduce agency rates and ensuring Executive Vacancy Control Panel (EVCP) were sighted on all agency requests has had a significant impact on the overall agency spend.

- Staffing levels including temporary staffing continue to exceed the established WTE's. Whilst there is a reduction in agency, overall temporary staffing is not reducing sufficiently to offset the increase in substantive staff. This remains a key focus area for PRM's, PQP meeting and EVCP with specific focus moving to bank staffing.

- Industrial action has impacted the pay costs by £0.5m in the YTD position, there is an expectation that these costs will be funded, but until confirmed by NHSE no income has been assumed.

- Non pay pressures have emerged including electricity and business rates relating to the prior year and clinical consumables relating to the current year. Each Division with significant non pay pressures are undertaking a review and through PQP meetings recovery actions have been requested and will be tracked.

- The Trust had a PQP target of £1.5m in M5 of which £1.3m was delivered. Year to date the plan is £7.7m with actual delivery of £5.4m. The under delivery against the PQP target is one of the main contributors to the Trust adverse position YTD but it must be noted that the plan is phased equally across the year which will have impacted on the performance to date as schemes get established.

- Elective Recovery Income has performed below plan (£0.6m) including the additional income stretch. Work continues with the Divisions to review income monthly and identify further opportunities for activity recording and capture.

- The closing cash balance at the end of August is £8.4m. There is an expectation that cash support will be required during 2024/25, but the Trust are working with the ICB to ensure cash advances for pay awards are received.

- Capital spend at M5 was £8.6m against a plan for 2024/25 of £39.9m. The plan assumed expenditure of £14.7m so M5 is behind plan although the nature of the programme would not be expected to be phased evenly across the year.

The Princess Alexandra Hospital NHS Trust

August - Month 05

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a deficit of £2.1m in month 5 of 24/25 against a planned deficit of £2.3m, therefore a £0.2m favourable variance to plan. Year to date the planned deficit was £9.2m with actual performance delivering £10.6m deficit creating an adverse movement to the plan year to date of £1.4m.

- The favourable position in month is predominantly due to the recognition of £0.5m relating to coding and capture of new activities. We also continue to recognise the system support funding which is planned to be recognised in M11 but we are recognising in twelfths. This improves the in month position by £0.5m and YTD position by £2.3m, of which we will see the adverse impact on our variance in M11 where the plan remains. It will not affect our overall year end position but does make us look artificially better until we reach M11. Bringing forward the system support funding allows time to implement recovery actions.

- In month 5, the Trust has reported a favourable income position of £1.2m against plan driven by:
    - £0.5m system support
    - £0.5m coding and capture of new activities
    - £0.2m income above plan on pass through drugs (offset within expenditure)

- The activity to be delivered through Vanguard commenced at the end of August. The Trust has not achieved the planned income in month to the levels expected but has also not incurred the fully budgeted expenditure value, we expect this to ramp up in the coming months.

- The Trust had a PQP target of £1.5m in month 5 of which £1.3m was delivered, the YTD position shows delivery of £5.4m versus a plan of £7.7m YTD. Despite the £5.3m delivery YTD, overspends elsewhere have meant the impact on the financial position has not been seen to the full extent of the savings delivered and as a result we are behind plan overall financially. Divisions have been requested to present full recovery plans at the PQP meetings taking place the week commencing 16th September. PQP is phased equally across the year which will have impacted on the performance in the first quarter, as schemes get established and budgets are received; note other Trusts have more of a 'hockey stick' plan.

- Areas of overspend contributing to the underlying deficit in month (once accounting for the system support income), despite some PQP delivery, include high outsourcing and clinical consumable costs within CSS. The pay position remains in excess of budget however agency costs are reducing. In month we saw the payment of the HCSW banding uplift which has been fully provided for in 23/24, therefore bearing no financial impact on the in month position, however in addition to these arrears there was an unprecedented level of medical arrears pay across multiple divisions (£255k in excess of the monthly average).

Summary financial results

The Princess Alexandra Hospital NHS Trust

	FY Budget £'m	Aug-24 Budget £'m	Aug-24 Actual £'m	Aug-24 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	369.3	30.5	31.7	1.2	151.3	155.9	4.6
Income Total	**369.3**	**30.5**	**31.7**	**1.2**	**151.3**	**155.9**	**4.6**
Pay							
Substantive	(241.9)	(20.3)	(18.6)	1.7	(101.6)	(92.0)	9.6
Bank	(7.9)	(1.0)	(3.3)	(2.3)	(3.3)	(13.3)	(10.0)
Agency	(6.9)	(0.9)	(0.7)	0.2	(2.9)	(4.6)	(1.7)
Pay Total	**(256.7)**	**(22.2)**	**(22.5)**	**(0.4)**	**(107.9)**	**(109.9)**	**(2.1)**
Non-Pay							
Drugs & Medical Gases	(29.7)	(2.4)	(2.4)	0.0	(12.2)	(12.7)	(0.5)
Supplies & Services - Clinical	(8.9)	(0.7)	(1.2)	(0.5)	(3.7)	(5.1)	(1.5)
Supplies & Services - General	(4.9)	(0.4)	(0.5)	(0.0)	(2.0)	(2.3)	(0.2)
All other non pay costs	(65.5)	(5.3)	(5.5)	(0.3)	(25.8)	(28.4)	(2.5)
Non-Pay Total	**(108.9)**	**(8.9)**	**(9.6)**	**(0.8)**	**(43.8)**	**(48.5)**	**(4.7)**
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.3)	0.1	(6.8)	(6.3)	0.5
PDC & Interest	(5.2)	(0.4)	(0.4)	0.0	(2.1)	(1.8)	0.3
Financing & Depn Total	**(21.7)**	**(1.8)**	**(1.7)**	**0.1**	**(9.0)**	**(8.2)**	**0.8**
Total	**(18.0)**	**(2.3)**	**(2.1)**	**0.2**	**(9.3)**	**(10.7)**	**(1.4)**
Technical Adjustment	0.3	0.0	0.0	0.0	0.1	0.1	0.0
Grand Total	**(17.7)**	**(2.3)**	**(2.1)**	**0.2**	**(9.2)**	**(10.6)**	**(1.4)**

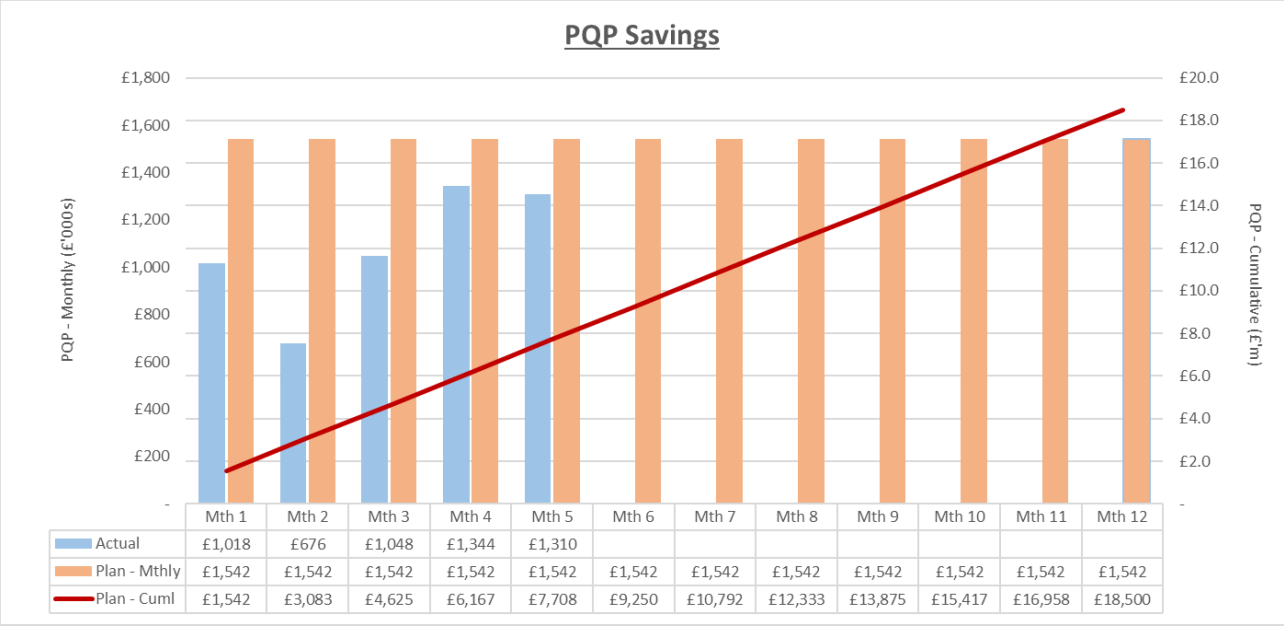
PQP

The Princess Alexandra Hospital NHS Trust

The Trust PQP plan for the year is £18.5m. The plan has been phased in twelfths to ensure continued focus on delivery of the £18.5m by the year end.

In month 5, the Trust delivered £1.3m PQP against a plan of £1.5m. Whilst some divisions are delivering PQP this financial year (Surgery, Corporate, Estates & Facilities and CHAWS) there are some divisions that are not delivering, and in addition to this have exceeded their budgets. YTD this has meant that the impact of the PQP delivery on the financial position is not the extent of the £5.4m delivery YTD, though we are endeavouring to still record over delivery in Divisions where it occurs.

Currently £12.9m of schemes have financial values against them. Work is continuing to assign a financial value to the schemes that have been identified as well as continued progress on identification of the schemes that will deliver the full extent of the plan.



	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12
Actual	£1,018	£676	£1,048	£1,344	£1,310							
Plan - Mthly	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542
Plan - Cuml	£1,542	£3,083	£4,625	£6,167	£7,708	£9,250	£10,792	£12,333	£13,875	£15,417	£16,958	£18,500

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

Statement of Financial Position

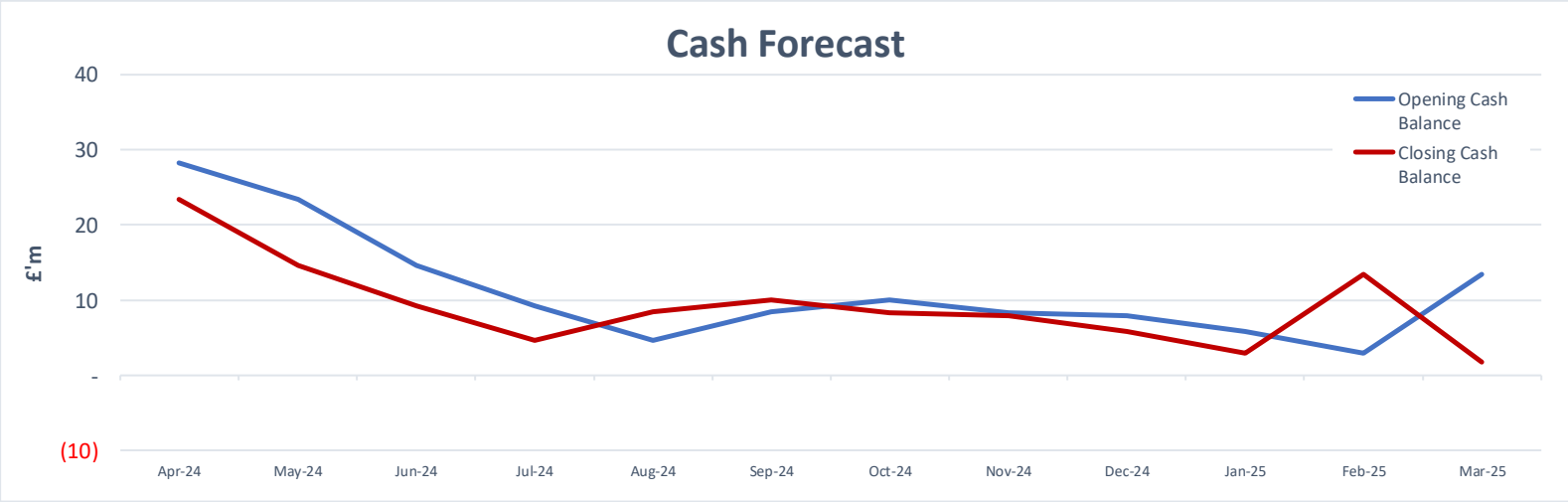
Statement of Financial Position	Mar-24 £'m	Jul-24 £'m	Aug-24 £'m	Movement In Month £'m	Movement YTD £'m
Non-current assets					
Property, plant & equipment	180.6	179.4	178.7	(0.7)	(1.9)
Right of use assets	41.7	40.9	40.7	(0.2)	(1.0)
Intangible assets	20.1	23.2	23.9	0.7	3.7
Trade & other receivables	1.1	1.1	1.1	0.0	0.0
Non-current assets	**243.5**	**244.5**	**244.3**	**(0.2)**	**0.9**
Current assets					
Inventories	5.0	5.0	5.0	0.0	0.0
Trade & other receivables	15.0	22.2	20.7	(1.6)	5.7
Cash & cash equivalents	28.2	4.7	8.4	3.7	(19.8)
Current assets	**48.2**	**32.0**	**34.1**	**2.1**	**(14.1)**
Total assets	**291.7**	**276.5**	**278.4**	**1.9**	**(13.3)**
Current liabilities					
Trade & other payables	(51.5)	(47.2)	(51.5)	(4.3)	(0.1)
Provisions	(0.9)	(0.9)	(0.9)	0.0	0.0
Borrowings	(2.4)	(2.3)	(2.2)	0.1	0.2
Current liabilities	**(54.8)**	**(50.4)**	**(54.7)**	**(4.3)**	**0.1**
Net current assets/ (liabilities)	**(6.6)**	**(18.5)**	**(20.6)**	**(2.1)**	**(14.0)**
Total assets less current liabilities	**236.9**	**226.0**	**223.7**	**(2.3)**	**(13.2)**
Non-current liabilities					
Trade & other payables	0.0	0.0	0.0	0.0	0.0
Provisions	(0.9)	(0.9)	(0.9)	0.0	0.1
Borrowings	(39.2)	(38.4)	(38.2)	0.2	1.0
Total non-current liabilities	**(40.2)**	**(39.3)**	**(39.1)**	**0.2**	**1.0**
Total assets employed	**196.8**	**186.7**	**184.6**	**(2.1)**	**(12.2)**
Financed by:					
Public dividend capital	356.3	356.3	356.3	0.0	0.0
Income and expenditure reserve	(172.4)	(181.0)	(183.1)	(2.1)	(10.7)
Revaluation reserve	12.8	11.4	11.4	0.0	(1.4)
Total taxpayers' equity	**196.8**	**186.7**	**184.6**	**(2.1)**	**(12.2)**

- **Non-Current Assets PPE has decreased by £0.7m and is due to current depreciation. A decrease of £0.2m in ROU is mainly due to in month depreciation. An increase of £0.7m in intangible assets represents an additions of £0.8m to the development expenditures and amortisation of (£0.1m).**
- **Trade and Other Receivables has decreased by £1.6m and this is mainly due to reversal of accrued income of £1.8m to NHS HWE ICB for system support against accrued Income of £0.2m for patient Income A&G YTD.**
- **Cash balances has increased by £3.7m and this is driven by receipt of £5.6m from the NHS HWE ICB for system support against payments of £0.7m to Actaccom Ltd, £0.4m to Softcat Plc, £0.3m to Alliance Healthcare, £0.3m to Roche Products, and £0.2m to Intuitive Surgical.**
- **Trade and Other Payables has increased by £4.3m and is mainly related to deferred income accrual to NHS HWE ICB of £3.2m for System support & £1.2m cash advance against reversal of deferred income of £0.1m for Cancer Alliance.**
- **Borrowings decrease representing payment of liability falling due & post audit adjustment in ROU assets, following revaluation of St Margaret's Hospital.**

Cashflow

The Princess Alexandra Hospital NHS Trust

	<----------Actual---------->					<----------Forecast---------->						
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Opening Cash Balance	28,242	23,358	14,653	9,261	4,701	8,401	9,983	8,357	7,902	5,823	2,982	13,497
Closing Cash Balance	23,358	14,653	9,261	4,701	8,401	9,983	8,357	7,902	5,823	2,982	13,497	1,829



An increase of £3.7m is due to receipt of £5.6m from NHS HWE ICB for system support. This is against payment of £0.7m to Actaccom Ltd, £0.4m to Softcat Plc, £0.3m to Alliance Healthcare, £0.3m to Roche Products, & £0.2m to Intuitive Surgical.

