The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 3 April 2025 at 09.30 – 12.45
Venue: Kao Park Boardroom, Kao Park, Harlow

	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	15
09.35		**Staff Story: Sexual Safety**			
02 Chair and Chief Executive's reports					
10.00	2.1	Acting Chair's Report	Inform	Acting Chair	Verbal
10.05	2.2	CEO's Report	Inform	Chief Executive	17
10.15		*Opportunity for members of the public to ask questions about the board discussions or have a question answered*			
03 Risk					
10.20	3.1	Corporate Risk Register	Approve	Medical Director	23
10.25	3.2	Board Assurance Framework 2024-25 *Diligent Resources: BAF 2024/25*	Review/ Approve	Director of Corporate Governance	28
04 Patients					
10.30	4.1	Reports from Quality and Safety Committee 28.03.25: • Part I • Part II	Assure	Committee Chairs	33 39
10.40	4.2	Maternity Reports: • Maternity Patient Safety Incidents (MPSIs) Update • Quarterly Maternity Assurance Report	Assure Assure	Chief Nurse/ Director of Midwifery	42 45
10.55	4.3	Nursing, Midwifery and Care Staff Levels	Assure	Chief Nurse	55
11.00	4.4	Learning from Deaths (Mortality) Report	Assure	Medical Director	72
		BREAK 11.10 to 11.20			
05 People					

11.20	5.1	Report from People Committee 31.03.25	Assure	Committee Chair	78
11.25	5.2	Staff Survey Update	Inform	Interim Chief People Officer	83
11.35	5.3	EDI Annual Report	Inform	Interim Chief People Officer	98
06 Performance/Pounds/Places					
11.40	6.1	Report from Performance and Finance Committee 27.03.25	Assure	Chair of Committee	117
11.45	6.2	M11 Finance Update	Assure	Chief Finance & Infrastruture Officer	125
11.50	6.3	Operational Plan 25/26	Assure	Chief Finance & Infrastructure Officer	135
12.00	6.4	Integrated Performance Report (IPR) M11	Discuss	Chief Information Officer	145
07 Strategy/Governance					
12.10	7.1	Host/Lead Provider Framework	Approve	Chief Strategy Officer	160
12.25	7.2	Annual Report: Emergency Preparedness Resilience & Response	Approve	Chief Operating Officer	167
12.30	7.3	Report from Executive Board Meeting held on 11 March 2025	Assure	Chair of Committee	172
12.35	7.4	Corporate Trustee: Report from CFC.18.03.25	Assure	Chief Finance & Infrastruture Officer	174
	7.5	*Opportunity for members of the public to ask questions about the board discussions or have a question answered.*			
08 Closing administration					
	8.1	Any unresolved issues			
	8.2	Review of Board Charter			
	8.3	Summary of actions and decisions	-	Chair/All	
	8.4	New risks and issues identified	Discuss	All	
	8.5	Any other business	Review	All	
	8.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	

12.45		Close			

Date of next meeting: 1 May 2025

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 2025/26			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Acting Trust Chair	Darshana Bawa	Chief Executive	Thom Lafferty
Non-executive Director and Senior Independent Director (SID)	Elizabeth Baker	Chief Nurse	Sharon McNally
Non-executive Director	George Wood	Chief Operating Officer	Stephanie Lawton
Non-executive Director	Colin McCready	Medical Director	Fay Gilder
Non-executive Director	Oge Austin-Chukwu	Chief Finance and Infrastructure Officer	Tom Burton
Associate Non-executive Director	Anne Wafula-Strike	**Executive Members of the Board (non-voting)**	
Associate Non-executive Director	Ralph Coulbeck	Chief Strategy Officer	Michael Meredith
NExT Non-executive Director	Bola Johnson	Interim Chief People Officer	Giovanna Leeks
Associate Non-executive Director	Ben Molyneux	Director of Quality Improvement	Jim McLeish
Associate Non-executive Director	Parag Jasani	Chief Information Officer	Phil Holland
Corporate Secretariat			
Director of Corporate Governance	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 February 2025 from 10:00 to 13:20

Present:

Hattie Llewelyn-Davis	**Trust Chair (TC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO-TB)
Ralph Coulbeck (non-voting) (joined late)	Associate Non-Executive Director (ANED-RC)
Fay Gilder	Medical Director (MD)
Phil Holland (non-voting)	Chief Information Officer (CIO)
Bola Johnson (non-voting)	NExT Non-Executive Director (NNED-BJ)
Giuseppe Labriola	Deputy Chief Nurse (DCN)
Thom Lafferty	Chief Executive Officer (CEO)
Stephanie Lawton	Chief Operating Officer (COO)
Giovanna Leeks (non-voting)	Interim Chief People Officer (I-CPO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Michael Meredith (non-voting)	Chief Strategy Officer (CSO)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)

In attendance/Observing:

Camelia Melody	Deputy Chief Operating Officer (DCOO)
Lauren Nash	Head of Communications (HoC)
Linda Machakaire (item 4.2)	Director of Midwifery (DoM)

Members of the Public
n/a

Apologies:

Sharon McNally	Chief Nurse (CN)
Liz Baker	Non-Executive Director (NED-LB)

Secretariat:

Heather Schultz	Director of Corporate Governance (DCG)
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 above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 05.12.24 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted. Members had no questions.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC presented her report. Since writing her paper she was pleased to report that the role of Associate Non-Executive Director (ANED) had been offered to two individuals, Ben Molyneux and Parag Jasani. Both were strong appointments and would bring significant

	acute and performance knowledge to the Board. She was also delighted to update that Helen Howe's role as the Independent Chair of the Charitable Funds Committee had been extended for another two years.
2.2	In response then to a question from NED Oge Austin-Chukwu (NED-OA) the TC confirmed the allocation of the new ANEDs to committees had not yet been finalised and may involve the movement of other NEDs.
2.2 CEO's Report	
2.3	The CEO presented his update and the key headlines were as follows: • **New Hospital Programme (NHP):** Members were aware of the recent Government announcement relating to all schemes and there was now a degree of certainty over when building works would begin for PAHT (a 2032 start). He informed colleagues this would mean huge frustrations for the public, patients and staff in terms of the significant delay now to a new hospital for Harlow. The announcement also meant some of the estates risks the hospital had lived with for some time, could no longer continue. He and the Chief Finance & Infrastructure Officer (CFIO) were therefore working on a risk prioritised plan to support access to emergency capital. This would not be to upgrade areas but would be to fix basic functionality within the estate. • **Alex Health (AH):** It was worth noting that whilst the huge success of the launch should be celebrated, it had become clear over the last few weeks that there were clinical and operational concerns and plans for dealing with and mitigating the associated risks were underway. • **Changes to the Executive Team:** The CEO asked colleagues to note these. The new Director of Communications would join the organisation on 07.04.25. He then asked the Chief Operating Officer (COO) to update members on a new responsibility she had acquired. The COO then updated that she had been appointed as Chair of the NHS Providers COO and Deputy COO Network, a joint appointment with the ENHT COO. The CEO congratulated the COO on this appointment. • **Operating Plan Guidance:** This had now been issued after some delay. Some of the operating targets whilst reasonable (ED and waiting lists) would be challenging for the Trust to achieve. Nevertheless the overriding principle should be that the Trust would set out to achieve those. • **West Essex Health & Care Partnership (WEHCP):** A second meeting had been held the previous week and the conversation had included the reality of what Host Provider would mean for the organisation. The CEO reminded members there had been agreement with the ICB and System Partners that the Trust would step into this space from April and be responsible for the acute provision of care but would also have the greater responsibility for health and care across the West Essex Place including the adult community services contract and the shift in focus of care into the community. There had been some anxieties in terms of the pace of change at the meeting and there would be more work to come on that but it was a positive move forward.
2.4	NED Darshana Bawa (NED-DB) then asked whether there were any funding implications related to the Health Sciences Academy at Harlow College. The Interim Chief People Officer (I-CPO) responded that the Trust had been transparent in that it had no funding to provide but there was work underway with the local council to try and secure some there. In response to a suggestion from ANED Anne Wafula-Strike (ANED-AWS) it was also agreed organisations within the community may also be able to support.
2.5	In terms of the delays to the new hospital, ANED-AWS asked whether some more concrete assurance could be gleaned from the Government/Treasury to ease the public fatigue around this. The CEO responded his view was there was greater certainty now than ever before, albeit no absolute guarantee. His reflection too was that the PAHT scheme was fairly early on in its development so there remained a lot for the organisation to do still, including addressing its current estates risks.
2.6	There were no questions from the public at this point in the meeting.