The Trust are working with the ICB to ensure sufficient cash to cover pay awards in October and November.

Capital Analysis 24/25

The Princess Alexandra Hospital NHS Trust

	Month 5			YTD			Forecast		
	In-Month Forecast £'m	In-month Actual £'m	Variance £'m	Forecast £'m	Actual £'m	Variance £'m	Plan & profile £'m	FY Forecast	Variance £'m
Internally Funded Schemes									
Estates									
Dispensing Robot (Pharmacy)	83	-	83	417	39	378	1,000	1,000	-
New UPS/IPS to critical areas - Phase 1 Main theatres/ED/ITU/HDU	130	(23)	153	650	49	601	1,559	1,559	-
Estates	21	96	(75)	104	419	(315)	250	250	-
Estates BLM									
Drainage - Internal and external works	10	(5)	15	52	16	36	125	125	-
Sitewide building management system upgrade installation works	29	-	29	146	4	142	350	350	-
Statutory Fire	50	(8)	58	250	(13)	263	600	600	-
HVAC	63	97	(35)	313	157	156	750	750	-
Environmental - localised refurbishment works & asbestos removal	42	63	(21)	208	157	51	500	500	-
EHR, ICT & Info									
ICT & Information Schemes									
EHR	645	-	645	3,224	-	3,224	7,738	7,738	-
Corporate									
Corporate schemes	1	-	1	7	30	(23)	17	17	-
Medical Equipment									
Medical Equipment (Surgery)	8	-	8	38	14	24	90	90	-
Medical Equipment (CSS)	13	76	(63)	67	76	(9)	160	160	-
23-24 schemes	-	(302)	302	-	1,683	(1,683)	-	-	-
Medical Equipment (Medicine & UEC)	5	-	5	24	-	24	58	58	-
Medical Equipment (CHAWS)	8	-	8	42	-	42	100	100	-
CRL to be allocated to plan	-		-	-	-	-	-	900	(900)
YTD Total	**1,108**	**(6)**	**1,114**	**5,540**	**2,631**	**2,909**	**13,297**	**14,197**	**(900)**
Externally Funded Schemes									
New Hospital (CPO)	206	(50)	256	1,029	37	992	2,470	2,470	-
New Hospital (OBC)	42	96	(54)	208	399	(191)	500	500	-
New Hospital Enabling Works	42	-	42	212	-	212	508	508	-
CDC	788	183	606	3,942	922	3,020	9,460	9,460	-
CDC Substation	167	-	167	167	-	167	2,000	2,000	-
EHR	570	845	(275)	2,848	4,357	(1,509)	6,836	6,836	-
ICS East Imaging	28	29	(1)	140	156	(16)	335	335	-
UTC Works	583	-		583	102	481	3,500	3,500	-
YTD spend on External Schemes	**2,426**	**1,103**	**739**	**9,129**	**5,973**	**3,156**	**25,609**	**25,609**	**-**
Total - Internal and External	**3,534**	**1,097**	**1,854**	**14,669**	**8,604**	**6,065**	**38,906**	**39,806**	**(900)**

The Princess Alexandra Hospital NHS Trust

Trust Board Public – 3 October 2024

6.3

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Antoinette Woodhouse – Head of Information
Date prepared:	26th September 2024
Subject / title:	M5 Integrated Performance Report (IPR)

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

Patients		
Patients	**Pressure Ulcers**	Increase in hospital acquired grade 3 and mucosal pressure ulcers in month. Pressure Ulcer prevention strategy in place and good oversight provided through improving essential care groups.
	Compliments	Decline in compliments logged onto our reporting system however they continue to be received within the organisation. In the interim, divisional based teams will be logging for their areas.
People		
People	**Appraisals**	Further conversations with line managers to understand if compliance is due to forms not being completed or appraisals not being carried out.
	Statutory and Mandatory Training	Further investigation being undertaken to understand why people are not logging into TiMS, however compliance is still steadily improving
	Vacancies	The Trust's vacancy rate has been steadily declinCSS, Surgery, CHAWS, E&F and Finance divisions are all carrying vacancies over the target rate of 9.0% whilst UEC and Medicine have vacancies of 7.6% & 6.3% respectively. The trust is under below the vacancy rate of 9%ng with an increase in April due to establishment review. The team is working hard to support the divisions in order to hire substantively and stop the reliance on temporary staffing.
	Sickness Absence	In month sickness is 3.86%, this is split by short term sickness at 2.20% and long term sickness at 1.66%. Hot spot areas are being identified by the people team and working with divisions to develop actions to help to support these areas.
Performance		
Performance	**Referral to Treatment**	The 18 week performance has remained steady at 50%, with the number of patients waiting more than 78 weeks decreasing to 5 from 24 and the patients waiting longer than 65 weeks also decreasing. Speciality trajectories to achieve the target of no patient waiting longer than 65 weeks at 30th September are in place with actions such as increased capacity & transfer of patients to the independent sector in place.
	Cancer standards	The 28 day diagnosis standard has maintained above the 75% standard for another month and the 62 day performance remains stable but significantly under the standard of 85%. The tumour sites have individual recovery action plans to reduce the backlog further and return to 62 day performance.
	Urgent Care	Performance to achieve 78% against the 4-hour standard is behind plan however this month shows 7 data points of improvement. Improvement programmes in place to address this. Ambulance handovers less than 15 minutes at second highest proportion dated on chart (October 2022).
	Diagnostics	Diagnostics performed within 6 weeks of referral has improved by just under 1% this month. There are concerns in ongoing demand in Echoes, Audiology and Cystoscopy and capacity pressures. Both modalities have a recovery plan in place.
Pounds		
Pounds	**Income\Activity**	The Trust put in Elective Recovery Fund weighted value of 112.65% of 2019/20 baseline weighted value. The performance to August is below planned levels. The focus is on activity capture and recording where there is an activity working group bringing together coding, data quality, income and contracts and the divisions to capture and record correctly the activity we do.
	Capital Spend	The Trust total Capital resourcing for 2024/25 is £39.9m, this includes external PDC including the new hospital project, CDC, EHR, and others. The capital plan was approved at the May 2024 CWG meeting, and also approved at Trust Board due to the amounts involved.
	Surplus\Deficit	The Trust reported a deficit of £2.1m in month 5 against a plan of £2.3m deficit. The YTD position is now a deficit of £10.6m against a planned deficit of £9.2m. Whilst some PQP has been delivered in a couple of divisions, other divisions have not delivered their PQP and have spent in excess of their budget which has outweighed the delivery elsewhere. In the month and YTD position includes system support funding which is planned for in M11, but being recognised in twelfths, therefore artificially improving the YTD position.
	Cost Improvement Plan	The 2024/25 PQP target is £18.5m. The YTD PQP plan is £7.7m, of which £5.4m has been delivered, this is predominantly within Corporate, Surgery, Estates and Facilities and some within CHAWS.
	Cash	The Trust's cash balance is £8.4m. The cash reserves which were boosted due to the national COVID support received by the Trust have started reducing as we continue to run with a deficit. The focus is now on reducing the level of unpaid invoices and maintaining the Trust's improved 30 days BPPC performance.
Places		
Places	**Facililties**	Automation of some processes ie. waste data from HK instead of kitchen. Initiation of PLACE. EHO visit - met with EHO to provide more assurance in management following last inspection in March 2024. They met our
	Capital Spend	Completion of external UEC funding - SRO ful brief awaited from options. Completion of BLM capital funded schemes across site with Estates team. Relocation of ITU Critical Care
	Estates	P1 and P2 - MiCAD system is showing that P1 tasks were not attended within KPI requirements and P2 with a low compliance, this is due to the jobs being put on system retrospectively and the lag in finishing of job. New Strategic Head of Estates in post and Director of Estates and Facilities at the Lister Hospital working with the department 2 days per week in readiness for the new Deputy Director to be in post.

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.26.09.24 and QSC.27.09.24
Risk / links with the BAF:	Links to all BAF risks.
Legislation, regulatory, equality, diversity and	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:	M5 IPR

6.3

Integrated Performance Report:

August 2024

As at 26/09/2024

Executive Summary

The Princess Alexandra Hospital NHS Trust

Patients		
Patients	**Compliments**	Decline in compliments logged onto our reporting system however they continue to be received within the organisation. In the interim, divisional based teams will be logging for their areas.
	Pressure Ulcers	Increase in hospital acquired grade 3 and mucosal pressure ulcers in month. Pressure Ulcer prevention strategy in place and good oversight provided through improving essential care groups.
Pounds		
Pounds	**Income/Activity**	The Trust put in Elective Recovery Fund weighted value of 112.65% of 2019/20 baseline weighted value. The performance to August is below planned levels. The focus is on activity capture and recording where there is an activity working group bringing together coding, data quality, income and contracts and the divisions to capture and record correctly the activity we do.
	Capital Spend	The Trust total Capital resourcing for 2024/25 is £39.9m, this includes external PDC including the new hospital project, CDC, EHR, and others. The capital plan was approved at the May 2024 CWG meeting, and also approved at Trust Board due to the amounts involved.
	Surplus \ Deficit	The Trust reported a deficit of £2.1m in month 5 against a plan of £2.3m deficit. The YTD position is now a deficit of £10.6m against a planned deficit of £9.2m. Whilst some PQP has been delivered in a couple of divisions, other divisions have not delivered their PQP and have spent in excess of their budget which has outweighed the delivery elsewhere. In the month and YTD position includes system support funding which is planned for in M11, but being recognised in twelfths, therefore artificially improving the YTD position.
	Cost Improvement Plan	The 2024/25 PQP target is £18.5m. The YTD PQP plan is £7.7m, of which £5.4m has been delivered, this is predominantly within Corporate, Surgery, Estates and Facilities and some within CHAWS.
	Cash	The Trust's cash balance is £8.4m. The cash reserves which were boosted due to the national COVID support received by the Trust have started reducing as we continue to run with a deficit. The focus is now on reducing the level of unpaid invoices and maintaining the Trust's improved 30 days BPPC performance.
Places		
Places	**Facilities**	Automation of some processes ie. waste data from HK instead of kitchen. Initiation of PLACE. EHO visit - met with EHO to provide more assurance in management following last inspection in March 2024.
	Capital Spend	Completion of external UEC funding - SRO ful brief awaited from options. Completion of BLM capital funded schemes across site with Estates team. Relocation of ITU Critical Care.

People		
People	**Vacancies**	CSS, Surgery, CHAWS, E&F and Finance divisions are all carrying vacancies over the target rate of 9.0% whilst UEC and Medicine have vacancies of 7.6% & 6.3% respectively. The trust is under below the vacancy rate of 9%
	Statutory and Mandatory Training	Further investigation being undertaken to understand why people are not logging into TiMS, however compliance is still steadily improving.
	Appraisals	Further conversations with line managers to understand if compliance is due to forms not being completed or appraisals not being carried out.
	Sickness Absence	In month sickness is 3.86%, this is split by short term sickness at 2.20% and long term sickness at 1.66%. Hot spot areas are being identified by the people team and working with divisions to develop actions to help to support these areas.
Performance		
Performance	**Referral Elective Standards***	The 18 week performance has remained steady at 50%, with the number of patients waiting more than 78 weeks decreasing to 5 from 24 and the patients waiting longer than 65 weeks also decreasing. Speciality trajectories to achieve the target of no patient waiting longer than 65 weeks at 30th September are in place with actions such as increased capacity & transfer of patients to the independent sector in place.
	Cancer Standards	The 28 day diagnosis standard has maintained above the 75% standard for another month and the 62 day performance remains stable but significantly under the standard of 85%. The tumour sites have individual recovery action plans to reduce the backlog further and return to 62 day performance.
	Urgent Care Standards	Performance to achieve 78% against the 4-hour standard is behind plan however this month shows 7 data points of improvement. Improvement programmes in place to address this. Ambulance handovers less than 15 minutes at second highest proportion dated on chart (October 2022).
	Diagnostics	Diagnostics performed within 6 weeks of referral has improved by just under 1% this month. There are concerns in ongoing demand in Echoes, Audiology and Cystoscopy and capacity pressures. Both modalities have a recovery plan in place.
Places		
	Estates	P1 and P2 - MiCAD system is showing that P1 tasks were not attended within KPI requirements and P2 with a low compliance, this is due to the jobs being put on system retrospectively and the lag in finishing of job. New Strategic Head of Estates in post and Director of Estates and Facilities at the Lister Hospital working with the department 2 daysper week in readiness for the new Deputy Director to be in post.

Section summaries

NHS
The Princess Alexandra Hospital
NHS Trust

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Compliments	Decline in compliments logged onto our reporting system however they continue to be received within the organisation. In the interim, divisional based teams will be logging for their areas.	For information	Oct-24
Pressure Ulcers	Increase in hospital acquired grade 3 and mucosal pressure ulcers in month. Pressure Ulcer prevention strategy in place and good oversight provided through improving essential care groups.	For information	

Section summaries

The Princess Alexandra Hospital NHS Trust

People Summary	Board Sub Committee: Workforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Vacancies	CSS, Surgery, CHAWS, E&F and Finance divisions are all carrying vacancies over the target rate of 9.0% whilst UEC and Medicine have vacancies of 7.6% & 6.3% respectively. The trust is under below the vacancy rate of 9%	For Information	
Statutory & Mandatory Training	Further investigation being undertaken to understand why people are not logging into TiMS, however compliance is still steadily improving.	For Information	
Sickness Absence	In month sickness is 3.86%, this is split by short term sickness at 2.20% and long-term sickness at 1.66%. Hot spot areas are being identified by the people team and working with divisions to develop actions to help to support these areas.	For Information	
Appraisals	Further conversations with line managers to understand if compliance is due to forms not being completed or appraisals not being carried out.	For Information	

Section summaries

NHS
The Princess Alexandra Hospital
NHS Trust

Performance	Board Sub Committee: Workforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Diagnostics	Diagnostics performed within 6 weeks of referral has improved by just under 1% this month. There are concerns in ongoing demand in Echoes, Audiology and Cystoscopy and capacity pressures. Both modalities have a recovery plan in place.		
RTT Elective standards	The 18-week performance has remained steady at 50%, with the number of patients waiting more than 78 weeks decreasing to 5 from 24 and the patients waiting longer than 65 weeks also decreasing. Speciality trajectories to achieve the target of no patient waiting longer than 65 weeks as 30th September are in place with actions such as increased capacity & transfer of patients to the independent sector in place.		
Urgent Care standards	Performance to achieve 78% against the 4-hour standard is behind plan however this month shows 7 data points of improvement. Improvement programmes in place to address this. Ambulance handovers less than 15 minutes at second highest proportion dated on chart (October 2022).	Information	Trajectory
Cancer standards	The 28-day diagnosis standard has maintained above the 75% standard for another month and the 62-day performance remains stable but significantly under the standard of 85%. The tumour sites have individual recovery action plans to reduce the backlog further and return to 62-day performance.		

* Denotes summaries from the previous month's IPR

Introduction

About this pack

The Trust produces this Integrated Performance Report (IPR) on a monthly basis to inform our Board, Executive team, Divisions and other stakeholders of the performance across core domains.

This particular report provides a summary of all metrics for the 'our patients' pillar and is structured as follows:

Indicators Summary	Overview of metric performance
Metrics Reports	SPC charts detailing trajectory and variation of metric performance
User Guide & Supporting Information	Outline of document interpretation, report content and SPC calculation logic

For further information about this IPR please contact paht.information@nhs.net

Contents


Indicators Summary


Metrics Reports


How to use this report


Supporting Information

Key Performance Indicators In Special Cause Variation

NHS
The Princess Alexandra Hospital
NHS Trust

5P Section	KPI	SPC Status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	Tissue viability (Pressure Ulcers) per 1000 bed days		0.63	1.1	16	12
	Serious Incidents		0	1.1	16	12
	Falls per 1000 bed days		4.53	1.1	16	12
	PPH over 1500mls		6.00%	1.1	16	12
People	Statutory & Mandatory training		84.6%	2.3	16	8
	Vacancy Rate		8.0%	2.3	16	8
	Voluntary Turnover		10.5%	2.3	16	8
	Appraisals - non-medical		68.1%	2.3	16	8
Performance	RTT over 65 week waiters*		455	1.3	16	12
	4 hour standard		61.0%	4.2	20	12
	Cancer 28 day faster diagnosis*		80.0%	1.3	16	12
	Diagnostics within 6 weeks*		75.0%	4.2	20	12

*July 2024 data

Figures included are for August 2024

Patients section measures in special cause variation

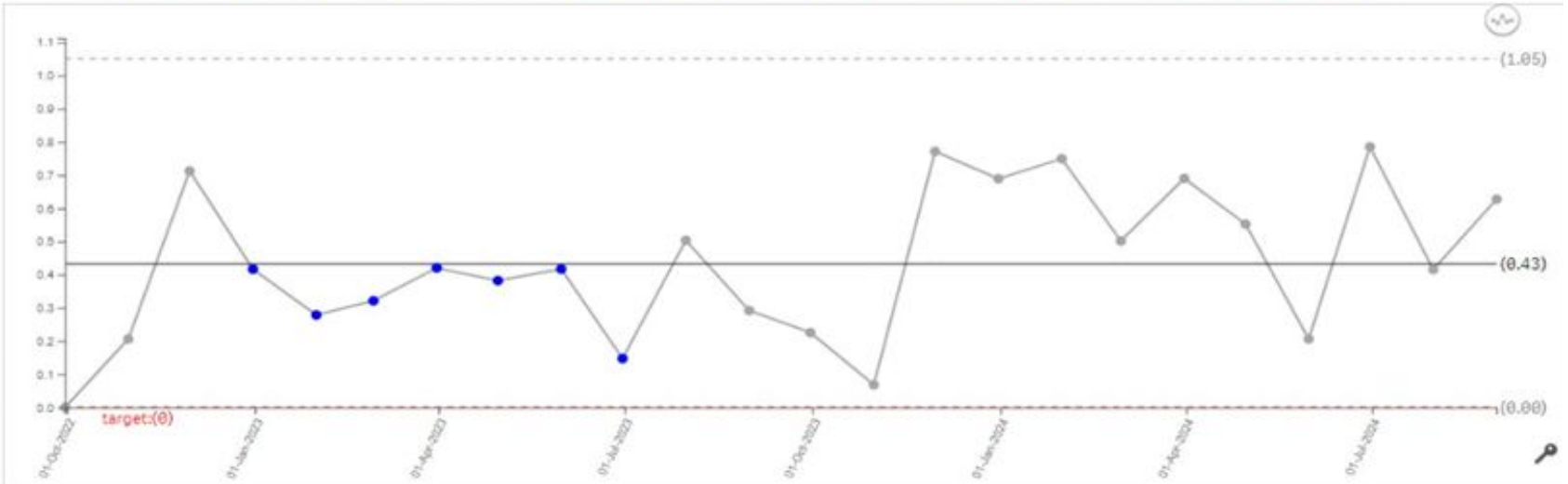
The Princess Alexandra Hospital NHS Trust

SPC for C.29 - Tissue Viability - (Pressure Ulcers Grade 3 or Above) per 1000 Bed Days

Previous month ...
August-2024
0.63

Month to date v...
September-2024
0.00

Target
Target is at Trust-wide level

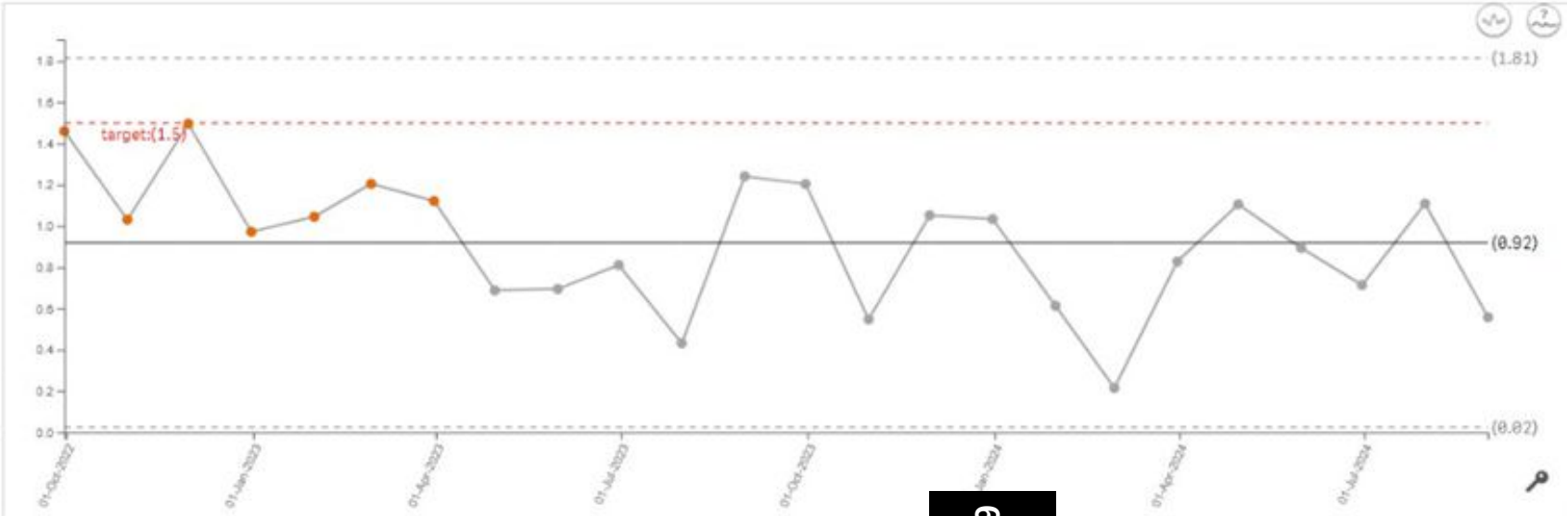


SPC for D.40 - Falls with Harm per 1000 Bed Days

Previous month ...
August-2024
0.56

Month to date v...
September-2024
0.69

Target
Target is at Trust-wide level



6.3

People section measures in special cause variation

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for D.28 - Appraisals – non-medical