03 RISK/STRATEGY	
3.1 Corporate Risk Register (CRR)	
3.1	This update was presented by the Medical Director (MD) and the paper was taken as read. She informed members two new risks had been added, both with a score of 16. The first related to maintaining Trust computer systems and the second to the out-of-hours Ophthalmology Service.
3.2	NExT NED Bola Johnson (NNED-BJ) asked how it was being ensured that risks with a score of 15 or below were being managed, as those could be outside the organisation's risk appetite. The MD responded those were managed by the divisions and the Risk Management Group (RMG). NNED-BJ then asked whether there was an escalation process in place for these. The MD responded there was and this was to the RMG if the divisions could not contain the mitigations themselves. The COO then added that risks were also discussed at the divisional board meetings and then at divisional performance review meetings with the Executive team.
3.3	NED Oge Austin-Chukwu (NED-OA) then voiced her concerns about the Ophthalmology risk referenced above. The COO responded this was a known risk and a risk across the ICS. There were clear opportunities here particularly with the recent improvements being seen in terms of the Vanguard Unit and conversations would continue within the ICS in terms of how to take this service forward. She acknowledged however it was a fragile position currently. The Director of Quality Improvement (DoQI) then added that emergency first aid could be provided in the ED, but he agreed acute service collaboration across the ICS was the way forward.
3.4	NED-DB then asked why the risk for fire alarms, raised in January 2021 was now increasing in score. The Chief Strategy Officer (CSO) responded that fire was an ongoing risk on the estate and the team continued to review this risk on a regular basis. However, each time there were building works, this identified new and different risks. The current works in the UEC/SDEC had uncovered some new issues which now required action. NED-DB then asked whether there was a complete map of the fire system across the site. The CSO responded there was an understanding of the infrastructure in place to manage fire. What was not available was a map of the compartmentalisation across the site.
3.5	The TC thanked members for their update.
3.2 Board Assurance Framework (BAF) 2024/25	
3.6	This update was presented by the Director of Corporate Governance (DCG). There were two risks to highlight that month. The first was BAF risk 1.5 (Cyber) - a new risk was being added to the BAF. The risk had been discussed at PAF and recommended to the Board. The second was BAF risk 2.1 (GMC Enhanced Monitoring) and it was proposed the risk score be reduced and the risk removed from the BAF. The remaining risk would continue to be monitored by the divisions. She then added that following the recent announcement regarding the new hospital, the new hospital risk and the estates risk were both being reviewed.
3.7	In line with the recommendation the Board was content to approve the closure of Risk 2.1 (GMC Enhanced Monitoring) and the addition of Risk 1.5 (Cyber) to the BAF. The remaining BAF risk scores were noted.
3.8	The TC and CEO commended colleagues on the huge achievement to reduce the score in relation to BAF risk 2.1. The CEO then flagged that with the exception of this BAF risk, the score for others had remained nearly the same for the previous ten months. He requested therefore some form of Executive review to provide assurance going into the new financial year that no new actions were required. This action should be taken through the newly established Executive Board.
ACTION **TB1.06.02.25/33**	**Undertake a review of the scoring/mitigations of all current BAF risks ahead of the new financial year.** **Lead: Director of Corporate Governance/Executive leads**

04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	Quality & Safety Committee (QSC) This update was presented by NED-OA. She updated that the IPC team had presented a quantified risk related to their challenges with Alex Health. Their highest risk had been contact tracing but the team had now been able to reduce this. There had also been an update on the rollout of Martha's Rule (to be known as Call for Concern). The pilot in adult services would rollout on 11.02.25 but there was still some more work to do around the Paediatric pathway. PALS/complaints continued to rise and there had been a particular spike in December. There would now be some work to look at this in more detail.
4.2	In terms of Oliver McGowan training, the Deputy Chief Nurse (DCN) confirmed that the trajectory set by the ICS was 20% compliance by March 25 and current performance was sitting at 21%. The further trajectory of 30% by March 25 was an internal target in an effort to improve compliance. The TC flagged at this point that the Board also needed to undertake this training. The DCN added this was also being picked up at divisional performance reviews due to its importance.
4.3	In response to a question from NED-DB in relation to the increase in PALS/complaints, it was noted that QSC had requested a deep dive. Some of the increase in PALS related to cancelled appointments and teams were working hard to address this theme.
4.4	Quality & Safety Committee Part II (QSCII) In the absence of the Committee Chair, this update was presented by the DoQI. He informed members there had been a lot to celebrate including the significant improvement in midwifery recruitment with vacancies now down to 3%. The Maternity & Perinatal Incentive Scheme (MPIS) would be discussed later in the agenda.
4.2 Maternity Reports	
4.5	Overview of Maternity Patient Safety Incidents This update was presented by the Director of Midwifery (DoM). She updated there had been no new maternity incidents declared since the last report for July 2024 and one maternity PSII closed since the last report (1 MNSI closed). Maternity Services currently had five ongoing investigations.
4.6	In response to a question from the CEO in relation to ICB deadlines, the DoM responded that some reports had been sent to the ICB but had been returned with queries. There had been some internal PAHT issues related to the governance team in terms of its midwifery component which she was pleased to confirm had now been resolved.
4.7	The TC confirmed that the Board was content to note the report.
4.8	Maternity & Perinatal Incentive Scheme (MPIS) The DoM drew members' attention to p53 of the paper and the update on progress against the ten safety actions. She was pleased to report that thanks to some support from the DoQI, the service would be declaring compliance with nine of the ten safety actions. In terms of Safety Action 1 (SA1), it would be down to NHS Resolution (NHSR) to review the mitigations presented in relation to this action and to make a decision around Trust compliance.
4.9	The DoQI was able to update that in relation to SA1, whilst the organisation had been four days late in submitting information into the system, it had met the timeframe and the learning had not been lost; this was its mitigation.
4.10	The DCN continued that meeting nine of the ten actions put the organisation in a strong position but it would have to await NHSR feedback. Given the timing of meetings, the Board was being asked that day to grant delegated authority to the Chair of Quality and Safety Committee Part II to sign-off the final position and accompanying Board declaration prior to 03.03.25.
4.11	The TC confirmed that the Board was content to approve the above request, noting that in the absence of the QSCII Chair, this could be undertaken by the QSCI Chair.
4.12	The TC thanked colleagues for their update, noting the Board approval for delegated authority for sign-off of the MPIS.

4.3 Nursing Midwifery & Care Staff Levels	
4.13	This update was presented by the DCN. He was pleased to report that there had been a sustained Registered Nurse overall fill rate of > 95%. Wards achieving < 75% overall fill rate were included under section 3 of the paper. The increase in overall fill rates was multifaceted with a combination of enhanced care needs and supernumerary time driving this. Nursing quality indicators had been reviewed and there was no correlation between fill rates or red flags. The review of quality indicators was available in appendix 4 of the paper.
4.14	The DCN continued that the Trust was part of the Enhanced Care Collaborative pilot in conjunction with NHSE to look at the workforce model. The outputs of this work should be available by March. To ensure good oversight of staffing there was a Trust-wide huddle three times daily to go through red flags. Some detail from Model Hospital and in relation to care hours per patient day was included in table 3 of the paper. He felt reassured by the data on organisational staffing and processes.
4.15	The TC thanked the DCN for his update.
4.4 Learning from Deaths Update	
4.16	This update was presented by the MD. The paper highlighted the stability of the Trust's HSMR and SMR position, currently sitting as 'within expected'. However, the July 2024 HSMR and SMR in-month position and the HSMR and SMR (12 month rolling) position were erroneous due to a data transfer problem to Telstra which was expected to be resolved by the following month. There was one new SMR outlier within the latest round of data: 'respiratory failure, insufficiency, arrest (adult)'. These cases would be reviewed as part of the monthly clinical coding audit and presented at the Strategic Learning from Deaths Group (SLfDG).
4.17	The MD continued there had been some good progress in relation to reducing the backlog of structured judgement reviews (SJRs) and that good progress should continue over the next few months.
4.18	The Chief Strategy Officer (CSO) asked whether the Board should be concerned by figure 4 which showed the 12 month rolling SMR from September 23 to August 24. The MD confirmed there were no concerns as she had already seen the data for the present month. The elevation had been due to the issue referenced above and an improved position would be visible in the next report.
4.19	The CEO then asked whether the Trust's regulators had been informed of the data issue so that this didn't become of concern for them. In response the MD agreed to write to the CQC to explain this. The ICB had been present at the previous QSC meeting so was already aware.
ACTION **TB1.06.02.25/34**	**Write to the CQC explaining the recent third party issue in relation to mortality data.** **Lead: Medical Director**
4.5 Electronic Health Record Update	
4.20	This update was presented by the Chief Information Officer (CIO) and the key headlines were as follows: • **Outpatients:** The biggest current challenge related to the Outpatient clinic builds and a significant amount of work was underway to set these up as they should be. . • **Data quality/processes:** The risks identified here were the usual ones expected with a new system until colleagues became more familiar with it. • **Patient Safety:** There were regular reporting processes via QSC/IMG and indeed a report had been presented to QSC the previous week in relation to the current challenges in Infection Prevention & Control. • **Governance:** As part of the move into business as usual, there would be a change to the programme governance. • **Reporting:** Whilst external reporting was effective, there was currently no internal reporting which was impacting on teams in terms of managing their services. It was not unusual to have these issues but the stress on colleagues was appreciated and the team was doing all it could to respond.

	• **Road Map:** This was provided at the end of the paper and was a plan for the coming two years. The first six months was the 'fixing' phase moving into 'integration' with other systems including a new cancer system.
4.21	The TC asked what the outstanding risks were . The CIO responded the Outpatient clinic build was the area of biggest focus and the risk was not seeing patients in a timely way. There was a daily task and finish group with a trajectory to resolution which currently was worst case April, best case early March. The DoQI added there was some way to go in terms of colleagues getting used to the system and in his view there was also a subtle risk around culture and behaviour. It was inherent to support colleagues through this and to manage the clinical risks so the focus, he agreed, had to be on Outpatients.
4.22	In response to a question from ANED-AWS in relation to support for colleagues, the DoQI confirmed that members of his team were supporting staff currently to get the best out of the system. He cautioned however it had only been 12 weeks since go-live so it was still early days.
4.23	The COO then continued it was important to listen to the teams and also to celebrate the successes. She provided assurance that where things were working well, the benefits were being seen.
4.24	The CEO then commented that whilst the implementation had been a huge success, some real risks remained. It would be critical to manage those risks effectively so that the organisation could continue to 'put its best foot forward'.
4.25	In response then to a question from NNED-BJ, the CIO confirmed there had been an initial 'lessons learned' piece of work six weeks previously. This would be iterative and there would be another one after the stabilisation phase (which was possibly a six to nine month phase). He agreed these would be shared, at which point the TC suggested these form part of a future Board Development session.
4.26	The MD then expressed some caution in terms of lessons learned and that her view was it was too early yet for this. The TC suggested the development session date be agreed by the CIO/DCG.
ACTION **TB1.06.02.25/35**	**Board Development: Date for 'Lessons Learned from Alex Health' session to be agreed.** **Lead: Director of Corporate Governance/Chief Information Officer**
Break 11:03 to 11:13	
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	This update was presented by NED-DB. She informed members it had been useful to see the KPI statistics around agency usage/temporary staffing and achievements were significant. Statutory/mandatory training compliance was at 87.71% and appraisals at 58.5% and the team were commended on achieving the NHS England Work Experience Standard Gold Award.
5.2	NED-DB continued that her view on appraisal compliance was that the organisation's structural review would be key to this and colleagues would need to act on that.
5.3	The Committee had reviewed a further draft of the People Strategy, which was still incomplete, and agreed it would be brought back for approval once finalised.
5.4	The I-CPO acknowledged that appraisal compliance required some improvement. There was work currently underway on the paperwork redesign and the process, the outputs of which she would bring to the Board on completion. The paperwork would be shortened to five pages because the focus was on the conversation rather than on filling out a form. A cascade process had been tried but this had not been successful so this would also be revised. She repeated that it was not just about compliance, it was also about ensuring conversations took place so that people felt cared for and developed.
5.5	As a final point the MD clarified that in relation to item 2.3 in the paper, the GMC Enhanced Monitoring BAF risk would now be monitored via the organisational risk register not the departmental one.