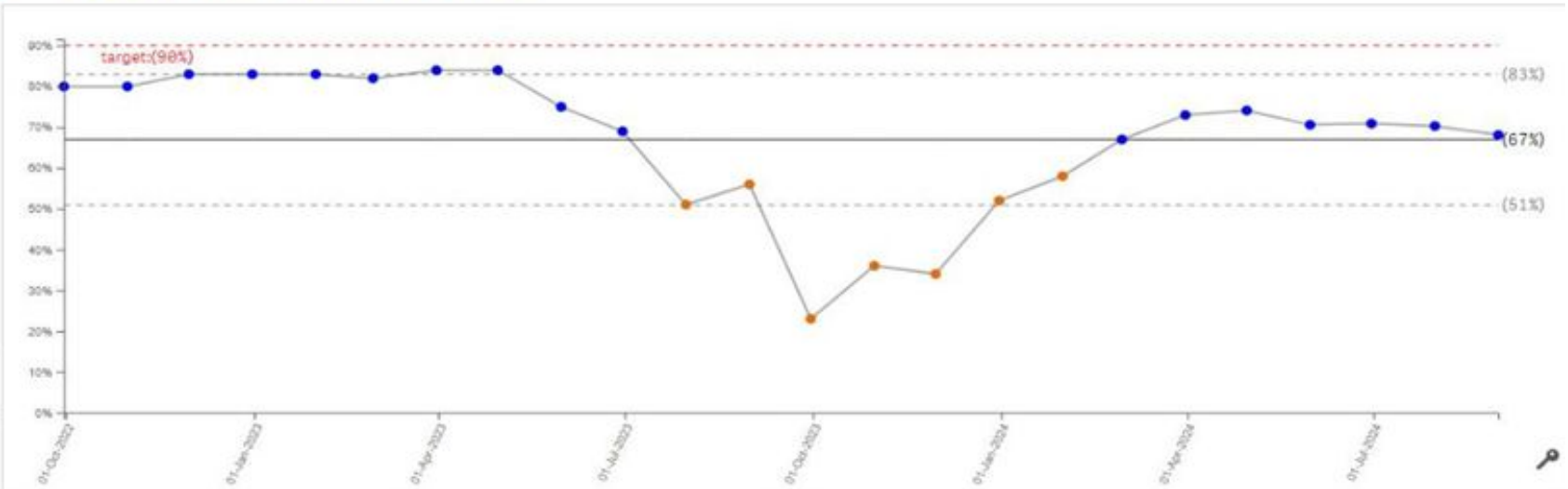
Previous month ...
July-2024

70.3%

Month to date v...
August-2024

68.1%

Target
August-2024
Target is at Trust-wide level



SPC for D.29 - Statutory & Mandatory training

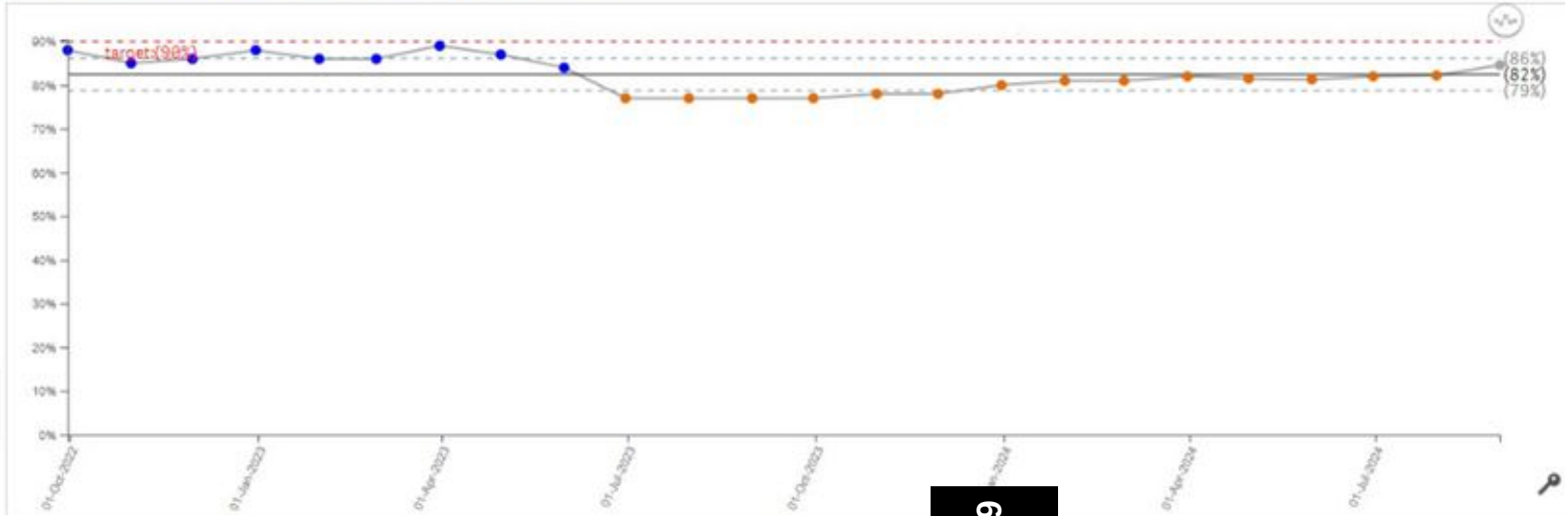
Previous month ...
July-2024

82.2%

Month to date v...
August-2024

84.6%

Target
August-2024
Target is at Trust-wide level



People section measures in special cause variation

The Princess Alexandra Hospital NHS Trust

SPC for D.27 - Vacancy Rate

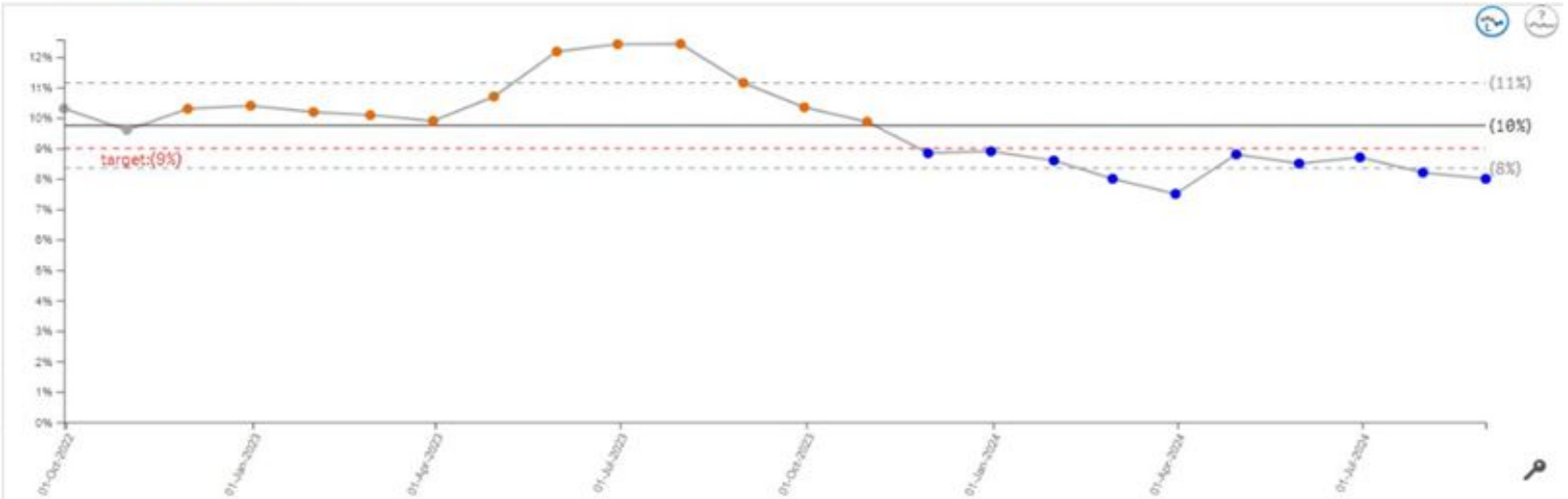
Previous month ...
July-2024

8.2%

Month to date v...
August-2024

8.0%

Target
August-2024
Target is at Trust-wide level



SPC for D.24 - Staff Turnover Voluntary

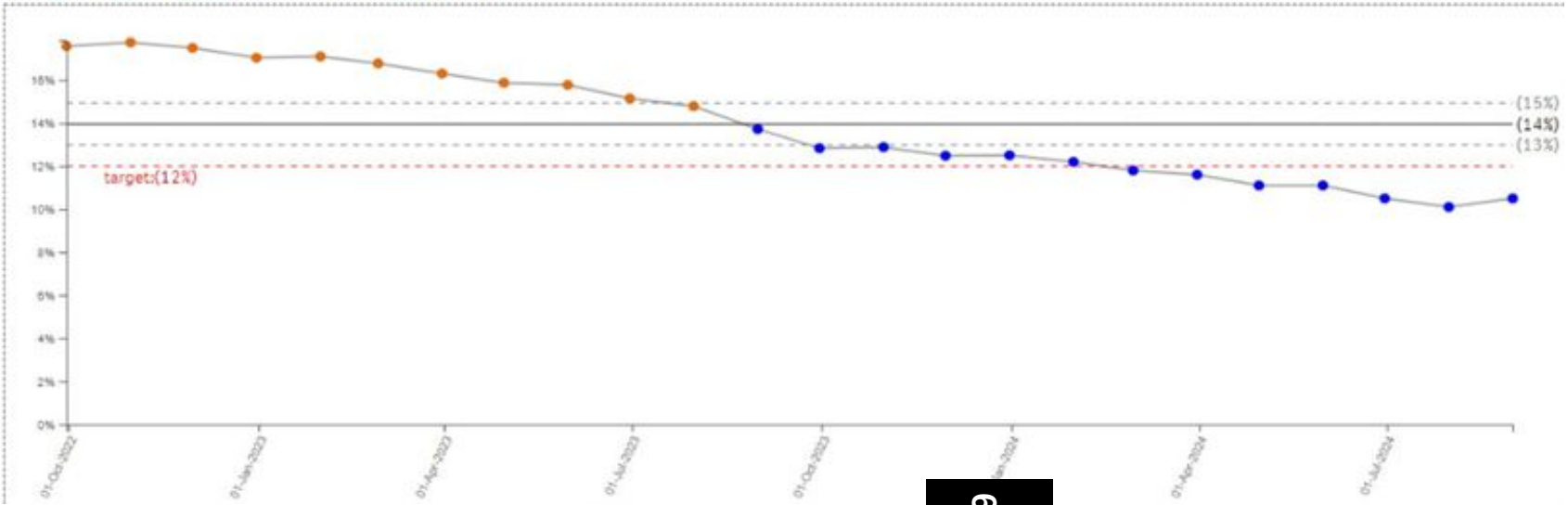
Previous month ...
July-2024

10.1%

Month to date v...
August-2024

10.5%

Target
August-2024
Target is at Trust-wide level



6.3

Performance section measures in special cause variation

The Princess Alexandra Hospital NHS Trust

SPC for C.16 - Diagnostic times - Patients seen within 6 weeks

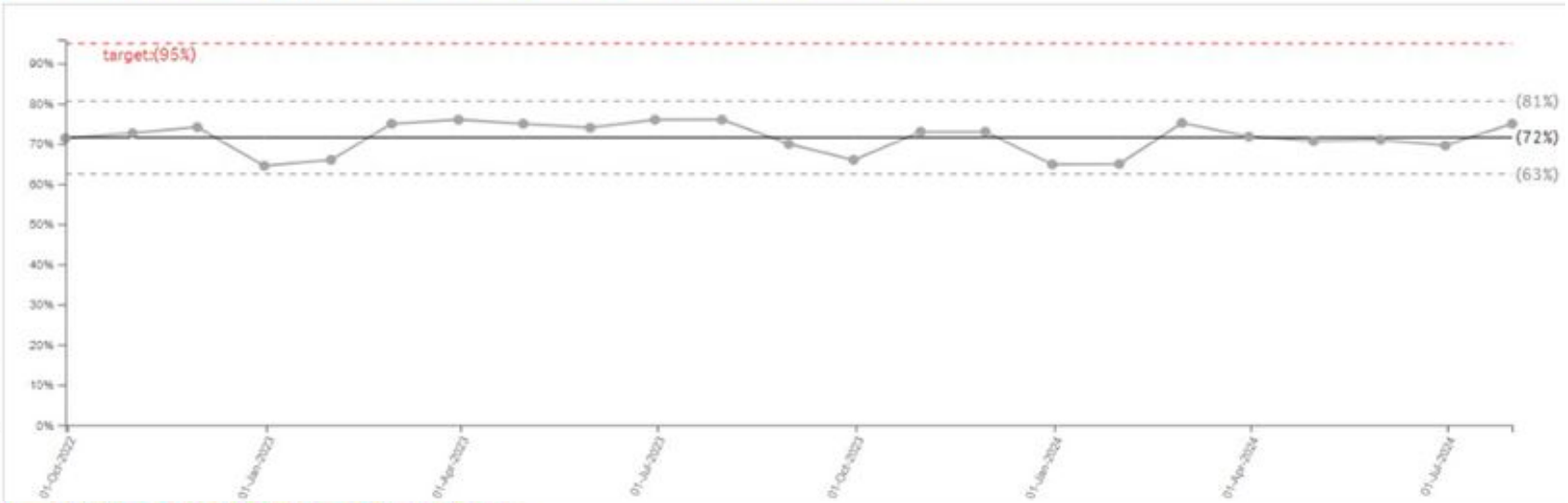
Previous month ...
June-2024

69.6%

Month to date v...
July-2024

75.0%

Target
Target is at Trust-wide level



SPC for D.41 - RTT over 65-week waiters

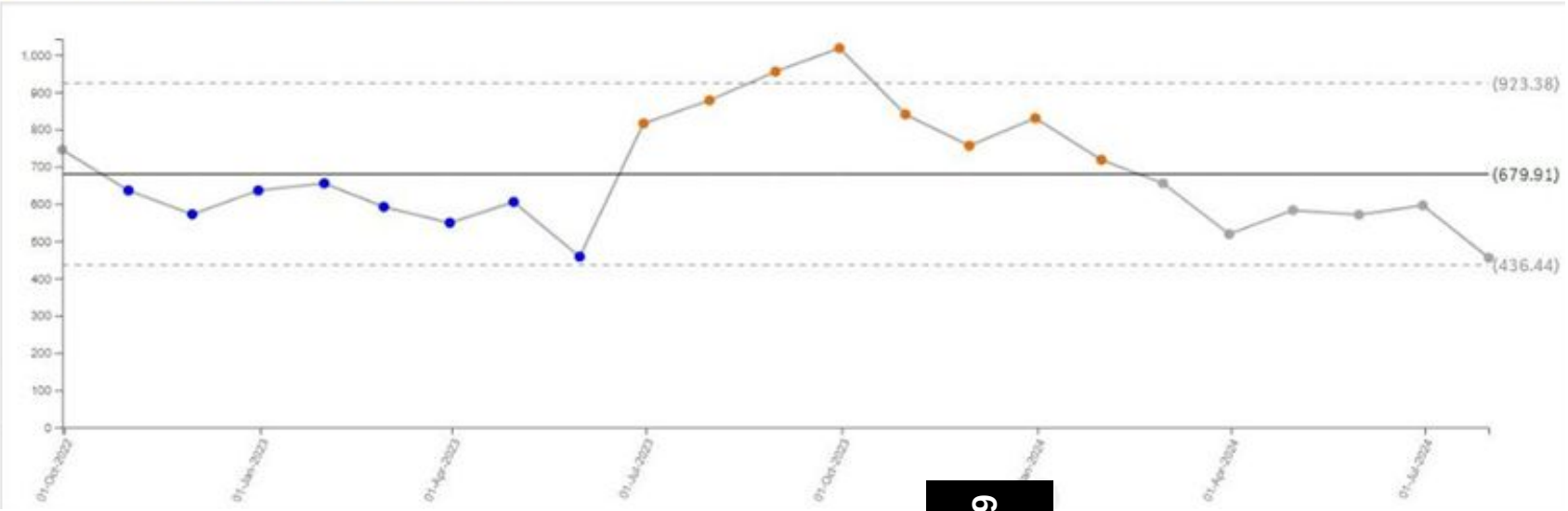
Previous month ...
June-2024

596

Month to date v...
July-2024

455

Target
Target is at Trust-wide level



6.3

Performance section measures in special cause variation

The Princess Alexandra Hospital NHS Trust

SPC for A.4 - Proportion of Patient treated within 4 hours in ED

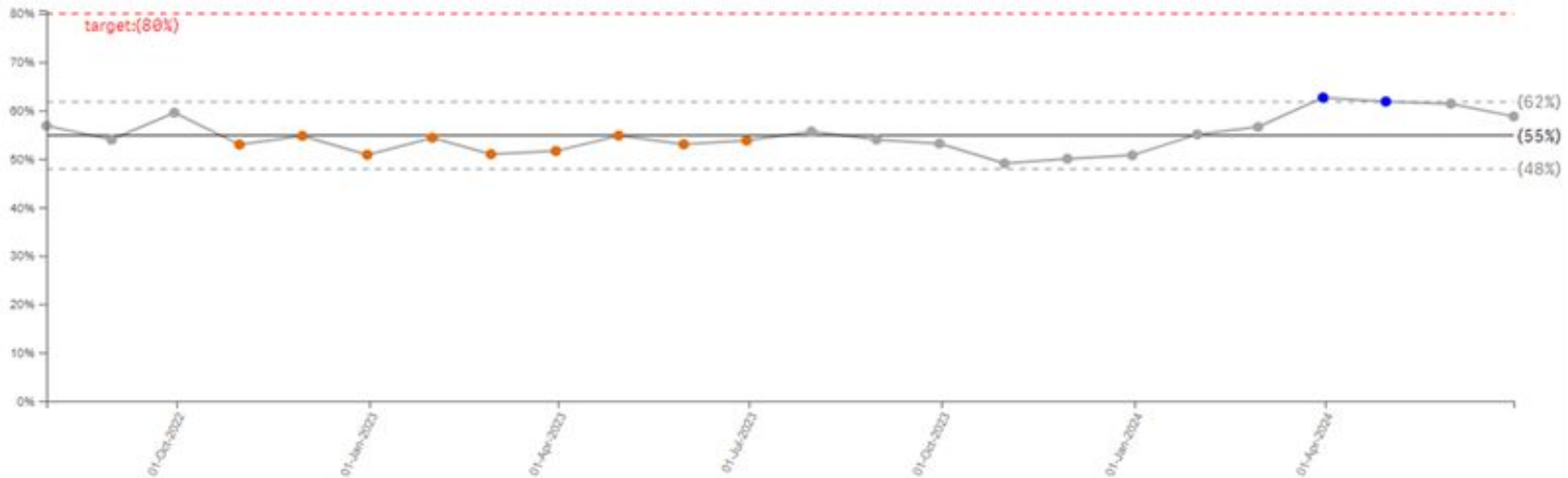
Previous month ...
June-2024

58.8%

Month to date v...
July-2024

58.7%

Target
June-2024
Target is at Trust-wide level



SPC for A.17 - Proportion of Ambulance Handovers less than 15 minutes

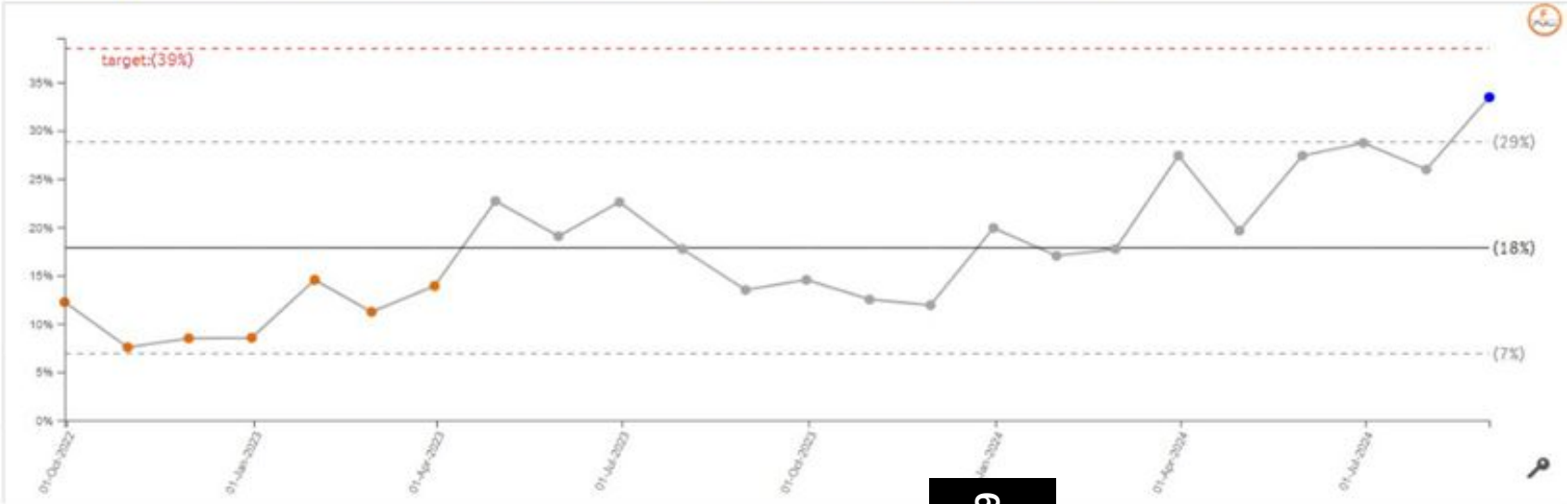
Previous month ...
August-2024

33.5%

Month to date v...
September-2024

28.9%

Target
August-2024
Target is at Trust-wide level



6.3

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 October 2024

6.4

Agenda item:	6.4
Presented by:	Stephanie Lawton – Chief Operating Officer / Accountable Emergency Officer Claire Aubrey Robson – Emergency Preparedness and Resilience Manager / Prevent Lead
Prepared by:	Claire Aubrey Robson
Date prepared:	12th September 2024
Subject / title:	Emergency Preparedness Resilience Response (EPRR), Business Continuity Testing and Exercising Annual Report

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	2024 EPRR Assurance Process for which the trust was initially assessed as partially compliant. Business Continuity Programme and Business Continuity Management System Major Incident preparedness.
Recommendation:	The board considers the approval of the core standards submission. Be assured that the Business Continuity Programme/ BCMS is now a work in progress and the executives give their full support to the MCMS Major Incident Preparedness including testing, training and equipment.

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:	Health and Safety Committee 16th September 2024 PAF.26.09.24
Risk / links with the BAF:	BAF 2.2 BAF 3.1 BAF 4.1
Legislation, regulatory, equality, diversity and dignity implications:	Civil Contingency Act 2004 Health and Social Care Act 2012 NHS England EPRR Core standards NHS England EPRR Framework 2021 NSH Core Standard Contract
Appendices:	Core Standards Report 2024

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2013 and on its annual core standards assurance return to NHS England. It covers the 4 main areas

1. Emergency Preparedness and measurement of that through the Core Standards Report;
2. Business Continuity, the BC cycle that is developed through the BC Programme;
3. Testing and exercising;
4. Major Incident preparation of staff, equipment and preparedness.

2.0 Background

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. PAHT is a category 1 responder and as such has a legal duty to ensure its preparedness and ability to respond during a civil emergency or event, and during that event it will be able to continue its responsibilities as an acute hospital.

To ensure compliance of provider and commissioner organisations, NHS England and Improvement undertake a yearly Core Standards Assurance process.

3.0 Content

1. Emergency Preparedness and measurement of that through the Core Standards Report

As an organisation the Trust scored partially compliant for 2024 NHS England and Improvement Core Standards Assurance. The core standards had been changed from previous years and required evidence of the self-assessment with documentation which was the first time for this level of scrutiny and will be the methodology for the core standards for next year. The 'deep dive' went into Cyber Security and IT incident related response. The Trust has shown fully compliant for the deep dive scrutiny. This forms part of the preparedness for the Trusts preparedness for its own cyber security and responses to a cyber attack and IT incident response.

The core standards report highlighted the several areas of improvement, for its business continuity and major incident preparedness. It also highlighted the need for additional staff needed within the EPRR department. The breakdown of the partial compliance 62 areas of business within 10 domains which included governance, Business Continuity (BC), several within the EPRR. Overall 55 areas were fully compliant and 7 partially compliant giving an overall rating of partial compliance at 88.7% See Appendix 1.

The scoring is based on the following criteria.

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

	Fully Compliant	Substantial Compliance	Partial Compliance	Non-Compliant
EPRR Core Standards	55	0	7	0
Deep Dive	11	0	0	0

2. Business Continuity

Review in is progress for the 2023/24 business continuity programme. All departments have a business continuity plan and their plan authors are currently undergoing training both in 2023 by the ICB and internally to be fully conversant with the completion, review and testing processes that are required. The BC policy is under review and new systems, processes and training will commence late 2024 in the new policy. Any BC incidents have had a after action review conducted, learning and good practices shared and implemented.

3. Testing and exercising

- PAHT EPRR manager took part in test and explore the effects of a structural failure in the RAAC (reinforced autoclave aeriated concrete). To test the evacuation and impacts of a catastrophic RAAC plank failure within the Eastern Region Hospitals as there are four whole hospital sites within the region constructed with RAAC planks.
- The Trust had command team in place for the receipt of the virtual patients including the EPRR and Site manager.
- Table top exercise with the IPC and ED took place to test the policy and procedure for reportable diseases such as Highly Contagious and Infectious Disease.
- EPRR manager also took part in the testing and exercising to be taken, Mighty Oak for power outage, PAHT has a key role as a category 1 responder and an acute trust.
- System wide table top exercise involving sever ICT failures including cyber-attack.

4. Major Incident preparation of staff, equipment and preparedness.

- New EPPRR policy has been approved and published
- Major Incident Policy is currently undergoing a complete review and update, with significant changes made to the policy in line with legislation and procedures.
- There were no major incidents other than the in the last period. There have, however, been business continuity incidents due to the industrial action and infrastructure and due to pressures on capacity within the organisation.

Training

- Major incident strategic and tactical commander training ran for all those who perform the roles of Gold and Silver and on call. This is external training at the cost to PAHT run by the ICB. Hazmat training began in February 2023, currently over 110 staff are now trained. This training is continuous and includes the erection and use of the Hazmat decontamination tent.
- All training dates will be circulated to the relevant personnel on completion.
- Business continuity training for the practitioners will commenced in 2022 to assist the practitioners/plan owners in writing or reviewing their BCPs, all BC practitioners were provided with training. Training in the system will commence October 2024.

Major Incident and Hazardous Materials Equipment

The major Incident store and the equipment is now in place with a full test on the decontamination test, generator along with staff October 2024.

4.0 Recommendation

The board approves or amends the Core Standards Return with formal sign off at the public board and is assured that the ongoing programme of work will be undertaken to mitigate any risks to the organisation.

Author: Claire Aubrey Robson
Date: 12th September 2024

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance										
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	AEO is Stephanie Lawton Chief Operating Officer, deputy AEO is Camelia Melody Deputy Chief Operating Officer. Both roles are described in their job descriptions.	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The policy has a review schedule and version control. The only reason for this not to be fully compliant is the resourcing levels. Further reports and requests for staffing levels and rebranding reviews are being progressed. Within it uses plain English with common terminology that is not ambiguous. Testing and exercising has been completed and thoroughly tested. Defined areas of responsibility, clear review dates set and responsible owner of the policy. -The statement of intent is included in the aims, objectiveness and scope of the policy. The EPRR policy has been written been though consultation and is published on AlexNet for all staff to view, Policy is dated 22/8/24 for review 14/08/2027 Resourcing commitment and access to funds are clearly outlined in the Policy as well as commitment to Emergency Planning, Business Continuity, Training and Exercising . The EPRR Team 1 manager 1 officer and a 0.5% Admin staff. S5	Partially compliant			
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Annual Report to board with the EPRR Core Standards. Public Board Meeting on the 1st February 2024 included EPRR Annual Report. The report included lessons learned from incidents and testing and exercising of significant note. The Accountable Emergency Officer provided to the Board EPRR reports to the Board in 2023, it showed that PAHT its readiness and preparedness, with reassurance around testing and exercising activities, BCP in place and major and critical incident plans and action cards are in place and readily available. Emergency Preparedness also included as part of the Trust Annual Report (Public document).Board Reports, Trust Board Committee Reports, Senior Management Team. A further Annual report to the Board and trust assurance is the Responding in an emergency preparedness report.	Fully compliant			
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Reporting process explicitly described within the EPRR Policy Statement, this is also in place for learning from any exercises carried out. After action review carried out post each incident, recommendations and actions from that given owners and a process of completion. This may feed into the practices, processes policies, procedure and training requirement with in PAHT An Annual work plan is in place for EPRR identifying all areas of work planned for the year ahead.	Fully compliant			
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR function has been signed off and the EPRR policy is embedded into the major incident policy, the EPRR role is part or the organisations structure and placed in the Org chart. A new EPRR Policy has been approved and is dated August 2024. There are no further resources to be given within the EPRR team and it remains 1 EPRR and 0.5 EPRR Admin.	Partially compliant			
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The organisation has a process capturing learning exercises and incidents. This process is written in to the After action Review process documentation. EPRR has shared the learning of some of these incidents with other trusts and partner organisations including the LHRP	Fully compliant				
Domain 2 - Duty to risk assess										

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The Trust engages with the Essex Resilience Forum and Essex LHRP to understand and manage community and national risks. and ISO 31000 EPRR risks are regularly considered, updated and recorded. There is a process for escalation of risk, monitoring and capturing risks. PAHT has a good enterprise risk management system as per COSO. Risks identified are also included in the Trust's Corporate risk register. Risk registers in place, BAF in place and reviewed at Trust Board. Risk assessments. Command and control structures in place.	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust engages with the Essex Resilience Forum and Essex LHRP to understand and manage community and national risks. There is a process for escalation of risk, monitoring and capturing risks. PAHT has a good enterprise risk management system as per COSO and ISO 31000 Risk registers in place, BAF in place and reviewed at Trust Board. Risk assessments. Command and control structures in place.	Fully compliant				
Domain 3 - Duty to maintain Plans										
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	PAHT is committed to partnership working with key stakeholders, as evidence by the ICS, ICB, and the Essex resilience Forum, the ERF various sub groups, NHSE regional forums and the LHRP. EPRR has represented PAHT and supported the tactical commander at live incidents such as the Sudan war repatriation	Fully compliant				
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major Incident Plan and Mass Casualty Plans are both currently being reviewed and updated and fall in line with current national guidance and risk assessment. Both plans have been tested during Enterprise Exercises part 1 and 2. The plans have been written through consultation and are being finalised before submission to the TPG for approval and sign off. Once approved these will be shared with all stakeholders and published to AlexNet Any staff training is outlined without our EPRR Policy	Partially compliant				
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Adverse weather plans are in line with the current guidelines and legislation, they include a plan for severe weather which are becoming more prevalent and consistent with the sustainability for planning of adverse weather. Regular messaging to all PAHT of any weather warning, EA alerts all shared situational awareness and action as required. SOPs in place and reviewed. Evidence of processes enacted during extreme weather. Plans are regularly tested and signed off by the relevant mechanism. Training and equipment is outlined within the plans.	Fully compliant				
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	The Trust has an ongoing fit testing programme and fit testing is recorded as a skill on Healthroster for individual staff members. An Infection Prevention and Control (IPC) clinical nurse specialist has completed a high-consequence infectious disease (HCID) train-the-trainer course, which enables him to competently train staff on HCID management. HCID training sessions have been arranged and completed for our frontline staff in ED (nursing and medical) and domestic staff. The training programme is ongoing. The IPC team keep a training log of all the staff members who have been trained on HCID management. The team are looking into getting this recorded as a skill on HealthRoster. The Viral Haemorrhagic Fever policy has been changed to High-consequence Infectious Diseases Policy to include other HCIDs such as Middle East Respiratory Syndrome (MERS) and Avian Influenza	Fully compliant				

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13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Arrangements in place are current and in line with current national guidance, as above horizon scanning for merging pandemics such as HVF, MPox etc in place, table top exercises including 'walk through' "measles round table" utilised for learning, improvement and consolidation of existing practices and knowledge. Board Reports, Trust Board Committee Reports, Senior Management Team.	Fully compliant				
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Systems are in place for escalation processes as required by the current legislation (The Public Health (infectious diseases) Regulations), the emergency powers during Covid have been revoked. Learning from COVID in place and shared. Systems, structures and processes in place, tested and reviewed in line with current legislation and the Systems Countermeasures plan. PAHT has proven capability for the delivery of mass countermeasures.	Fully compliant				
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Major Incident Plan is being reviewed and updated this includes arrangements for management of mass casualty events and is linked to both the regional mass casualty plan and current national guidance in line with risk assessments. Plan Testing is with the key stakeholders and regional plans, this has been tested as part of Enterprise Exercise Part 1 and 2. This Plan has been written through consultation and is being finalised before submission to the TPG for approval and sign off. Once approved this will be shared with all stakeholders and published to AlexNet. Systems are in place for the mass casualty receipt of patients including haematology, clinical equipment etc. Outline of training requirements in included in EPRR Policy.	Partially compliant				
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	This evacuation plan works in tandem with the fire evacuation plan, testing is on a regular basis and compliant with fire regulations and health and safety. Staff training, awareness is part of this too. Arrangements are in place to ensure the ability to safely shelter and evacuate staff and patients in the event of an emergency.	Fully compliant				
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a current lockdown plan to enable the security of the site in the event of an incident and is fully conversant with national guidelines. The plans were reviewed and updated post Operation London Bridge as well as recent events, with new Action cards issued as a result of these events. Plans are tested regularly and include an outline of any equipment requirements, as well as staff training. We are in the process of updating plans due to the introduction of new legislation.	Fully compliant				
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has plans in place for the management of High Profile Persons, including the management of the media. Plan is current and has been live tested. The plan is regularly viewed as Stanstead airport is regular used by VIP's as well as other protected individuals. New policy is under review and is in line with national guidance	Fully compliant				

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19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Full arrangements are in place for the investigation side of the DVI process. PAHT is not a recipient of DVI and the investigations, DVI bodies are moved from PAHT to where the investigation of the disaster victim can be conducted. PAHT does have a morgue capacity and planned expansion of the morgue should that be required. The Major Incident Plan includes current plan guidance in line with national guidance as well as the Essex LRF DVI plan. Arrangements for management of excess fatalities and is linked to the regional mass casualty plan. PAHT is engaged with the Herts LRF and Essex LRF and as well as the local authority for the additional morgue requirements.	Fully compliant				
Domain 4 - Command and control										
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	PAHT has described with the EPRR policy statement the On-Call process On Call standards and expectations are set out in the On-Call Job Description. There is a system of training so that the strategic and tactical on call (gold and silver) command, ensuring they are competent and capable, there is also a readily available file structure (cloud based and hard copy) containing the relevant documents for their on call, including major incidents. Training has also been implemented nationally and via our HWE ICB/ICS Personal Training records are maintained for each member of both Strategic and Tactical on Call command to ensure compliant in addition to a Training Needs Analysis used to identify training requirements for each individual member of the On-Call command team.	Fully compliant				
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	As previously describe there is a system of training so that the strategic and tactical on call (gold and silver) command, ensuring they are competent and capable, there is also a readily available file structure (cloud based and hard copy) containing the relevant documents for their on call, including major incidents. Training has also been implemented nationally and via our HWE ICB/ICS. The national decision making model is used as the specific process during the decision making within the command and control. It is also used when dealing with specific incidents and decision making. They are also encouraged to use it in their day to day decision making so that it become second nature during an incident. Alongside this this the use of subject matter experts both inside and external to the trust are consulted. Decision making logs are available and recording of decision making and other records essential during the incidents. All command staff are trained and a record of their training is kept as per requirements.	Fully compliant				
Decision making										
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	EPRR Policy explicitly described PAHT EPRR training needs. PAHT maintains Training Needs analysis records for all staff on Call and those performing a role within the ICC Personal training records are maintained for each individual member of the Strategic and Tactical Command. Incident training, silver and gold. Scenario training sessions, major incident training offered across the organisation. Operational development	Fully compliant				
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	PAHT testing and exercising programme is continuous, with a variety of table top exercises being carried out including Major Incident, Cyber and Regional exercises including Enterprise Exercise, Measles and live incidents. Training needs analysis undertaken. Operational development. Exercising schedule is included in the EPRR annual workplan.	Fully compliant				

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24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	There is a training needs analysis in place, all strategic, tactical and operations commanders and on call have received training or in the process of being trained. Records are kept by EPRR folders plus recorded on the individuals personal records on a system called TIMS. This is part of the annual appraisal process for essential/mandatory training. In addition to TIMs EPRR hold personal Development plans for each Strategic and Tactical commander which is populated with their indivudal training records, live incidents and exercises	Fully compliant				
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Major incident including HazMat training continues through a programme throughout 2024/2025 and refresher training will commence after that. There is an audit trail of all those undergoing training in relation to this core standard. All training is recorded for any participant in the above training within EPRR records, ED staff training records are also recorded on Healthroster. The training compliance and attendance is reported in the annual EPRR board report.	Fully compliant				
Domain 6 - Response										
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The incident command and control location is in the site office with 24/7 access. Local command and control arrangements in place. Command structure is embedded in the action cards. It is fully equipped with telephony, computers, paper manuals including action cards. Secondary site is at Kalmar House or Drummen House. There is a third option which is at Kao Park. In the event of a Major incident the command and control will be located at Chelmsford Police HQ. This process has had live testing from several incidents including the industrial action. Off site and virtual is also in place using the Alertive system for communication messaging, MS teams for meetings, there is a separate Wi-Fi connection also in the ICC in case of PAH WIFI failure. Onsite presence as dictated by action cards. Site team presence 24/7. Inbox and 24/7 response to requests in place. IMT and cell structure in place and monitored.	Fully compliant				
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	All documentation is version controlled dated and with a review date. Location of the major and critical incidents documentation is known by staff and spot check are carried out. Documentation is available in hard copy and virtually on the PAH systems and stored on MS Teams files in the On call Commanders and EPRR folders. Intranet and policies and procedures documents are accessible via MS Teams, and hard copy available in the ICC.	Fully compliant				
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The command structure using strategic, tactical and operational are in place, business continuity plans have been reviewed and in place for 2024. All business continuity plans are being reviewed and updated. Mitigations processes are in place however should a BC incident occurs there are plans in place to deal with that. Command and control structures to respond to incidents in place. Example business continuity incident. Action logs, IMT notes.	Fully compliant				
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Decision documentation is accessible via MS Teams and in hard copy for decision logs. There are trained Loggists in place. Training is available. Action and log books in place. Decision log and records of all cells stored and accessible. Training records of the loggists are held in the EPRR mater copy of training.	Fully compliant				
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Standard sit rep templates in line with NHSE requirements. Consistent across the ICS. On a local level sitreps are given in the incident management meetings IMT which form par of the ICC process. Signing off he sitreps is by strategic or silver commander depending on the situation.	Fully compliant				
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	This version has been emailed several times to the clinical staff and is accessible in the major incident and on call folders on MS Teams, hard copy and the PAH X-drive (shared drive)	Fully compliant				
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	This version has been emailed several times to the clinical staff and is accessible in the major incident and on call folders on MS Teams, hard copy and the PAH X-drive	Fully compliant				