5.2 Full Year Nursing & Midwifery Establishment Review	
5.6	This update was presented by the DCN and had previously been discussed at both PAF/QSC. The paper contained the outputs of the full year review and he informed members a review took place very six months. Key points to note were as follows: 1) No additional funding requested for the areas undertaking reviews in line with the SNCT tools. However, Nightingale Ward (winter pressures ward) establishment was not funded for 25/26. 2) Outside of the SNCT review there were a number of service reviews underway in departments where demand/activity had increased where consideration of increased staffing may be required. 3) Any workforce requirements as a result of the service reviews would be managed through respective divisions and where appropriate, business plans. 4) A recommendation for supporting patients who required enhanced care would be submitted in Q1 25/26, following completion of NHSE's Enhanced Care Collaborative project. 5) The next mid-year establishment review was due to be completed in March 2025 reporting to Trust Board in June 2025. 6) The Maternity staffing review, as part of Birthrate Plus, would be available in early 2025.
5.7	The Board was content to approve the recommendation as stated in point 1) above.
5.8	In terms of Nightingale Ward, the COO informed members there had been a conversation at PAF the previous week in terms of the opportunities to work differently with community partners and via the virtual hospital.
5.9	The TC thanked the DCN for the update and it was noted the outputs of the mid-year review would be presented to the Board in June.
5.3 Gender Pay Gap Report	
5.10	This update was presented by the I-CPO and was a mandatory report which required the Board's approval to publish. The key headlines were as follows: • The gender pay gap as at 31.03.24 reported men had a higher mean and median average pay than women. This was however skewed by the Medical & Dental data. • The difference between mean pay for men and women was 22% and that of median pay was 13%. • When accounting for AfC and VSM only, the mean showed that women earned 0.16% more than men and the median pay gap showed that women earned 9% more than men. • When accounting for Medical & Dental only, the mean showed that women earned 12% less than men and the median pay gap showed that women earned 16% less than men.
5.11	The DoQI asked whether the data could be taken further/localised to evidence gender pay gaps in other departments. The I-CPO responded this had been done but had not been included in the paper as it fell outside the requirements.
5.12	The CEO suggested some additional work was required to clarify what the data was really saying, some generic messaging and some targeted actions.
5.13	NED-DB then stated the report was not about unequal pay for the same role, it was about the general differences and what the organisation could do to make things more attractive.
5.14	In response to a question from NED-OA, it was confirmed that the report was produced on an annual basis. There was an action plan behind it by which to track actions/progress through the year. The TC responded that whilst the subject belonged with People Committee, it would be useful for the Board to see/approve the associated action plan.
ACTION **TB1.06.02.25/36**	**Gender Pay Gap Action Plan to be presented to the Board for approval.** **Lead: Interim Chief People Officer**
5.15	In response to a further question from ANED-AWS the I-CPO confirmed the paper presented that day was the report for publication. The action plan would allow potential deep dives and highlight areas for future work.
5.16	NED-DB commented that her view would be there was a need to be clear on the objective of the report and what the organisation wanted to glean from it. The data should then be based

	on achieving this. The report was clear on Medical & Dental but less clear on everyone else. The CEO agreed the Executive team would take this away for consideration.
ACTION TB1.06.02.25/37	**Executive Team, to review the structure/requirements of the Gender Pay Gap Report and action plan. Lead: Executive Team**
5.17	In line with the recommendation, the Board approved the report for publication.
5.4 Ethnicity Pay Gap Report	
5.18	This update was also presented by the I-CPO and she informed members this was not a mandated report. The key headlines were as follows: • As at March 2024, PAHT employed 1794 'BME' staff representing 43% of the workforce, 137 'not stated' representing 3% of the workforce and 2232 'white' representing 54% of the workforce. • The mean ethnicity pay gap between 'BME' and 'white' staff was -14.52% in favour of 'BME' staff and median pay gap was -20.97% in favour of 'BME'. • The mean and median hourly rate was in favour of all listed ethnicity against 'white British'.
5.19	ANED-AWS commented that from the data it appeared people from the minority were earning more than white people. She felt the data was deceiving. NED-OA responded that in context, a lot of the upper quartile staff were medical & dental and the lower quartiles were the local population in Harlow who were predominantly white. The expectation therefore would be that the latter were more in number – the context was key.
5.20	The TC then stated that the recommendation in her view was the same as with the previous paper. To glean any meaningful information from the report it had to be clear what was trying to be achieved.
5.21	It was then noted that there had been a request from NHSE not to use the term 'BME' and the trend now was towards using 'global majority'. The TC requested this be discussed further by the Executive team with agreement on the term to be used by PAHT (with 'BME' in brackets after).
ACTION TB1.06.02.25/38	**Agree the PAHT term to be used for 'BME' going forward. Lead: Executive Team**
5.22	The TC also requested consideration of an action plan around the ethnicity pay gap as with the previous paper.
ACTION TB1.06.02.25/39	**Consider an action plan for the work around the Ethnicity Pay Gap. Lead: Interim Chief People Officer**
5.23	In line with the recommendation the Board approved the report.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This update was presented by NED-CM. PAF had noted recent challenges with the integrated performance report and the proposal for a more streamlined version moving forward with fewer key, metrics. For December the Trust had achieved zero 78+ week waits and sixty one 65+ week breaches (which included 20 choice breaches). There had been a deep dive into the Vanguard Theatre. Operationally things were going in the right direction but some Alex Health challenges were being addressed. Capital funding for the community diagnostic centre could now be rolled forward into the coming year.
6.2	The TC thanked NED-CM for his update.
6.2 M9 Finance Update	
6.3	This update was presented by the CFIO and the paper was taken as read. There would be further discussion at the private session on planning and the associated risks.
6.4	The TC confirmed the paper had already been discussed at PAF and the Board was content to note it that day.

6.3 M9 Integrated Performance Report (IPR)	
6.5	This paper was presented by the CIO and had previously been presented to relevant Board Sub-Committees. As referenced above, the proposal now was for a more stream-lined version with fewer KPIs.
6.6	The CIO continued there had been a spike in complaints in-month but agency spend remained encouraging. There had been a slight upturn in patients waiting over 65 weeks in December due to the impact of Alex Health, but performance remained in positive cause variation with an upward trend.
6.7	At this point the CEO informed members that the refresh of the clinical strategies would support a review of those metrics that were on or off track. That work would however take a few months to conclude. In the interim there would be work to whittle down the metrics and once those were correct those would be presented to Committees and the Executive meeting. There was some urgency in his mind to have something more manageable with a clear narrative owned by the Executive Leads. The TC agreed this would be very valuable for the Board.
6.4 New Hospital Programme	
6.8	This update was presented by the CSO. The announcement on 20.01.25 by the Secretary of State for Health had provided some clarity for the Trust on the anticipated delivery plan for the new hospital in the context of the national programme. It was in Wave 2 with expected commencement for construction between 2032 and 2034. Wave 1 included all the RAAC hospitals plus two additional acutes. Construction for Wave 1 would be 2025 to 2030 and for Wave 3 2035 to 2039.
6.9	Given the significant delay to construction this could have an impact on the Trust's ability to maintain continuity and safety of services. To underpin the quality and safety of delivery required, a development control plan had been commissioned which would set out both the critical infrastructure and the developments to the site that would be required to meet increasing demand and to replace infrastructure beyond its functional life. For instance, the existing hospital steam infrastructure had been assessed to be 15 years beyond its normal life and would require replacement or reprovision. The programme team had been working to complete a refresh of key demand and capacity analysis, clinical strategy and a model of care to support the new development.
6.10	The CSO continued that the site acquisition remained in train.
6.11	In summary there was good news that PAHT remained within the NHP but some clear frustration in terms of the delay and the associated impact on patients and staff.
11:52 ANED Ralph Coulbeck arrived.	
6.12	NED-GW asked, given West Herts Hospital was in the same position as PAHT, whether there would be some discussion about interim steps for surgical hubs to deal with the increasing capacity. The CSO confirmed there would be and this had already started. The current strategy clearly showed two new hospitals in the ICS by 2030 which would no longer be the case so the impact of this needed to be carefully worked through.
6.13	The CEO then informed members there was good progress on the CDC at SMH and there should also, in his view, be an elective hub there too. There was also a site at Saffron Walden Community Hospital which was currently only 40% utilised and there needed to be some urgent conversations about this with primary care because it was a fairly good piece of estate. This had already been reported to primary care colleagues and they had been very clear how they could work with PAHT on this to turn that site into something that could work for the community.
6.14	The TC summarised that the national update on the new hospital had been noted, Colleagues were working hard to develop options to manage the current risk at PAHT.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	In the absence of the STC Chair, members were happy to note the update.