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Domain 7 - Warning and informing										
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Warning and informing of incidents are documented and processes in place from the initial incident reporting through the incident to completion and cascade of incident closure. Warning and informing processes in place, with communication team support in and out of hours. Messaging sent out has to be approved by strategic lead and give control over the single point of truth by PAHT A process is in place to log incoming requests, track responses to those requests and information is stored securely.	Fully compliant			
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Trust has a clear communication cascade in place in the event of an incident. The Incident communication plan is tested regularly through live incidents and communication cascades in and out of hours. Communication structure in place as required. PAHT Communications team are multi-disciplined and are able to respond to all types of responses. Action cards are being developed Plan as are regularly tested, in and out of hours through live incidents and exercises. Sign off process is included in the plan, communications are signed off by incident leads.	Fully compliant			
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	There are arrangements in place for communication, internally, with stakeholders, other organisations, and with patients and the public. These are in place on a local level and wider via the LHRP, ICS/ICB and ERF List of key local stakeholders is available and an established process is in place with a process in place as a means of warning and informing these organisations, as well as information sharing. PAHT has published public information on its status of preparedness in February 2024. All EPRR risks are included in the Corporate Risk Register.	Fully compliant			
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	In place and shared across the organisation. Communication cell in place to manage an incident. Regional and national engagement through communication channels as appropriate. Examples of daily communications, incident briefings, webinar, media etc.	Fully compliant			
Domain 8 - Cooperation										
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The deputy Chief Operating officer/ deputy AEO and the EPRR manager has written delegated authority and signed off by the AEO (COO). Minutes and attendance. Delegated to the EPPR Manager. COO attendance as required.	Fully compliant			
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Minutes and attendance are recorded and socialised. The governance system is organised and owned by the LRF or ERF (Essex Resilience Forum) Delegated to the EPPR Manager. COO attendance as required.	Fully compliant			
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	There are mutual aid agreements in place within the region that the Trust is a signatory of, and there are details of MACA arrangements within the On Call Information pack. MACA requests are via the LRF and government. Template and documentation available virtually and in hard copy. There is also a process via the IBC escalation.	Fully compliant			
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	n/a	Not applicable			
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	• Detailed documentation on the process for managing the national health aspects of an emergency	n/a	Not applicable			
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	• LHRP terms of reference • Meeting minutes • Meeting agendas	n/a	Not applicable			

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43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Information sharing protocols in place as required by DSPT. " examples of ISP given as additional evidence to the ICB	Fully compliant				
Domain 9 - Business Continuity										
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The BCP dies not specifically have the title of Statement of intent, it does have scope, aims objectives that over the manner, direction and has executive buy in. The policy provides strategic direction from which the business continuity programme is delivered. PAHT are currently in the process of updating business continuity plans with additions being made following BC Auditors recommendations.	Fully compliant				
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	PAHT has business continuity plans process in place which includes regular reviews post activation of plans to ensure that they remain fit for purpose. It is signed of by the CEO and reflective of the size and complexity of PAHT. There is a robust risk management process and good enterprise risk management as described in COSO to management the risks including a risk register and regular risk management meetings. The BCMS is in the process of being updated in line with BC Auditors recommendations and those required within the standard.	Partially compliant				
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	BIA system is in place and described within the BC policy and is an integral part of creating the BC plans. It is part of the review of the BC policy and will be updated as such, however this is fully compliant at present. PAHT undertakes a review of its critical functions using a BIA. A consistent and robust approach is used when performing the BIA and PAHT are currently undergoing a review of all plans.	Fully compliant				
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	The business continuity policy has been signed off by the CEO, it contains all of the relevant standard details as required by this core standards review. There are business continuity plans in place with regular reviews post activation to ensure they remain fit for purpose. PAHT are currently undergoing a review of all BCP's and these are being updated to be compliant with ISO 22301 as well as ensuring that the updates include the 5 BC triggers.	Partially compliant				
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	BCPs in place across the organisation. Scenario and live incidents as evidence. Full RCA and lessons learnt from BCI and shared across governance meetings and committees	Fully compliant				
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The trust is fully compliant and has been certified by NHS digital Data Security and Protection Toolkit 2022-23 (version 5) The Senior information responsible officer has ensured compliance with GDPR and the data protection act. The security certificate is in place.	Fully compliant				

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50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	There is a BC policy in place, the BCMS is part of the policy. Performance reporting is part of the papers submitted to the board and included in the overarching EPRR report	Fully compliant				
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The BCP is aligned to the audit programme of PAHT. Reporting to the board is part of the annual EPRR report. An external Business Continuity Audit was carried out by BDO LLP and recommendations following the audit are being added to BCP which are all currently being reviewed.	Fully compliant				
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Process is documented within the EPRR policy/ Business Continuity Policy. BCMS is part of the report to the board. There are regular reviews post activation of a BCP to ensure they remain fit for purpose, Action plans take place for recommendations following and incident included in the debrief process, after action review process. Governance structure is in place to ensure compliance. The review process of all the BCPs is part of the self-assessment and quality assurance is completed by the EPRR after the management review. Supplier performance is dealt with by the procurement team and it is monitored in a bi weekly meeting After action reviews and Lesson learnt through exercises and live incidents ensure continuous improvement and updates to plans are made to ensure that these are fit for purpose.	Partially compliant				
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Business continuity requirements included as part of tendering / procurement processes.	Fully compliant				
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	• Exercising Schedule • Evidence of post exercise reports and embedding learning	n/a	Not applicable				
Domain 10 - CBRN										
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	The overarching governance of Hazmat/CBRN and are in the Major and critical incident plans, outlying the accountability is with the AEO , training record keeping and equipment checks	Fully compliant				
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	This is all in place as is the remit of the Estates and waste management. The risk assessments have been logged on the risk register and have sufficient mitigation not to remain open on the risk register. This also form part of the major and critical incident plan.	Fully compliant				
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	This information is available to staff, along with guidance how to contact specialist for specialist clinical advice. An email is sent to all staff following their attendance of training with confirmation of the contact details in the event of a CBRNe or Hazmat incident.	Fully compliant				

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58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	There is monthly / twice monthly training of staff in collaboration with the East of England Ambulance Service. Their training material and decontamination practices are in-line with the EoE ambulance service. The equipment is standardised too. Command and control of the situation including the zones is rehearsed, trained and plans in place	Fully compliant			
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Documentation including the entry control officer is available. The training of staff is currently on going on a monthly, twice a month basis. The capability will be stretched at night but capable, the identification of the hazmat trained people is included in E-Rostering. A detailed list of all of those completing training is sent on a monthly basis to update Health Roster.	Fully compliant			
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	The inventory check list is compatible and compliant with NHSE check list. The major incident store has a complete inventory. The PRPS/ hazmat suits are regularly serviced. There is equipment and training for collapsed patients too. The sops for using specialist equipment is in the major and critical incident plan. Broken missing or out dated equipment has a budget to replenishing stocks. There is currently no waste water bladder. A supplier is being sorced and purchase of this and other essential equipment being made.	Fully compliant			
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	All equipment has been checked, PRPS suits has a servicing process in place. Full records are kept for the servicing and maintenance of all equipment.	Fully compliant			
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53		Fully compliant			

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63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	PAHT does not have a qualified trainer for CBRN/Hazmat. The training is carried out by the EoE ambulance Hazmat and CRN trainer and facilitated by the EPRR lead. There has not been any courses for train the trainer for the EPRR lead to become a qualified trainer. TNA and staff training began early 2023 and programme of training will continue each year.	Fully compliant				
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	PAHT has the training slide and this evidence has been sent to HWE ICB	Fully compliant				
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	This is in place, no decontamination has taken place during 2023/2024. A number of PRPS suits are currently on loan from the East of England. Due to an issue with new Filters an order for replacement suits has only been raised in July following testing by Respirex. The new PPRS suits will replace those currently on loan and have a lead time of approximately six to eight weeks. There is the ability of a triservice response should there be a need for wet decontamination. There is also a decontamination shower in ED however this is not ideal as it currently is not known where the water flow goes to.	Fully compliant				
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	This is part of the Testing and exercising plan and form part of a table top exercise. Learning is embedded into the training slides such as the roles and responsibilities of ED staff and will form part of the review on the major incident action cards later in 2023. There have no been any post exercise reports for CBRN	Fully compliant				
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.	Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).	n/a	Not applicable			
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.	Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.	n/a	Not applicable				
69	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).	Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.	n/a	Not applicable				

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70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.	Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.	n/a	Not applicable				
71	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it	Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.	n/a	Not applicable				
72	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.	NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.	n/a	Not applicable				
73	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the	Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to	n/a	Not applicable				

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant)** = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART										
Domain: Capability										
H1	HART	HART tactical capabilities	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials (HazMat) • Chemical, Biological Radiological, Nuclear, Explosives (CBRN) • High Consequence Infectious Disease (HCID) • Marauding Terrorist Attack • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • All-Terrain Vehicle Operations • Support to Security Operations These represent both local and national capabilities that mitigate risks within the National Risk Register. They must be maintained even through	Y						
H2	HART	National Capability Matrices for HART	Organisations must maintain the HART capabilities in compliance with the scope and interoperable specification defined within the National HART Capability Matrices.	Y						
H3	HART	Compliance with National Standard Operating Procedures	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. It is the personal responsibility for each member of HART staff to access and know the content of the National Standard Operating Procedures (SOPs)	Y						
Domain: Human Resources										
H4	HART	Staff competence	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies	Y						
H5	HART	Protected training hours	I Training Information Sheets for HART. Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies. 1 – 4 H5 H5 Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). Organisations must ensure that *all* operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). If HART staff are given additional local skills and training requirements outside of the scope defined within the National HART Matrices, that local training must be provided in addition to the 37.5 hours protected for core HART training.	Y						
H6	HART	Training records	Organisations must ensure that comprehensive training records are maintained for each member of HART in their establishment. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets. It must also include any restrictions in practice and corresponding action plans. Individual training records must directly cross reference the National Training Information Sheets	Y						
H7	HART	Registration as Paramedics	All operational HART personnel must be professionally registered pre-hospital clinician. This will normally be an NHS paramedic, but this standard does not preclude the use of other NHS clinical professionals providing the Trust ensures the individuals have an appropriate level of pre-hospital experience and training. To ensure the appropriate clinical standard of care is maintained in accordance with the original DHSC mandate, the expectation is that the clinical level will be equivalent to or exceeding that of an NHS Paramedic.	Y						
H8	HART	Six operational HART staff on duty	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Y						
H9	HART	Completion of Physical Competency Assessment	All HART applicants must be recruited in accordance with the minimum requirements set out in the national HART recruitment and selection manual. Local recruitment provisions can be added to this mandatory minimum as required by NHS Ambulance Trusts.	Y						
H10	HART	Mandatory six month completion of Physical Competency Assessment	All operational HART staff must undertake an ongoing Physical Competency Assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. The Trust must then implement appropriate support for individuals on a restriction of practice.	Y						
H11	HART	Returned to duty Physical Competency Assessment	Any HART staff returning to work after a period of absence which exceeds 7 weeks must be subject to a formal review to ensure they receive sufficient catch up training and to ensure they are sufficiently fit (evidenced through the successful completion of a Physical Competency Assessment) and competent to continue with HART operational activity. It is the responsibility of the employing Trust to manage this process.	Y						
Domain: Administration										
H12	HART	Effective deployment policy	Organisations must maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H13	HART	Identification appropriate incidents / patients	Organisations must maintain an effective process to identify incidents or individual patients, at the point of receiving a 999 call, that may benefit from the deployment of HART capabilities. Organisations must also have systems in place to ensure unreasonable delays in HART deployments are avoided.	Y						
H14	HART	Notification of changes to capability delivery	In any event that the organisation is unable to maintain the HART capabilities safely or if consideration is being given to locally reconfigure HART to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the HART capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y						
H15	HART	Recording resource levels	Organisations must record HART resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily at shift change over even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where HART staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y						
H16	HART	Record of compliance with response time standards	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.	Y						
H17	HART	Local risk assessments	Organisations must maintain a set of local specific HART risk assessments which supplement the national HART risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation must also ensure there is a local process to determine how HART staff should conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H18	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H19	HART	Safety reporting	Organisations must have a robust and timely written process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 24 hours of the risk being identified.	Y						
H20	HART	Receipt and confirmation of safety notifications	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.	Y						
H21	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H22	HART	Initial deployment requirement	Four HART personnel must be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations. The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						