7.2	The CEO then highlighted there was significant overlap now between STC and the WEHCP Board so the Place Board would become a formal committee of PAHT.
7.2 Report from Leadership Management Team	
7.3	Members were content to note this report and had no comments.
7.3 Executive Meeting Structure	
7.4	This paper was presented by the CEO and set out a proposal for a revised Executive meeting structure to be implemented from February 2025. To note were: • LMT would transition into a monthly Executive Board reporting into Trust Board. The Executive Board would consider key strategic and escalated operational matters and operate as the most senior Executive-level meeting within the organisation. • In March 2025, a new monthly Operational Board would be established to manage operational issues with key clinical and operational colleagues in attendance (Divisional trios). The Operational Board would report into the Executive Board. SMT would transition into a quarterly Senior Leaders' Forum; a half-day, workshop-style engagement session for all clinical and non-clinical leaders across the organisation.
7.5	The CEO continued that for approval that day were the Terms of Reference for the Executive Board.
7.6	In response to the above NED-DB stated that she fully supported the changes referenced above. Experience had previously evidenced to her it was useful to separate the operational board from the main Executive in order to provide focus and clarity.
7.7	In line with the recommendation the Board: • Approved the transition of LMT into the Executive Board. • Approved the Terms of Reference for the Executive Board. • Noted the revised Executive meeting structure.
7.8	At this point in the meeting there were no questions from the public.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public at this point.
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. The TC reminded members this was a very useful document and she would encourage colleagues to re-read it.
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 confirmed delays to the new hospital were noted as a new risk.
9.4 Any Other Business (AOB)	
9.5	There were no items of AOB.
9.5 Reflections on Meeting	
9.6	It was agreed there had been some good discussion.
9.7	The meeting closed at 12:05.

Signed as a correct record of the meeting:	
Date:	03.04.25
Signature:	
Name:	Hattie Llewelyn-Davies

The Princess Alexandra Hospital NHS
NHS Trust

Title:	Trust Chair

ACTION LOG: Trust Board (Public) 03.04.25

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.02.25/33	Board Assurance Framework	Undertake a review of the scoring/mitigations of all current BAF risks ahead of the new financial year.	DCG Executive Leads	TB1.03.04.25	To be incorporated in the bi-monthly reviews with Executive leads.	Proposed for closure
TB1.06.02.25/34	Mortality Data	Write to the CQC explaining the recent third party issue in relation to mortality data.	MD	TB1.03.04.25	Actioned 27.02.25.	Closed
TB1.06.02.25/35	Board Development: Alex Health Lessons Learned	Board Development: Date for 'Lessons Learned from Alex Health' session to be agreed.	DCG CIO	TB.11.09.25	Item not yet due.	Open
TB1.06.02.25/36	Gender Pay Gap	Gender Pay Gap Action Plan to be presented to the Board for approval.	I-CPO	TB1.03.04.25	Report and action plan reviewed at Executive Cabinet meeting on 19 March. Action plan also to be discussed at People Committee 31.03.25.	Proposed for closure
TB1.06.02.25/37	Gender Pay Gap	Executive Team to review the structure/requirements of the Gender Pay Gap Report and action plan.	Executive Team	TB1.03.04.25	Report and action plan reviewed at Executive Cabinet meeting on 19 March. Action plan also to be discussed at People Committee 31.03.25.	Proposed for closure
TB1.06.02.25/38	BME (agreement of PAHT term going forward)	Agree the PAHT term to be used for 'BME' going forward.	Executive Team	TB1.03.04.25	REACH network to discuss and report back to Executive team by end of April 2025.	Proposed for closure

ACTION LOG: Trust Board (Public) 03.04.25

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.02.25/39	Ethnicity Pay Gap	Consider an action plan for the work around the Ethnicity Pay Gap.	I-CPO	TB1.03.04.25	To be presented to PC.31.03.25.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 April 2025

Agenda item:	2.2
Presented by:	Thom Lafferty - CEO
Prepared by:	Thom Lafferty - CEO
Date prepared:	25 March 2025
Subject / title:	Chief Executive Officer's report

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report provides an update since the last Board meeting on the key changes, challenges and successes. The report is framed around our five strategic priorities: Patients, People, Performance, Places and Pounds.
Recommendation:	The Trust Board is asked to note the update.

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

Previously considered by:	N/A
Risk / links with the BAF:	CEO report links with all the BAF risks.
Legislation, regulatory, equality, diversity and dignity implications:	• 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

The Princess Alexandra Hospital NHS Trust

Chief Executive's Report
Trust Board: Part I – 3 April 2025

1.0 Context

On 13 March 2025, the Government announced a number of significant changes to the structures of the NHS. The announcements were made in the context of global events and recognised the need for health and care services to be high-quality, economically efficient and sustainable in the long-term.

As a result, the following changes were announced:

- NHS England (NHSE), the national/regional regulator of NHS organisations will be formally incorporated into the Department of Health & Social Care (DHSC) and thereby cease to exist as a standalone authority;
- Integrated Care Boards (ICBs) will continue to exist but will need to reduce current resources by 50%; limiting its functions to that of strategic commissioner;
- NHS provider organisations must seek to reduce growth in non-clinical costs by 50%, against pre-pandemic levels;
- Other system-wide infrastructure will also be reviewed in the context of the need to deliver efficiencies (e.g. Acute Provider Collaboratives, Clinical Networks).

Further guidance is currently awaited with regard to the delivery plans/timescales for these changes. All changes are expected to take place over a two-year period.

It is important to note that the above changes are *in addition* to the Government's previously announced 'three shifts' which are expected to be the pillars around which the new NHS 10-Year Plan is developed:

1. Analogue to Digital
2. Sickness to Prevention
3. Acute to community

From a local perspective, it is likely that these changes will serve to expedite our plans to develop integrated care arrangements that respond seamlessly to population health need and it is vital that we seize the opportunity for change that this provides.

At the same time, it is important to recognise the human impact of these changes - for many, the 13 March announcements would have come as a great shock with some staff being directly affected by the proposals and others concerned regarding the knock-on ramifications of them.

It is critical that we, as the senior leadership team for PAH, work hard to support staff to embrace and adapt to these changes, as we pursue the necessary transformation to make health and care services across West Essex high quality, integrated and sustainable.

2.0 Our Patients

2.1 New Hospital Programme: requirement for significant additional funding to maintain our estate

The new hospital will provide an exciting opportunity to transform the care we deliver and will be part of the wider growth and regeneration agenda for Harlow and its neighbouring communities.

We know now that construction on the new build is likely to commence in 2032-2033 and we continue to work closely with the national programme team to ensure our plans for the new hospital are robust and strategically aligned.

In the meantime, our ageing hospital estate continues to pose significant challenges and we have further assessed our key infrastructure risks:

- **Electrical systems:** The hospital's electrical distribution system is aging and has been identified as a significant risk. Issues include outdated wiring, insufficient capacity to handle current loads, and potential for system failures. We are carrying out upgrades and remedial works, with further investment in upgrades required.
- **Water systems:** We have ageing water systems, with issues including the impact on water flow and circulation and achieving the required temperature at taps and outlets. We are carrying out upgrades and remedial works, with further investment in upgrades required. We also have significant issues with our drainage infrastructure which has led to a number of recent operational issues and do not lend themselves to affording a good environment for our staff.
- **Ventilation systems:** There are aged and adapted ventilation systems with some inadequate airflow and temperatures serving clinical areas. We are carrying out upgrades and remedial works, with further investment in upgrades required to ensure airflow, filtration and temperatures.
- **Uninterruptible power supply (UPS/IPS):** UPS systems are critical for providing backup power during outages and ensuring the continuous operation of essential medical equipment. A significant number of key critical clinical areas do not have these systems and some are aged. We are carrying out works to replace essential systems and we are installing systems in key critical clinical areas, with further investment required.
- **Fire compartmentation:** Fire compartmentation is crucial for containing fires and preventing their spread within hospitals. Work is underway to upgrade areas including fire-stopping measures, aged and damaged fire doors and aged fire system panels, wiring and detectors, with further investment required.
- Other areas of focus include repairing and replacing components of lifts to maintain operational service.

We have estimated that we will require £120m of additional funding over the next 10 years to maintain our estate, ahead of the new hospital being built. We will also be proposing other schemes that may include additional capacity or more significant works, such as additional theatre works.

We are focusing on developing our infrastructure plan further in the coming months to prioritise investment. Our absolute priority is patient safety and continuing to provide services effectively.

2.2 Alex Health

On 19 March 2025, PAHT became the 100th acute NHS Trust to successfully integrate its online patient portal with the NHS App, offering patients quick and easy access to their electronic health information using their smartphone, tablet or computer.

The NHS App is a simple and secure way to access a range of NHS services, currently used by millions of patients to view messages, order prescriptions and more.

My Alex Health is PAHT's new patient portal, a web-based, secure digital service where patients can access information relating to their care at the Trust. The portal works in a similar way to the NHS App but is specific to the care provided in hospital.

3.0 Our People

3.1 Hattie Llewelyn-Davies

The chair of our Trust Board, Hattie Llewelyn-Davies, left PAHT on 28 March. Hattie has been appointed to the role of chair at Essex Partnership University NHS Foundation Trust (EPUT), commencing 1 April.

I would like to acknowledge and thank Hattie for her leadership of our Trust Board and her service to the wider organisation. I am eternally grateful for her individual support to me as the new incoming Chief Executive at PAHT. We will very much miss her wise, compassionate leadership.

I am delighted that Darshana Bawa, previously a non-executive director and senior independent director on the PAHT Trust Board, has taken up the role of acting chair for the next year. I have no doubt that our Board will continue to make great progress in driving forward positive, transformational change under Darshana's leadership.

3.2 Staff Survey

Our 2024 Staff Survey response rate was 49.33% and, overall, showed a workforce satisfaction level consistent with previous years' performance.

However, we are absolutely committed to improving on this. We want to create a working culture and environment where staff feel supported, valued and recognised for their efforts and achievements. In particular, we want all of our staff to proudly recommend PAHT as both a place to work and a place to receive care.

From this year's survey, we are focusing on three key themes which align with the NHS People Promise:

1. People Promise: Compassionate and inclusive
2. People Promise: We are a team
3. People Promise: We are recognised and rewarded

In addition, we are engaging staff on the 3-4 'big interventions' which will genuinely respond to specific concerns and feedback received through the survey.

More information on the Survey can be found within the papers for the Board meeting.

4.0 Our Operational Performance

I would like to acknowledge the significant operational pressures at the start of the new year which continued into February. I am extremely grateful to all of our staff who continued to work tirelessly through this busy period to keep our patients safe.