H23	HART	Additional deployment requirement	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.	Y							
H24	HART	Attendance at strategic sites of interest	Organisations maintain a HART service capable of placing six HART personnel on scene at strategic sites of interest within 45 minutes. These sites were initially determined through the Model Response Doctrine which led to the strategic placement of HART units. The 45 minute standard is therefore primarily associated with key transport infrastructure and densely populated areas. Where a Trust through their LRF have identified additional strategic sites of interest which may be beyond a 45 minute HART response, the Trust must have local multi-agency plans to act as a contingency for a potentially delayed HART response. A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region. If the HART Team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y							
H25	HART	HART Mutual aid	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30-minute notice to move to anywhere in the United Kingdom following a mutual aid request endorsed by NHS England or NARU. Trusts can also maintain the 30-minute notice to move by way of a recall to duty or on-call process (i.e. where members of the on-duty team are unable to deploy due to child care or personal commitments at the time of the notification). A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region.	Y							
Domain: Logistics											
H26	HART	Capital depreciation and revenue replacement schemes	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment. This must include maintaining capital provisions of at least £1.9 million depreciated over 5 years to maintain the HART fleet and incident ground equipment. Internal HART budgets and expenditure must be in accordance with the reference costs set nationally for HART units. Given that the HART capabilities are national as well as local, HART funding provision must not be reallocated internally away from HART within the express permission of NHS England (the National EPRR team).	Y							
H27	HART	Interoperable equipment	Organisations must procure and maintain minimum levels of interoperable equipment specified in National Equipment Data Sheets. To maintain minimum levels of interoperability, national interoperable equipment that has not be specified within National Equipment Data Sheets should not be utilised as part of the HART capabilities.	Y							
H28	HART	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks (where applicable) coordinated by NARU unless they can provide assurance that the local procurement is interoperable and meets the requirements of the National Equipment Data Sheets. Any locally procured equipment that does not have a National Equipment Data Sheet which has been procured locally to support the delivery of training, sits outside of the national safe system of work. Trusts must ensure that they have local risk assessments and governance provisions in place to manage the use of such equipment. Any such equipment must not be deployed at incidents in support of HART capabilities.	Y							
H29	HART	Fleet compliance with national specification	Organisations must ensure that the HART fleet and associated incident ground technology remain compliant with the national specification. Nationally specified vehicles must conform to the national loading lists for each vehicle and the vehicles state of readiness must be updated on the national monitor systems. This will include national location tracking.	Y							
H30	HART	Equipment maintenance	Organisations must ensure that all HART equipment is maintained according to applicable standards and in line with manufacturers recommendations. This will include standards specified in the National Equipment Data Sheets and relevant associated BS or EN related standards (or equivalent).	Y							
H31	HART	Equipment asset register	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y							
H32	HART	Capital estate provision	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	Y							
SORT **Domain: Capability**											
S1	SORT	Maintenance of national specified MTFA capability	NHS Ambulance Trusts must maintain a combined MTA (Marauding Terrorist Attack) and CBRN (Chemical Biological Radiological Nuclear) capability in accordance with national specifications. These capabilities operate in support of Hazardous Area Response Team deployments when required.	Y							
S2	SORT	Compliance with safe system of work	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).	Y							
S3	SORT	Interoperability	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain nationally interoperable and confirm the scope of operational practice defined within national capability matrices published by NARU.	Y							
S4	SORT	Access to specialist scientific advice	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. All Commanders and NILOs / Tactical Advisors must be able to access this advice at all times (24/7).	Y							
Domain: Human Resources											
S5	SORT	SORT establishment	NHS Ambulance Trusts must maintain a minimum establishment of 290 SORT trained staff. For compliance purposes this must be for at least 90% of the calendar year. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year). Recall to duty programmes must be in addition to this on duty requirement. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant. • Less than 25 at any time = non compliant.	Y							
S6	SORT	Completion of a Physical Competency Assessment	All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually). The physical competence assessment must be conducted to the nationally specified standard (as specified by the National Ambulance Resilience Unit). 'Active' staff means staff that are undertaking operational shifts where their numbers are being included within SORT staffing level data for the Trust. SORT staff that have not successfully completed a physical competency assessment within a 12 month period must be placed on a restriction of practice. They must not respond to an incident as a SORT operative whilst on such a restriction of practice and the Trust must have robust processes in place to ensure compliance with this provision. Staff on a restriction of practice for SORT must not be counted as part of the SORT on-duty staffing levels.	Y							
S7	SORT	Staff competency	NHS Ambulance Trusts must ensure that each individual SORT member of staff remains compliant with the competency standards defined within national Training Information Sheets (TIS's) published by NARU for SORT staff and CBRN training is aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by chemical, biological, radiological or nuclear incident. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).	Y							
S8	SORT	Training records	NHS Ambulance Trusts must ensure that comprehensive training records are maintained for all SORT personnel in their establishment. These records must include; a record of mandated training completed aligned to the national Training Information Sheets (TISs), when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the SORT skill sets. It must also include any restrictions in practice and corresponding action plans.	Y							
S9	SORT	Provision of clinical training	NHS Ambulance Trusts are required to provide supportive training to statutory Fire and Rescue Services within their Trust geography that have a declared MTA capability. That supportive training must cover the clinical elements of the response and working jointly with Ambulance HART and SORT deployments for MTA incidents.	Y							
S10	SORT	Staff training requirements	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.	Y							
S11	SORT	Arrangements to manage staff exposure and contamination	NHS Ambulance Trusts must ensure they have robust procedures in place to document all staff who may have become exposed or contaminated during incidents involving CBRN or hazardous materials. These procedures must include attendance at scene monitoring, exposure monitoring and post exposure management.	Y							
S12	SORT	CBRN Lead trainer	NHS Ambulance Trusts must have sufficient capacity of dedicated training or instructional staff for SORT to enable the Trusts to deliver and maintain the nationally specified training requirements each year.	Y							

S13	SORT	FFP3 access	NHS Ambulance Trusts must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent such as a Powered Respirator Protective Hood PRPH) and that they have been appropriately fit tested (where applicable). The specification and standards for this protection (including the Air Particulate Filtration) must comply with the provisions set out in the relevant national Equipment Data Sheet (EDS).	Y							
S14	SORT	IOR training for operational staff	NHS Ambulance Trusts must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR) principles of Remove Remove Remove. Organisations must maintain records to demonstrate how many staff are trained (and when the training occurred).	Y							
Domain: Administration											
S15	SORT	Effective deployment policy	NHS Ambulance Trusts must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the SORT capability. These procedures must be aligned to the MTA Joint Operating Principles (produced by JESIP).	Y							
S16	SORT	Identification appropriate incidents / patients	NHS Ambulance Trusts must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of SORT personnel to an incident requiring the MTA or CBRN capability. This must include specific mechanisms to identify on-duty SORT staff and make them available to response to the incident as quickly as possible. These procedures must be aligned to relevant Joint Operating Principles (JOPs, produced by JESIP).	Y							
S17	SORT	Change Management Process	NHS Ambulance Trusts must use the national Change Management Process coordinated by NARU before reconfiguring (or changing) any SORT procedures, equipment or training that has been specified as nationally interoperable.	Y							
S18	SORT	Record of compliance with response time standards	NHS Ambulance Trusts must monitor their compliance with the SORT core standards set out in this document. The Accountable Emergency Officer in each Trust is responsible to their Board for the levels of compliance against these standards. Each NHS Ambulance Trust must maintain accurate records of their compliance with the core standards set out in this document and make those records available during annual audits or inspections commissioned by NHS England. These records should also be made available to NHS commissioners and regulators as required.	Y							
S19	SORT	Notification of changes to capability delivery	SORT is both a national and regional capability. It provides critical mitigation to risks articulated in the risk register for the United Kingdom. NHS Ambulance Trusts must not take the SORT capability offline or reconfigure it locally without first obtaining permission from the National Ambulance Resilience Unit or NHS England's national EPRR team. In the first instance, the discussion needs to be with the NARU On-Call Duty Officer. In any event that the organisation is unable to maintain the SORT capability safely or if consideration is being given to locally reconfigure SORT to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the SORT capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y							
S20	SORT	Recording resource levels	NHS Ambulance Trusts must record SORT resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where SORT staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y							
S21	SORT	Local risk assessments	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y							
S22	SORT	Lessons identified reporting	NHS Ambulance Trusts must have a robust and timely process to report any lessons identified following a SORT deployment or training activity that may affect the interoperable service to NARU within 12 weeks using the nationally approved lessons database. Note: the 12 weeks starts from resolution of the incident.	Y							
S23	SORT	Safety reporting	NHS Ambulance Trusts have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the SORT service as soon as is practicable and no later than 24 hours of the risk being identified. Reports must be made using the national safety alert system managed by NARU.	Y							
S24	SORT	Receipt and confirmation of safety notifications	NHS Ambulance Trusts have a process to acknowledge and respond appropriately to any national safety notifications issued for SORT by NARU within 2 days.	Y							
S25	CBRN	HAZMAT / CBRN plan	NHS Ambulance Trusts must ensure that their major or complex incident plans include specific provisions to manage a MTA or CBRN incident. These provisions must align to the national SORT matrices and operating procedures published by NARU. All SORT staff must have access to both the Trust plans and the national safe system of work provisions (including procedures, generic risk assessments etc) published by NARU and should be familiar with their contents. These plans must also be aligned to the relevant JESIP / JOP provisions.	Y							
S26	SORT	SORT Audit and inspections	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the SORT capability that are commissioned by NHS England.	Y							
S27	SORT	SORT capability funding	NHS Ambulance Trusts must ensure that the national funding provided to support the SORT capability within Trusts is used to support the maintenance of that capability. The Trust must not redirect these funds and use them for other internal purposes within the express permission of NHS England or NARU.	Y							
Domain: Response time standards											
S28	SORT	SORT Readiness to deploy	NHS Ambulance Trusts must ensure their SORT capability remains at a high state of readiness to deploy to MTA or CBRN related incidents between the hours of 0600 and 0200 daily. On receipt of an emergency call or notification by a partner agency of a potential incident involving CBRN or a marauding terrorist attack, NHS Ambulance Trusts must immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed or that can be made available from lower priority calls.	Y							
S29	SORT	SORT response time	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.	Y							
S30	SORT	SORT Mutual Aid	NHS Ambulance Trusts must maintain their SORT capability at a state of readiness which is able to support a national deployment under mutual aid with reference to the national mutual aid policy. As an interoperable capability, it is nationally expected that Trusts provide SORT mutual aid when requested by NHS England, NARU or the National Ambulance Coordination Centre.	Y							
Domain: Logistics											
S31	SORT	PPE availability	NHS Ambulance Trusts must ensure that the nationally specified personal protective equipment is available for all operational SORT personnel and that the equipment remains compliant with the relevant national Equipment Data Sheets (EDSs).	Y							
S32	SORT	Equipment procurement via national buying frameworks	NHS Ambulance Trusts must procure SORT (MTA and CBRN) equipment specified in the SORT (MTA and CBRN) related Equipment Data Sheets and where applicable through the buying frameworks maintained by NARU. NHS Ambulance Trusts must also ensure sufficient financial provisions are in place to replace SORT equipment as specified by the relevant national Equipment Data Sheets. For MTA equipment, this should include an annual programme of rolling replacement.	Y							
S33	SORT	Equipment maintenance	All SORT equipment must be maintained in accordance with the manufacturer's recommendations and applicable national industry standards. This must include a programme of regular inspections and preventative maintenance as specified in relevant national Equipment Data Sheets.	Y							
S34	SORT	SORT asset register	NHS Ambulance Trusts must maintain an asset register of all SORT (MTA and CBRN) assets specified in the relevant national capability matrices and associated national Equipment Data Sheets. The register must include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y							
S35	SORT	PRPS - minimum number of suits	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.	Y							
S36	SORT	Individual / role responsible for SORT assets	NHS Ambulance Trusts must have a named individual or role that is responsible for ensuring SORT assets are managed appropriately.	Y							
S37	SORT	CBRN countermeasures	NHS Ambulance Trusts must ensure that they make CBRN countermeasures available for use by frontline Ambulance staff. This must include distribution of countermeasures across frontline assets in accordance with the specification and requirements defined within the relevant national matrix and Equipment Data Sheets (EDSs).	Y							
S38	SORT	Water supply for clinical decontamintion	NHS Ambulance Trusts must ensure they have local or regional agreements and procedures in place to facilitate access to water supplies to carry out clinical decontamination. This may be achieved in conjunction with Fire and Rescue Services.	Y							
S39	SORT	Equipment Vehicles	Organisations must maintain a minimum of four vehicles to provide the MTA pooled equipment These vehicles should be replaced at a maximum of every 7 years. A minimum of 160 sets of pooled ballistic PPE and associated medical consumables must be available split over the organisations geographical area based on a local Trust assessment of risk.	Y							

6.4

S40	SORT	Equipment vehicle readiness	In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident. Failure to rapidly mobilise the equipment on these vehicles will delay the deployment of responders at the scene	Y						
S41	SORT	Vehicle Tracking	NHS Ambulance Trusts must ensure that vehicles used to deploy interoperable capabilities can be tracked nationally by NARU via nationally approved systems. This includes the vehicles associated with the SORT capability that are used to transport either pooled MTA equipment or CBRN resources to the scene of an incident	Y						
Mass Casualty Capability **Domain: Capability Alignment Standards**										
M1	MassCas	Mass casualty response arrangements	NHS Ambulance Trusts must ensure they have plans and procedures in place that specifically cater for a mass casualty incident and that those provisions are aligned to the national framework or concept of operations for managing mass casualty incidents published by NHS England.	Y						
M2	MassCas	Arrangements to work with NACC	NHS Ambulance Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) in the event that national coordination is required or activated.	Y						
M3	MassCas	EOC arrangements	NHS Ambulance Trusts must have effective and tested arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving medical facilities (including designated Acute Trusts) within the first hour of mass casualty or major incident being declared	Y						
M4	MassCas	Casualty management arrangements	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.	Y						
M5	MassCas	Casualty Clearing Station arrangements	NHS Ambulance Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station or multiple Casualty Collection Points at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation / evacuation	Y						
M6	MassCas	Management of non-NHS resource	NHS Ambulance Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources, as part of the patient distribution model: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
M7	MassCas	Mass Cas Audits and Inspections	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the mass casualties capability that are commissioned by NHS England	Y						
Domain: Mass Casualty Equipment										
M8	MassCas	MCV accommodation	NHS Ambulance Trusts must maintain the number of mass casualty vehicles assigned to them by the National Ambulance Resilience Unit. These vehicles must be maintained in compliance with the national specification and any guidance produced by NARU to ensure effective interoperability	Y						
M9	MassCas	Maintenance and insurance	NHS Ambulance Trusts must insure, mechanically maintain and regularly run the mass casualty vehicles. Each nationally specified mass casualty vehicle must be securely accommodated undercover (garaged) when not deployed and must be maintained with an appropriate shoreline / electrical feed. The vehicle must be parked in a way that would facilitate rapid mobilisation and a high state of readiness. In the event of a mass casualty vehicle being unavailable, within 2 hours the national electronic dashboard must be updated and the NARU On Call Duty	Y						
M10	MassCas	Mobilisation arrangements	NHS Ambulance Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts must ensure that their mass casualty vehicle (MCV) assets maintain a 30-minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the MCV is already deployed at a local incident or is non operational.	Y						
M11	MassCas	Mass oxygen delivery system	NHS Ambulance Trusts must maintain the mass oxygen delivery system on the vehicles, in accordance with the manufacturers guidance (including regular servicing and maintenance)	Y						
M12	MassCas	Drug and pharmaceutical stock management	In accordance with agreements and instructions from NHS England and local Pharmacy Leads, the drugs and pharmaceuticals which form part of the minimum nationally specified stock for each MCV must be appropriately and effectively maintained by the NHS Ambulance Trust.	Y						
M13	MassCas	Fleet compliance with national specification	NHS Ambulance Trusts must ensure that the minimum contents for each MCV (specified through the national load list) are maintained on the vehicle and remain fit for operational deployment / utilisation.	Y						
M14	MassCas	Compliance with safe system of work	NHS Ambulance Trusts must ensure that each MCV is managed in accordance with national procedures and other associated national safe system of work provisions.	Y						
Command and control (C2) **Domain: Generic Standards**										
C1	C2	Consistency with NHS England EPRR Framework	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements. Each NHS Ambulance Trust must comply and fully engage with any audits or inspections of the command and control capability that are commissioned by NHS England	Y						
C2	C2	Consistency with Standards for NHS Ambulance Service Command and Control.	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the National Command and Control Guidance published by NARU.	Y						
C3	C2	NARU notification process	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure (strategic commander down to functional roles) and utilisation of the Trusts interoperable capability assets to manage an incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS ambulance strategic commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are	Y						
C4	C2	AEO governance and responsibility	The Accountable Emergency Officer in each NHS Ambulance Trust is responsible for ensuring compliance with these core standards and the provisions set out within the National Command and Control Guidance published by NARU. NHS Ambulance Trust Boards are required to provide annual assurance against these standards	Y						
Domain: Resource										
C5	C2	Command role availability	NHS Ambulance Trusts must ensure that the command roles defined within the National Command and Control Guidance published by NARU are maintained and available at all times within their service area.	Y						
C6	C2	Support role availability	NHS Ambulance Trusts must ensure that there is sufficient resource in place to provide each command level (strategic, tactical and operational) with the dedicated support roles set out in the National Command and Control Guidance published by NARU standards at all times.	Y						
C7	C2	Recruitment and selection criteria	NHS Ambulance Trusts must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident	Y						
C8	C2	Contractual responsibilities of command functions	Staff expected to discharge strategic, tactical, and operational command functions must have those responsibilities explicitly defined within their individual contracts of employment.	Y						
C9	C2	Access to PPE	The NHS Ambulance Trust must ensure that each commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function. To ensure interoperability at a national incident, this must include access to tabards that are compliant with the specification defined within the National Command and Control Guidance published by NARU.	Y						
C10	C2	Suitable communication systems	The NHS Ambulance Trust must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	C2	Risk management	NHS ambulance commanders must manage risk in accordance with the method prescribed in the National Command and Control Guidance published by NARU and the JESIP principles	Y						
C12	C2	Use of JESIP JDM	NHS ambulance commanders at all levels must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established	Y						
C13	C2	Command decisions	NHS ambulance command decisions at all three levels must be made within the context of the legal and professional obligations set out in the National Command and Control Guidance published by NARU. Tactical and operational commanders must utilise the national Standard Operating Procedures (SOPs) for command and associated safe system of work considered	Y						
Domain: Record keeping										
C14	C2	Retaining records	All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years	Y						
C15	C2	Decision logging	Commanders at all three levels (strategic, tactical and operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. Ambulance Trusts are under a legal, professional and contractual obligation to ensure their commanders maintain appropriate decision logs	Y						
C16	C2	Access to loggist	Each level of command (strategic, tactical and operational) must be supported by a trained and competent loggist. A minimum of three loggists must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one operational commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for additional logs to be kept by non trained loggists should the need arise.	Y						
Domain: Learning Lessons										
C17	C2	Lessons identified	NHS Ambulance Trusts must ensure they maintain an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards and that such learning is shared on the national systems produced by NARU and/or JESIP	Y						
Domain: Competence										