Particularly in this context, it is gratifying to see that our 4 hour emergency department performance continues to improve month on month and is better than previous years' performance for the same time of year. Within this, there has been a sustained improvement in our non-admitted pathway; resulting in better patient experiences. The work led by the clinical teams on improving the discharge pathways for our patients continues, with greater utilisation of the discharge lounge and improved flow through the assessment unit.

We have also been able to demonstrate ongoing improvements in meeting various diagnostic and treatment standards including:

- Patients seen within 6 weeks for diagnostics;
- The 28 Day Faster Diagnosis standard;
- Referral to Treatment performance.

Being able to describe a performance narrative of where we have been, where we are now and where we are headed is critical to us, as an organisation, being able to 'put our best foot forward' and I have little doubt that the strides we make toward place-focused working in 2025/26 will further increase our ability to adhere to national best practice.

A more detailed assessment of our operational performance can be found within the Integrated Performance Report.

5.0 Places and Partnerships

5.1 Host Provider

As previously reported, PAHT will take on the role of 'host provider' for the West Essex Health & Care Partnership (HCP) in 2025/26; as part of our ambitions to join-up services at place and allows the populations we serve to receive the vast majority of care closer to home. Our host provider status brings with it the following changes:

- We will act as 'Lead Provider' for the Adult Community Services contract, directly contracting with our primary community/mental health partner, Essex Partnership University NHS Foundation Trust (EPUT). This is a unique opportunity to jointly deliver new models of care that prioritise the holistic needs of patients, over organisational considerations;

- The West Essex HCP Board will become a formal Committee of the PAH Board;

- Primary care representatives and EPUT representatives will join our PAHT Executive Board, ensuring that all of our Executive deliberations incorporate primary/community/mental health perspectives;

- We are in the process of developing a joint transformation programme with place-based partners, focusing on the greatest areas of need: children & young people's services, care of the elderly and frail and Urgent & Emergency Care (UEC);

- We will be working with our Integrated Care Board (ICB) and other partners to look to 'devolve' additional responsibilities and resources to 'Place' to allow for genuinely integrated working.

It is reassuring that, amidst the national changes described at section 1, integrated care at Place to meet the needs of local populations remains the direction of the travel for the NHS. I very much hope we will be able to 'lead from the front' in this regard.

5.2 Welcoming Dr Neil Hudson MP to our Community Diagnostic Centre

We welcomed a visit from Dr Neil Hudson, MP for Epping Forest, to the Community Diagnostic Centre (CDC) site at St Margaret's Hospital, Epping, on 14 February 2025.

Dr Neil Hudson had the opportunity for a tour of the site, where construction work is underway, and to meet with me and the CDC project team.

The CDC programme is part of our plans to support quicker and more local access to diagnostic tests close to patients' homes. The CDC building is due for completion in December 2025, with the first patient planned for the following month.

6.0 Our Pounds

As we approach year end, we have seen a marked improvement in our financial position over the course of the year and are on course to achieve our control total which has been agreed within the wider HWE system. The target for the Trust has moved throughout the year due to the redistribution of non-recurrent funding made available within the system and hence the c.£24m plan we began the year with has moved to a breakeven plan for the year.

The Trust will likely achieve its PQP Plan for the year of c. £18m with a mixture of recurrent and non-recurrent measures. These include significant reductions in our reliance on agency costs, increased

delivery of elective work (c. 125% of the level delivered in 2019/20) and improved grip and control of wider pay and non-pay.

Planning for 2025/26 has been undertaken since January 2025 and a draft agreed plan has been submitted for the coming year that achieves breakeven; again, this is reliant on further non-recurrent support from the ICB to support the Trust's wider structural deficit. This will require significantly more PQP delivery in 2025/26 equivalent to 5.8% of our operating expenditure base. This will be extremely challenging but we feel it is deliverable, especially given the transformative work we are undertaking across West Essex Place.

Thom Lafferty
Chief Executive
March 2025

The Princess Alexandra Hospital NHS Trust

Trust Board - Public – 3 April 2025

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:	31 March 2025							
Subject / title:	Corporate Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents a summary of risks scoring 15 and above for all our services. It is a snapshot taken from our Datix database on 26.02.25. No further risks have been added to the corporate risk register since then. **Table 1** details the numbers of risks scoring 15 and above, by division / corporate team, that have been approved for inclusion onto the corporate risk register. The total number is 32. **Table 2** details the numbers of risks by category that breach the Trust appetite tolerance. **Section 3** provides a summary of the three risks scoring 20. They are: • Risk id 85 relating to emergency access standard • Risk id 497 relating to referral to treatment constitutional standard • Risk id 388 relating to the Trusts fire alarm system **Section 4** - There are no newly approved risks scoring 16 **Section 5** - There is one newly approved risk scoring 15: • Risk id 638 relating to anaesthetic out of hours service **Section 6** shows the number of risks that have a score of 15 or above, that are not yet on the corporate risk register.							
Recommendation	• Review and discuss the contents of the corporate risk register • Note the 1 new risk scoring 15							
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	√	√	√	√	√			
Previously considered by:	Nil							

	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 implications:	Management of risk is a legal and statutory obligation. This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	Nil

1.0 Introduction

Within the Trust, risk is managed as a dynamic process across services.

Trust wide oversight of risk is via the Risk Management Group (RMG) which is a monthly meeting that reviews risk by exception. It follows an annual work plan (AWP) to ensure that risks are reviewed, managed and escalated in accordance with the risk management strategy and policy. It is chaired by the medical director and reports into the Executive Board (previously the Leadership Management Team).

This paper covers risks that have a current score of 15 or more that have been agreed for placement onto the corporate risk register.

2. Risk data

There are 32 risks that have a current score of 15 or above that have been approved for inclusion onto the corporate risk register.

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 (0)	6 (6)	0 (0)	0 (0)	**6 (6)**
Corp - Estates & Facilities	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Corp - IM&T	0 (0)	2 (1)	0 (1)	0 (0)	**2 (3)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	0 (1)	0 (0)	**0 (0)**
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	2 (1)	3 (3)	0 (0)	0 (0)	**5(4)**
Urgent & Emergency Care	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Trust wide	0 (1)	8 (8)	3 (3)	0 (0)	**11 (11)**
Totals	**6 (5)**	**23 (23)**	**3 (3)**	**(0)**	**32 (32)**

The numbers of risks that exceed their risk appetite tolerance is recorded in table 2. This is detailed by risk category.

Divisions and services are able to submit those risks that breach appetite and score less than 15 by exception to the RMG if they consider they meet the criteria for recommending for inclusion onto the corporate risk register.

Table 2 – Number of risks by category that exceed appetite tolerance	Risk Appetite	Risk Score					Totals
		10	12	15	16	20	

	tolerance level						
Quality – Safety	≥ 10	20 (20)	59 (60)	8 (9)	20 (19)	3 (3)	**110 (111)**
Quality – Patient Experience	≥ 12		11 (11)	0 (0)	4 (4)	0 (0)	**15 (15)**
Quality – Clinical Effectiveness	≥ 12		11(13)	1 (1)	7 (5)	0 (0)	**19 (19)**
People	≥ 15			1 (1)	4 (3)	0 (0)	**5 (4)**
Statutory Compliance & Regulation	≥ 12		12 (9)	2 (2)	0 (0)	2 (3)	**16 (14)**
Finance	≥ 12		5 (5)	0 (0)	0 (0)	0 (0)	**5 (5)**
Reputation	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**
Infrastructure	≥ 15			1 (1)	1 (1)	0 (0)	**2 (2)**
Information and Data	≥ 10	2 (1)	6 (7)	0 (0)	1 (1)	1 (1)	**10 (10)**
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, mitigations and actions is below, information is taken from risk entries and leads:

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 on the corporate risk register.
  Actions / mitigations: Use of the Manchester Triage tool and rapid assessment and treatment (RAT) process to improve clinical information and prioritisation of patients. ED Speciality Board and Urgent Care Board have oversight of the Trust wide improvement plans to improve achievement of 4hr target.

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.

3.1.3 Maintaining a fully functional fire alarm system

- There is a risk that the functionality of the site fire alarm system will be compromised due to the aging system, inability to fully monitor its functionality and non-availability of most of the parts.
  Risk id 388: Risk originally raised in January 2021, the score increased end of September 2024 due to lack of progress with actions relating to installation of monitoring system.
  Actions / mitigations: Service contract in place with regular servicing taking place. Fire detectors being replaced and all new refurbishments include replacing detectors and

compartmentation. Regular monitoring of activations completed. Trust has an established Fire Safety Group. Quotes have now been requested for x10 of 18 panels that require replacement.

4.0 New risks scoring 16 added to the corporate risk register – none

5.0 New risk scoring 15 added to the corporate risk register - one

5.1 Quality - Safety

NEW: Anaesthetics – out of hours service

- There is a risk that there will be a delay reviewing emergency patients
  This is caused by increasing demand for out of hours anaesthetic service across the Trust in addition to changes to multiple National guidance recommendations relating to the delivery of anaesthetic care
  Risk id 638: This is a new corporate risk added to the register January 2025
  Actions / mitigations
  Senior consultant oversight of the anaesthetic rota. Monitoring of out of hours activity. Advertisement out for x2 further consultants

6.0 Recommendation

Trust board is asked to

- Review and discuss the contents of the corporate risk register
- Note 1 new risk scoring 15

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 April 2025

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**	**x**	**Decision**		**Information**		**Assurance**			
Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated for April 2024/25 with executive leads and reviewed at the relevant committees during March 2025. A summary of the year end position is included in the attached report. The risk scores have not changed this month and are summarised in Appendix A. The description of the EHR risk (1.4) has been amended as follows: There is a risk to the delivery of safe and high quality care caused by the stabilisation of Alex Health post go live The full BAF is available in the resources section of Diligent.									
Recommendation:	The Board is asked to: - Approve the change to the wording of the EHR risk - Note the remaining BAF risk scores and the yearend summary									
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**					
	x	x	x	x	x					
Previously considered by:	QSC, PC, and PAF in March 2025									
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 A – BAF Summary									

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Board Assurance Framework 2024-25

Purpose

This report provides an update on the BAF risks for April 2025, an overview of the process for reviewing the BAF, a summary of the risks added or closed in year and the risk trends for the year (Appendix A).

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

Board assurance framework process

The Board assurance framework (BAF) encompasses systems, processes and procedures that enable the Trust to define and identify the risks to achieving its principal strategic objectives (currently the 5Ps), and to ensure that effective plans are in place to control these risks to within tolerable levels.

The BAF is owned by the Trust Board. The Medical Director is the executive lead for risk management and the Director of Corporate Governance is responsible for leading on the update of the BAF on behalf of the Medical Director.

Each risk on the BAF has a named lead executive. Risks on the BAF are also allocated to Board committees to review and challenge the management of the risk as well as the effectiveness and assurances on controls for each risk on behalf of the Board. Assurances on this review are provided to the Board at its bi-monthly review of the BAF along with any changes to the BAF since last review. The risks on the BAF are reviewed regularly by the lead Executive Directors (usually monthly), at the relevant Trust Board Committees (bi-monthly) and by the Board (bi-monthly).

April 2025 review

The risks have been reviewed by executive leads and discussed at committees during March 2025.

There are no changes to the risk scores.

The description of the EHR risk has been updated as below to reflect the current risk:

EHR
There is a risk to the delivery of safe and high quality care caused by *the stabilisation of Alex Health post go live.*

Summary of 2024-25

The risk scores and trend information for 2024-25 is detailed in Appendix A.

During 2024-25 the following risks were added/closed:

BAF risk	Description	Commentary
BAF risk 1.4 EHR	There is a risk to the delivery of safe and high quality care caused by the Trust relying on an unsupported and	**New risk added** to the BAF in April 2024.

	unstable EHR if Alex Health is not deployed by October 2024 and is delayed beyond the end date of the Cambio support contract	Risk score of 6 and reviewed by STC and Trust Board bi-monthly.
BAF risk 1.2 EPR	The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	**Risk closed** at Trust Board in December 2024. Target risk score of 12 achieved and risk reviewed at STC
BAF risk 4.3 Industrial action	There is a risk that patient safety will be impacted by further industrial action	**Risk closed** at Trust Board in December 2024. Target risk score of 8 achieved and risk reviewed at PAF
BAF risk 2.1 GMC Enhanced Monitoring	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.	**Risk closed** at Trust Board in February 2025. Target risk score of 10 achieved

Recommendation:

The Board is asked to:

- Approve the change to the risk description for the EHR BAF risk
- Note the year end update

Author:

Heather Schultz – Director of Corporate Governance

Board Assurance Framework Summary 2024.25

Risk Ref. Committee	Risk description	Year- end score (Apr 24)	June 24	October 2024	December 2024	February 2025	April 2025		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	16	16	16		↔	12	CN MD
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15	15	15	15	15	16		↔	10	COO
1.4 STC	EHR There is a risk to the delivery of safe and high quality care caused by the stabilisation of Alex Health post go live	16	16	16	16	16	16		↔	12	CIO
1.5 PAF	Cyber There is a risk of Trust-wide loss of IT infrastructure and systems from Cyber attack					15	15		↔	10	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										
2.3 PC	Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust	16	16	16	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	20	20	20		↔	8	CSO
3.2 STC	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16	16	16	16		↔	12	CSO
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	20	20	20		↔	9	CSO
	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	12	12		↔	8	COO
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	20	20	20	20	20	20		↔	12	COO
	Strategic Objective 5: Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way										
5.1 PAF	Risk that the Trust will fail to meet the financial plan due to the following factors:	16	12	12	12	12	12		↔	8	CFIO

Board Assurance Framework Summary 2024.25

	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.										

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.03.25.**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Host/Lead Provider Status				In line with the recommendation, Quality & Safety Committee: • Supported the draft proposed Delegation Framework and noted the HCP terms of reference. • Noted the need to consider the impact on future governance arrangements in light of any forthcoming changes to NHS structures. • Supported the route to decision with the aim of launching the host provider arrangements from May 2025. • Noted the lead provider requirements based on the current position and the associated timescales.
2.2 Reports from Feeder Groups	Y	Y	N	Reports were presented and noted for Patient Experience Group, Patient Safety Group and Clinical Effectiveness Group.
2.3 Learning from Deaths Update	Y	Y	N	Key headlines were: • HSMR+ is the new risk model being used by Telstra. It replaces HSMR as the mortality index for Trusts who work with them. Critically important under the new methodology will be how frailty is accounted for and this has been shared with the coding team.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.03.25.**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• QSC noted the Trust's very favourable position for HSMR+ when compared nationally.
2.4 Patient Safety Report	Y	Y	N	Key headlines were: • 1165 incidents reported during February of which 588 (52%) had been investigated, validated and closed. Validated data included 409 no harms, 172 minor, totalling 98%. 7 (2%) moderate graded harms. • 1411 incidents open of which 886 were patient safety incidents and of which 354 (40%) had been open >30 working days. • 16 open serious incidents (SIs/PSIIs) and 2 PSII investigations commissioned in-month. • 80 Alex Health incidents reported during February 2025 with 33 (41%) of the incidents reported as patient safety incidents. • Six new claims received in-month and one claim closed. • HM Coroner notified the Trust of three new inquests to be heard and three were closed in-month. No criticism of care received for the Trust. • National Quality Account Audits for 24/25 show 50 audits (86%) on track, 4 (7%) yet to commence and not participating in 4 (7%).

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.03.25.**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 4 Monthly Patient Experience Update	Y	Y	N	Key headlines were: **Complaints** • 159 cases open and since April 2024 – 242 received (100 surgery), 180 closed. • 5 open PHSO cases (prev. 6) • Since April 2024, 52 complaints have come from PALS systems. **PALS** • 902 cases open (down from 1100), 502 in Surgery. • Sustained increase in elective specialty cases and themes of delay. • 293 compliments received since April 2024 led by Surgery (99) **Friends and Family test data** • 81% reported in January 2025.
2.6 Quality Account Objectives	Y	Y	N	QSC reviewed progress against the Trust's quality account objectives that were agreed for the period April 2024 to March 25. The proposed objectives for 25/26 were endorsed but it was noted these could be further revised right up to submission of the Quality Account in June.
2.7 Report Against Operating Plan	Y	Y	N	QSC considered the quality and safety elements of our position:

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.03.25.**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• ED 4 hour constitutional standard: Performance is now at 67% and the best since December 2021. There had been a significant change in non-admitted patient performance which was now at 77% month-to-date. • The 28 day faster diagnosis performance standard was 66.4% in January, with February's unvalidated position currently at 75.5%. The 62 day finalised performance for January was 50.0% against a trajectory of 64%. • 18 week performance had deteriorated for November and December to 41.8% due to Alex Health implementation and reduced activity, migration and post migration DQ and a reduction in validation. Positively, this had increased to 44.3% for January and 44.5% for February. For February, the Trust achieved 0 x 78+ week breaches and 51 x 65+ week breaches (34 choice). • The Trust remained under Tier 2 monitoring with fortnightly performance meetings on cancer and routine elective standards.
2.8 Update from Patient Panel	Y	Y	N	The key activities (current and future) were noted and once again the Panel was commended for its hard work and commitment.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.03.25.**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.9 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. It was agreed some narrative would now be added to the risk in terms of any patient safety risks related to Alex Health.
3.1 M11 Integrated Performance Report	Y	Y	N	There were no escalations and QSC noted the work to develop a new suite of (fewer) metrics continued.
3.2 Organ Donation Annual Report	Y	Y	N	In 2023/24, from 2 consented donors, the Trust facilitated 2 actual solid organ donors resulting in 8 patients receiving a transplant.
3.3 Research & Development 6 Monthly Update	Y	Y	N	Key headlines were: • **36** Studies currently open to recruitment. • **25** Studies closed to recruitment but follow up is still provided. • **13** Studies in the pipeline. • **3** of the open to recruitment trials and **3** of the pipeline studies are commercial. • The recruitment of patients into studies so far this year is **576**, however, there has been no target set by EoE RRDN as the National Institute for Health Research

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.03.25.**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				(NIHR) structure has recently been reconfigured – PAHT became part of EoE RRDN in October 2024.

BOARD OF DIRECTORS:	**Trust Board 03.04.25**			**AGENDA ITEM: 4.2**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**28 March 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Monthly Maternity Report	Y	Y	N	Highlights included; • Total midwife vacancies now 7.96wte (4.80%). Mass recruitment of support workers. Agency midwife usage 0.95wte (<1.0wte last 2 months). • Labour Ward activity and safety actions; compliance improved to 82% • Recruitment of consultant obstetrician and gynaecologist • Sixty Supportive Safety Steps – visit from external colleagues. Positives highlighted during the visit included; CQC Maternity Survey results improved, Continuity of carer, caseload team and the Antenatal and Newborn Screening team highly commended by region • Concerns regarding the estate were discussed (issues with drainage and toilets) and plans are in place to address them. This was also acknowledged in the sustainability plan, as an interim plan was required between now and the development of the new hospital. • Patient evacuation in the antenatal clinic was highlighted as a concern and drills will be planned to test this and mitigate potential risks • Staff have been supported through two recent inquests
2.2 Maternity Patient Safety Incidents	Y	Y	N	One new maternity incident has been declared since the last report; an indirect maternal death and one maternity PSII closed since the last report. Maternity services currently have 7 investigations ongoing; 2 SI's, 4 PSII's and 1 MNSI.