C18	C2	Strategic commander competence - National Occupational Standards	Personnel that discharge the strategic commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Strategic commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Strategic commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions.	Y						
C19	C2	Strategic commander competence - nationally recognised course	Personnel that discharge the strategic commander function must have successfully completed a nationally recognised strategic commander course (nationally recognised by NHS England / NARU). Individuals must not be placed on an active command rota or fulfil strategic commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets	Y						
C20	C2	Tactical commander competence - National Occupational Standards	Personnel that discharge the tactical commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Tactical commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Tactical commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service tactical commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to a tactical commander understanding the capabilities under their command.	Y						
C21	C2	Tactical commander competence - nationally recognised course	Personnel that discharge the tactical commander function must have successfully completed a nationally recognised tactical commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil tactical commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets	Y						
C22	C2	Operational commander competence - National Occupational Standards	Personnel that discharge the operational commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Operational commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Operational commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service operational commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to an operational commander understanding the capabilities under their	Y						
C23	C2	Operational commander competence - nationally recognised course	Personnel that discharge the operational commander function must have successfully completed a nationally recognised operational commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil operational commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C24	C2	Commanders - maintenance of CPD	All strategic, tactical and operational commanders must maintain appropriate Continued Professional Development (CPD). This CPD must be aligned to the relevant National Training Information Sheet for Command and the NHS England Minimum Occupational Standards for EPRR. The core competency requirements defined within the relevant Training Information Sheet must be specifically referenced within the CPD portfolio maintained by the individual commander. Individual CPD portfolios must demonstrate sufficient maintenance of skill and competence against the relevant competencies for the role	Y						
C25	C2	Commanders - exercise attendance	All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must result in the individual being immediately suspended from their command duties until such time as they are able to fulfil this mandatory competency requirement.	Y						
C26	C2	Training and CDP - suspension of non-compliant commanders	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be removed from any active command rota and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.	Y						
C27	C2	Assessment of commander competence and CDP evidence	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are maintaining the minimum levels of competence defined within the National Training Information Sheets. As a minimum, this must include obtaining an annual signed declaration from all active commanders that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake 'dip sampling' of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is immediately suspended from discharging command functions at an incident.	Y						
C28	C2	NILO / Tactical Advisor - training	Personnel that discharge a NILO or Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU)	Y						
C29	C2	NILO / Tactical Advisor - CPD	Personnel that discharge the NILO or tactical advisor function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to date competence in the NILO or tactical advisor discipline	Y						
C30	C2	Loggist - training	Personnel that discharge the loggist function must have completed a loggist training course which covers the elements and requirements defined by the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C31	C2	Loggist - CPD	Personnel that discharge the loggist function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	C2	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	The medical director of each NHS ambulance service is responsible for ensuring that the strategic medical advisor, medical advisor and forward doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the National Ambulance Service Command and Control Guidance published by NARU).	Y						
C33	C2	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the medical advisor or forward doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises will form part of mandatory continued professional development and evidence must be included in the form of documented reflective practice for each exercise	Y						
C34	C2	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures	Commanders (strategic, tactical and operational) and the NILO and tactical advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in compliance with these principles	Y						
C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors (or equivalent) must be aware of the ambulance service's operational capabilities, including the interoperable capabilities, and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the National Command and Control Guidance published by NARU to enable the initial steps to be taken (e.g. notifying the Trust command structure, wider alerting mechanisms, following action cards etc.)	Y						

C36	C2	Responders awareness of NARU major incident action cards	Front line ambulance responders will often be, by default, the interim first commander at scene. So, all frontline operational ambulance staff must be aware of basic major incident principles, including their Trust's major incident plan and the need to follow major incident action cards. They must all have access to such cards. All frontline operational ambulance staff must be sufficiently competent to provide accurate information back to the control room and take the initial steps detailed on relevant major incident action cards safely and effectively.	Y						
JESIP Specific Core Standards										
J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine must be incorporated into all organisational policies, plans and procedures relevant to a multi-agency emergency response within NHS Ambulance Trusts.	Y						
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine	Y						
J4	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that commanders and command support staff have access to the latest JESIP products, tools and guidance.	Y						
J5	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene.	Y						
J6	JESIP	Awareness of JESIP - control room staff	NHS ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets.	Y						
J7	JESIP	Training records - staff requiring training	NHS ambulance service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J8	JESIP	Command function interoperability command course	All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Y						
J9	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J10	JESIP	Commanders - interoperability command course	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.	Y						
J11	JESIP	Participation in multiagency exercise	At least every three years, all NHS ambulance commanders (at strategic, tactical and operational levels) must participate as a player in a joint exercise with at least Police and Fire Service command players where JESIP principles are applied.	Y						
J12	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J13	JESIP	Training records - 90% operational and control room staff are familiar with JESIP	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.	Y						

Ref	Domain	Standard	Deep Dive question	Supporting evidence- including examples of evidence	Acute Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in EPRR arrangements. Amber (partially compliant) = Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)											
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	Y	Draft TOR for EPRR group includes Cyber Security/ IT lead as a member of the group	Fully compliant				
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'	Y	Plannns are complete and fully documented.	Fully compliant				
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	Y		Fully compliant				
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	Y		Fully compliant				
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	Y		Fully compliant				
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	Y		Fully compliant				
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	Y		Fully compliant				
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package	Y		Fully compliant				

DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	Y	Fully compliant
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	Y	Fully compliant
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Y	Fully compliant

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BOARD OF DIRECTORS:	**3 October 2024**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Liz Baker - Chair**	
DATE OF COMMITTEE MEETING:	**16 September 2024**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Strategic/System Update	Y	Y	N	A revised scope for the strategy review programme; workstream 3 was presented. The ICB had been developing this high level operating model over the last 18 months and was now seeking to complete this phase and move to implementation of the model to support the ICB medium term plan and ambitions. The paper outlined the work completed to date, the key assumptions now being made, the questions that remained to be resolved and outlined the process to be taken during Q2/Q3.
2.2 Report from West Essex Health & Care Partnership Board	Y	Y	N	This paper provided an update on progress of the West Essex Health & Care Partnership Delivery Plans for 2024. These plans were for the three priorities agreed by the partnership that the partnership would be accountable for delivering in 2024. Progress had been made on all priorities with the exception of Adult Mental Health and Wellbeing (Prevention Priority 1). The WEHCP Board would be undertaking a deep dive at its meeting in September to inform this programme. Delivery of these programmes was overseen by Expert Oversight Groups reporting to the WEHCP Transformation Committee.
2.3 East & North Hertfordshire Health & Care	Y	Y	N	Areas of work were similar to those within West Essex with a big focus on frailty. There had been some movement on reshaping the governance to align with a previous review. The Board now had its own chair and under its new terms of

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Development Programme Update				reference, PAHT would no longer be represented on this Board. A detailed discussion then followed around this with the place director from West Essex confirming that there would now be a E&N Herts representative on the West Essex HCP. There was an agreement it would be escalated to the PAHT Board. It was agreed the ENH Place Director would be asked to attend alternate STC meetings to update the Committee.
2.4 HCP Development Plan	Y	Y	N	This paper was presented by the new Development Director West Essex HCP and detailed the work to date on developing the West Essex Health & Care Partnership. There were three areas of focus for the approach to developing the West Essex HCP. 1. Development of WE HCP in 24/25 to clarify the governance, responsibility and accountability, reporting flows. Develop data reporting on finance, activity, population health, performance and quality. Clear arrangements for HCP influence on system wide programmes of work. 2. Design an HCP led process for 25/26 operational planning leading to a West Essex integrated delivery plan supported by all partners. 3. Discussion and agreement of further delegated functions for 25/26 including financial delegation and development of horizontal & vertical integration plans for implementation in 26/27.

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Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.6 BAF Risk 3.2 (System Pressures)	Y	Y	N	The risk score remained unchanged at 16.
3.1 PAHT2030 Update	Y	Y	N	The paper provided an update against PAHT2030 milestones. 2023/24 milestones for 'Digital Health' and 'New hospital' and 'Our Culture' had been closed. 'Transforming Our Care' and 'Corporate Transformation' were rated amber. The 2024/25 milestone for 'Our Culture' was rated green and 'Transforming Our Care', 'Corporate Transformation' and 'Digital Health' were rated amber and 'New Hospital' was rated red. The 'New Hospital' rating had changed to red from green to reflect overall programme status rather than PAH internal status (request of STC). 'Transforming our Care' had moved from green to amber due progress and updates received.
3.2 Transforming our Care Update	Y	Y	N	Colleagues provided a presentation on the New Hospital Programme clinical workstream. Transforming our Care and the New Hospital Programme workstreams for PAHT2030 work is underway to align the PWC clinical model with the clinical strategies and once compete the key milestones for TOC will be updated to2025 and beyond.

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BOARD OF DIRECTORS:	**3 October 2024**			**AGENDA ITEM: 7.1**
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REPORT FROM:	**Liz Baker - Chair**			
DATE OF COMMITTEE MEETING:	**16 September 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 Digital Workstream Update	Y	Y	N	The paper provided the monthly update on the programme with specific reference to progress to full dress rehearsal and readiness for go-live in early November which was still tracking to plan. There had been a full discussion around this at the Trust Board the previous week.
3.4 BAF Risk 1.2 (EHR)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
3.5 BAF Risk 1.4 (Alex Health)	Y	Y	N	In line with the recommendation it was agreed that the current risk score would remain at 16.
3.6 New Hospital Update	Y	Y	N	The Trust continues to work with the new hospital programme.
3.7 BAF Risk 3.5 (New Hospital)	Y	Y	N	It was agreed that the risk score would remain at 20.
3.8 Corporate Transformation Update	Y	Y	N	**Pathology Services Update:** The paper outlined what mobilisation would look like post signature of the contract and summarised the progress made with specific workstreams that affected PAH. **Dragon Medical One (DMO)** continued

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BOARD OF DIRECTORS:			**3 October 2024**	**AGENDA ITEM: 7.1**
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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				to be deployed within the Trust with near universal take up in all areas though there remained some blockages within T&O which were being resolved.
3.9 Strategic Capital Projects	Y	Y	N	**Elective Hub:** NHSE approval had been granted for £22m of capital funding from the Targeted Investment Fund (TIF) to support the project. In addition, the system had approved £2.99m to achieve the originally forecasted capital cost of £24.99m. In April 2024 the system was appraised on unforeseen construction issues which increased the total capital requirement to £29.3m. The system CFOs were currently reviewing where the additional £4.3m would be obtained from.
3.10 Vanguard Theatre Update	Y	Y	N	The success of the Vanguard theatre had been discussed at the Trust Board in detail the previous week. It was agreed oversight of progress would be undertaken at PAF going forward.

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Trust Board – 03.10.24 **Item No: 7.2**

REPORT TO BOARD FROM: Leadership Management Team (LMT)
CHAIR: Sharon McNally
DATE OF MEETING/S: 10 & 24 September 2024

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the LMT meeting on **10 September 2024**:

- **Risk Management Group:** Risks were approved by LMT subject to some amendments to risk descriptions.
- **Tiering Inc Cancer, Electives & Urgent Care improvement:** An update was discussed. Divisions had been asked to provide their best case/worst case scenario positions for 65 week waits as at the end of September to confirm the overall trust position.
- **Finance Update:** An updated was discussed. The financial position was noted. Challenges were discussed including non-pay which was overspent by £4.7m. Further scrutiny was needed on requests for additional sessions/clinics.

The following items were discussed at the LMT meeting on **24 September 2024:**

- **CDC Project Approval – Contractor: LMT supported the onward progression of the request for** a decision on whether to switch contractors. Further actions were agreed and PAF considered the options at its meeting later that week.
- **Nursing & Midwifery Establishment Review:** approved and recommended to PC, PAF and Board
- **AlexHealth - Full dress rehearsal and Cutover Plan:** An update was provided on how the full dress rehearsal was progressing; it was noted that it was going well. Plans to reduce clinic activity over the EHR go live period were also discussed.

7.2

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board 3 October 2024**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Committee Chair- Helen Howe**			
DATE OF COMMITTEE MEETING:	**13 September 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Breast Unit Fundraising Update	Y	Y	N	An update was received on planned events for the year ahead. Two further events were approved by the Committee; House of Commons Charity Dinner in March 2025 and Holland & Holland Charity Shoot in May 2025.
2.2 Charity/Fundraising Update	Y	Y	N	The appointment of the Head of Charity and Charity Assistant was acknowledged. The strategy would now be reviewed by the Head of Charity. A finance database system was being explored as an add on to the finance system
3.1 Charitable Funds Annual Report (Draft) and Accounts	Y	Y	N	The Committee approved the Charitable Funds Accounts and recommended them to the Corporate Trustee for approval. The Annual Report was reviewed, further amendments were required, and would be presented for approval at the next meeting.
3.2 Report of External Auditors on Accounts including Letter of Representation	Y	N	N	The independent examiners report was noted. No issues were raised.
3.1 Charitable Funds Finance Report	Y	N	N	The total fund balance at M3 was £736k (£743k as at 31st March 2024). The total income received at M03 2024/25 was 275% of the amount received at the same period last year. The plans for the dormant funds were discussed as well as a fund holder register.