BOARD OF DIRECTORS:	**Trust Board 03.04.25**			**AGENDA ITEM: 4.2**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**28 March 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Perinatal Mortality Review Tool (PMRT) Quarter 2 & 3	Y	Y	N	In the Q2 reporting period, there were six losses eligible for surveillance under the PMRT process. All standards have been met and all actions have been completed and closed off. In the Q3 reporting period, there were six losses eligible for surveillance under the PMRT process. All standards have been met and all actions have been completed and closed off.
2.4 Maternity Assurance Report – Quarterly review October – December 2024 (Q3)	Y	Y	N	• Clinical Guidelines: the service have 12% of guidelines that have expired (88% compliance), an improvement of 7% over the last quarter. The service continues to have an active focus on updating the expired guidelines and ensuring sustainability of compliance. • In relation to the number of outstanding SI's and PSII's within the Division, there is a commitment to complete all the incidents declared before 1 January 2025 by end of March 2025 • Demand and Capacity for Gynaecology Services – high number of referrals leading to long waiting times
2.6 Maternity Safety Champions Update	Y	Y	N	Visits in month included the bereavement service, neonatal care and labour ward. The hard work of the unit was evidenced during the visits. Feedback regarding the estate was highlighted and discussions were ongoing on how the environment could be improved for staff and patients.
2.6 Maternity Safety Support Programme	Y	Y	N	Regional team supportive of a meeting going ahead on 4 April 2025 in relation to the Maternity Safety Standards Programme.
Other items noted: - Horizon scanning - MNSI Update				

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 April 2025

Agenda item:	4.2
Presented by:	Linda Machakaire - Director of Midwifery (DoM)
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance
Date prepared:	03 March 2025
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 (PSIRF) and therefore the service has a combination of Serious Incidents (SI's) and Patient Safety Incident Investigations (PSII's). There has been 1 new maternity PSII declared since the last report for February 2025. There has been 1 maternity SI closed since the last report (February 2025). Maternity services currently have 7 investigations ongoing. SI's - 2 PSII's - 4 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:	QSCII.28.03.25
Risk / links with the BAF:	BAF 1.1
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

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.

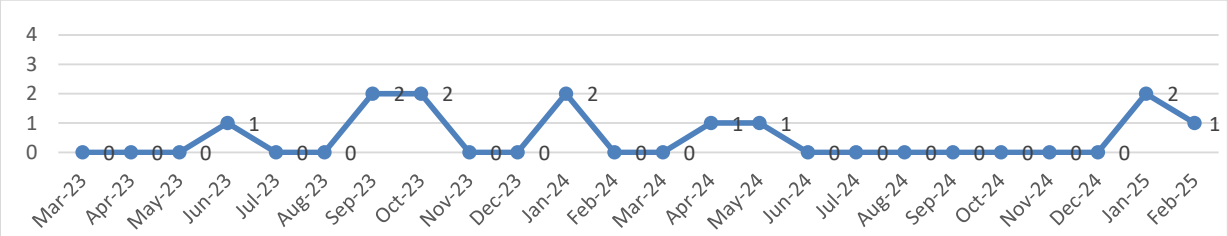
2.0 Background

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 7 investigations 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 February 2025.

Table 1. Comparison of Patient Safety Investigations reported for Maternity in last 24 months (to February 2025)



There was 1 new Maternity Patient Safety Incident Investigation (PSII) declared in February 2025 which will be investigated by MNSI.

Table 2. Serious Incidents declared, submitted and closed for February 2025

Investigations			
Number Declared for February 2025			**1**
Number Submitted for February 2025			**1**
Number Past ICB Deadline as of February 2025 (Not including MNSI/Approved Extensions)			**4**
New Investigations declared in February 2025			
Ref	**Ethnicity**	**Summary**	**Learning Points**
PAweb 160767	**White European**	MNSI: Indirect maternal death of pulmonary embolism in first trimester.	• Understanding of MEOWS across the Trust and usage with Alex Health. • Ensure obstetric pathway when attending other areas of the hospital.
Investigations closed in February 2025			
Paweb 137585	**White British**	Neonatal death at 36 weeks gestation due to fetal anaemia.	• Formalised process to be developed for communication between the obstetric unit and the neonatal unit. • Handover document to form part of SOP for communicating babies that may need neonatal support or advice.

The service has set a trajectory that all remaining SI's/PSII's that are outside of the expected due date will be submitted by the end of March 2025.

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to February 2025.

Table 3. Top Themes

Total Number of SI's	Theme	Number
12	Neonatal death	4
	Medical Equipment	2
	Therapeutic Cooling	2
	Birth Injury	2
	Hypoxic ischaemic encephalopathy (HIE)	1
	Cardiotocograph (CTG) interpretation	1
	Retained Object	1
	Escalation	1
	Screening Incident	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 the Trust 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.

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 Board 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: 03 March 2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 April 2025

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery and Gynaecology
Prepared by:	Erin Walters – Head of Maternity Governance and Assurance
Date prepared:	3 March 2025
Subject / title:	Maternity Assurance Report – Quarterly review October – December 2024 (Q3)

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

Key issues:	• Clinical Guidelines: the service have 12% of guidelines that have expired (88% compliance), an improvement of 7% over the last quarter. The service continues to have a active focus on updating the expired guidelines and ensuring sustainability of compliance. • Number of outstanding SI's and PSII's within the Division. Commitment to complete all the incidents declared before 1 January 2025 by end of March 2025 • Demand and Capacity for Gynaecology Services – many referrals and not enough appointments leading to long waiting times
Recommendation:	To provide assurance to the Patient Safety Group 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.28.03.25.
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme Year 6 safety standards Compliance with the Ockenden Interim Report (December 2020) with immediate and essential actions for maternity services. To also monitor outcomes of those in black and brown ethnicities (evidenced 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

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.

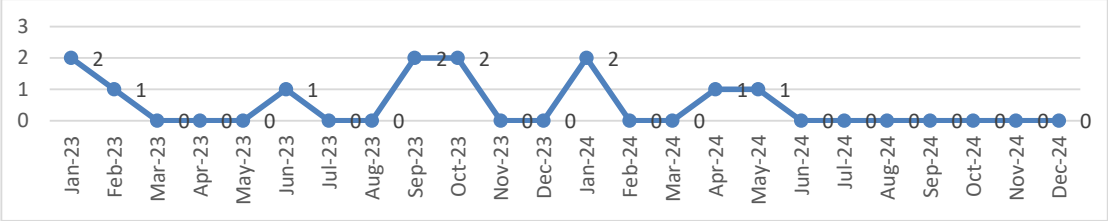
2.0 Background

Within maternity there is an inpatient area which covers 4 wards. Outpatient services are within the hospital in Antenatal Clinic and community midwifery covering 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 SI's/PSII's reported for Women's Health in last 24 months (to December 2024)



Patient Safety Incident Investigations Declared October – December 2024			
Ref	**Ethnicity**	**Summary**	**Learning Points**
No new PSII's declared in quarter			

4.0 Themes

Table 3. Top Themes

Total Number of SI's	Theme	Number
12	Neonatal death	4
	Cardiotocograph (CTG) interpretation	2
	Obstetric Haemorrhage	2
	Intrauterine death	2
	Hypoxic ischaemic encephalopathy	2
	Retained Object	2
	Escalation	2
	Medical Equipment	2
	Oncology	2
	Screening Incident	1
	Therapeutic Cooling	1
	Ectopic	1

The Princess Alexandra Hospital NHS Trust

Clinical Incidents

Current Clinical incidents open and closed

The number of open incidents has remained at 77% for incidents reported in Quarter 3. 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. A task and finish group has been set up to ensure timely investigation and closure of incidents. A critical incident review meeting has been commenced every Wednesday to review incidents and hold services to account with compliance with investigation and closure.

Table 3 – Q3 review of clinical incidents (Datix)

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter **Quarter two**	376 ↓ 488
Number of Incidents Moderate Harm or Above	28 ↓(Haemorrhage and perineal trauma)
DoCs Outstanding	None
Number of Open Incidents	290 (26 moderate harm, 1 severe, 0 death)
Number of Incidents Submitted for last financial year April 2023 – March 2024	1874
Percentage of Open Incidents	77% →

Table 4. Legal Cases overview October - December 2024 (Q3)

New Claims

0 new claims for Quarter 3

Closed Claims

0 claims closed in Quarter 3

Inquests Opened

0 Inquests opened in Quarter 3.

Guidelines

Expired documents – 22; this is 12% of total active documents. This is a 7% reduction from last quarter.

Ongoing issue with review of expired documents due to:

- Availability of specialist availability to review documents
- Improving the engagement to procedural document forum
- Strengthening the response to peer-review
- Strengthening communications

NICE Guidance

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

2025/26 programme to be developed and agreed at Divisional Governance meeting.

The Princess Alexandra Hospital NHS Trust

Risk Register

Women's health services have 26 risks open on the register. Of these risks 3 score >15:

ID	Specialty	Description	Rating (current)	Controls	Comments
640	Obstetrics	There is a risk that the theatre table cannot go into the correct lithotomy position. This causes a risk to patient safety for mothers and unborn babies when birth via caesarean section or instrumental births are required. Additionally, the lithotomy position is used for a manual removal of the placenta and suturing of perineal trauma. This could result in a poor maternal and fetal outcome such as extensive blood loss to the mother and fetal injury/death to the unborn baby. There is a risk to staff physically injuring themselves as the theatre table leg is not functioning as it should and takes several attempts / efforts to lift it into the lithotomy position which goes against manual handling policies. The existing table is not safe to use and is obsolete so the company cannot repair the table. A theatre table was loaned from ADSU however this is due to be returned.	16	Escalated to EBME to source a theatre operating table Able to loan lithotomy leggings from main theatre when needed.	Current status: new table ordered
614	Obstetrics	There is a risk that there are insufficient evacuation routes in Antenatal Clinic for staff and service users This is caused by the locality of the service and the cohort of patients that utilise the service. This could result in serious harm.	15	The stretcher is currently located in the cardiac corridor which is through the discharge lounge. The access is via the emergency exit, across the roof and through another door which has a digi-lock. The stretcher does not go to the floor and therefore we need to use a "Hoverjack device" to lift patients to a safe height to transfer from the floor to the trolley Live drill of patient collapse in ANC which identified a total time of 35 minutes to transfer the patient EVACUsafe chair installed at the top of the stairs Ski Mat installed in the waiting room	Training completed on equipment. Long term solution under review.

647	Obstetrics	There is a risk of serious Harm/Death from wrong route of epidural medication. This is due to lack of availability of preloaded syringes available for procurement with the NRFIT Connector. This could result in noncompliance with national safety standards and patient safety alerts	15	Safety alert issues 31st January 2024 has been widely shared throughout maternity and is included in mandatory teaching to midwives Maternity currently use NRFit for spinals (this is done by an anaesthetist who is familiar with NRFit) Contact pharmacy to ascertain if ready made epidural "top ups" are NRFit compliant	Service currently reviewing available options.

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.

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.

Reporting to Board continues on a quarterly basis as per Maternity (and Perinatal) Incentive Scheme Year 6 guidance. Year 7 will launch in April 2025.

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: 6 Intrapartum stillbirth: 0 Neonatal death: 3 all below 35 weeks gestation

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* No formal reviews undertaken. As of December 2024 PAHT, had 2 incidents that were subject to MNSI (Maternity and Neonatal Safety Investigations) formerly the Health Safety Investigations Branch (HSIB) investigations.

Staffing

Table 8. Current staffing across Maternity and Obstetric Workforce

Staffing				
Staff feedback from frontline champions and walk-abouts:				
Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)			
Resident Doctor Rota Gaps	No rota gaps			
Midwifery Staffing		Oct-24	Nov-24	Dec-24
	Midwife vacancies (wte)	13.41	12.71	5.53
	Midwife Maternity Leave (wte)	9.79	8.99	10.19
	Bank and Agency usage (wte)	16.73	11.62	14.50
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)	NHS Staff Survey 2024 running September – November 2024. Awaiting final report.			
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 2023			

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.

The This is Me System (TiMS) where training data are held and reported from is still challenging. Director of Midwifery and Women's Health Clinical Director work closely with the Organisation Development team to ensure that training data held are current and accurate as there are still some difficulties encountered by divisions in extrapolating these data themselves. 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

Table 10 below illustrates the final position declared to NHSR beginning of March 2025. PAHT worked collaboratively with the Herts and West Essex Integrated Care Board and the HWE Local Neonatal and Maternity System for assurance.

Table 10. MIS Progress Year 6 final submission

MIS Progress Year 6			
SA 1 Perinatal Mortality Review Tool	Action not met – mitigation submitted to NHSR	SA 6 Saving Babies Lives	Action met
SA 2 Maternity Services Data Set	Action met	SA 7 Maternity and Neonatal Voices	Action met
SA 3 Transitional Care	Action met	SA 8 MDT training	Action met
SA 4 Workforce obstetrics and neonatal	Action met	SA 9 Board and Safety Champions	Action met
SA 5 Midwifery Workforce	Action met	SA 10 MNSI and early notification scheme	Action 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 September 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.

Remaining action pertain to preconception care and women with complex health needs. Actions due to be completed by November 2025.

Three-year delivery plan for maternity and neonatal services

This plan published at the end of March 2023 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.

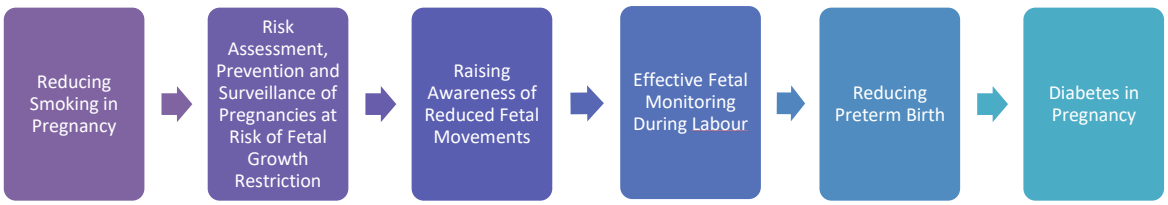
Delivering this plan will continue to require the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women and families and improve care.

As of September 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. This is evidenced by the sustainability plan which is reported locally, regionally and nationally.

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.

For MIS year 6, an assessment has been undertaken by Herts and West Essex LMNS and the PAHT service has been declared compliant for 2025.

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.

Action Outstanding	Progress
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.	
0/185 actions remain open	

Complaints/PALS

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

Complaints	Pals
October – 1 November – 0 December – 5	October – 8 November – 6 December – 4

4.0 Oversight

All highlighted concerns have been escalated at CHAWS Divisional Board. All incidents are discussed at the Divisional Governance and Trust Incident Management Group and escalated where relevant for further investigation.

The service continues to maintain the safety actions that keep us compliant with the maternity incentive scheme, move us to achieving the goals of Three-Year Delivery Plan for Maternity and Neonatal Services 2023 and the Ockenden IEAs. Escalation will occur through Board where non-compliance is anticipated or found to occur.

5.0 Recommendation

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

Author: Erin Walters – Head of Maternity Governance and Assurance
Date: 3 March 2025

Trust Board (Public) – 3 April 2025

Agenda item:	4.3
Presented by:	Sharon McNally – Chief Nurse
Prepared by:	David Dellow – Safe Staffing Lead and Giuseppe Labriola – Deputy Chief Nurse
Date prepared:	19.02.2025
Subject / title:	Report on Nursing and Midwifery staff levels for January 2025.

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x	
Key issues:	There has been a sustained overall registered fill of > 95%. No wards achieved < 75% overall fill rate in month. The increase in overall fill rates is due to enhanced care needs. The next interim establishment review (which underpins the rota templates) is due to commence in March 2025.								
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.31.03.25
Risk / links with the BAF:	BAF: 2.1 Workforce capacity
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. **Appendix 2**: Ward and divisional CHPPD data **Appendix 3:** Nursing red flags **Appendix 4:** Nursing quality indicators

1.0 Introduction

This paper illustrates how PAHT's nursing and midwifery staffing has been deployed for the month of January 2025. 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 January 2025. 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 January 2025 within the data submission deadline. Table 1 shows the summary of the overall fill rate for this month. Table 2 shows a summary of overall fill rate percentages for a rolling 12-month period.

Appendix 1 illustrates a ward-by-ward breakdown for this period.

3.1 Wards with < 75% average fill rate

No wards that had an overall fill rate of < 75%:

3.2 Wards with > 100% average fill rate

Henry Moore Ward has an increased fill rate due to fluctuating capacity and opening of additional surgical beds and a Level 1 area for post-operative patients, the Level 1 bay is staffed by ITU and the staffing is reflected in their numbers. Therefore, the additional staff are reflective of the required workforce to meet the activity demands.

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 demonstrated in wards such as Penn, Saunders, Nightingale and Henry Moore Wards night fill rate for Healthcare support workers (HCSWs). The fill rate is based against the standard ward template

Greater than 100% fill rate for Registered Nurse (RN) shifts continues to be mainly attributable to enhanced care requirements, although supernumerary status for newly qualified nurses contributes towards this.

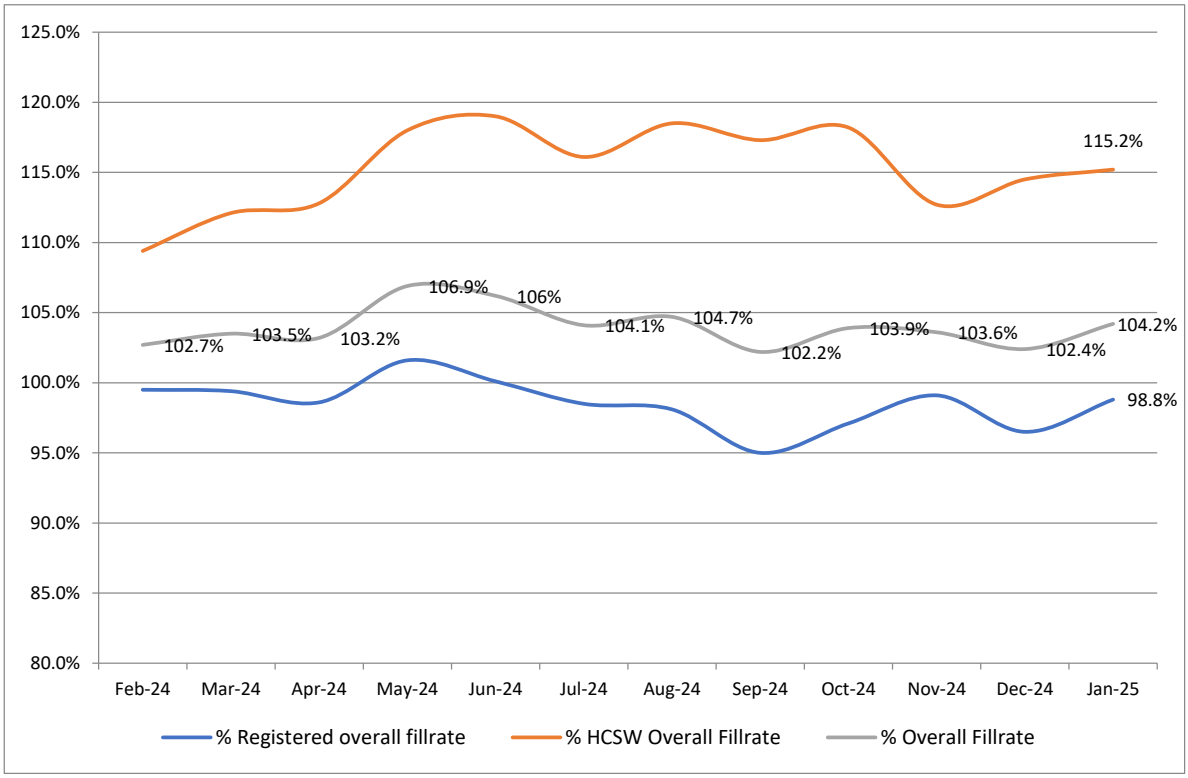
The Trust continues to utilise NHS Professionals and agency to mitigate vacant shifts. Additional control measures continue to be in place regarding the creation of additional duties. Furthermore, our senior nurses and midwives are also supporting individual areas when required. SafeCare data continues to be collected three times a day to enhance staffing governance across the organisation.

Further detail can be found in Appendix 1

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
94.7%	101.5%	103.9%	132.1%	98.8%	115.2%	104.2%

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

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.

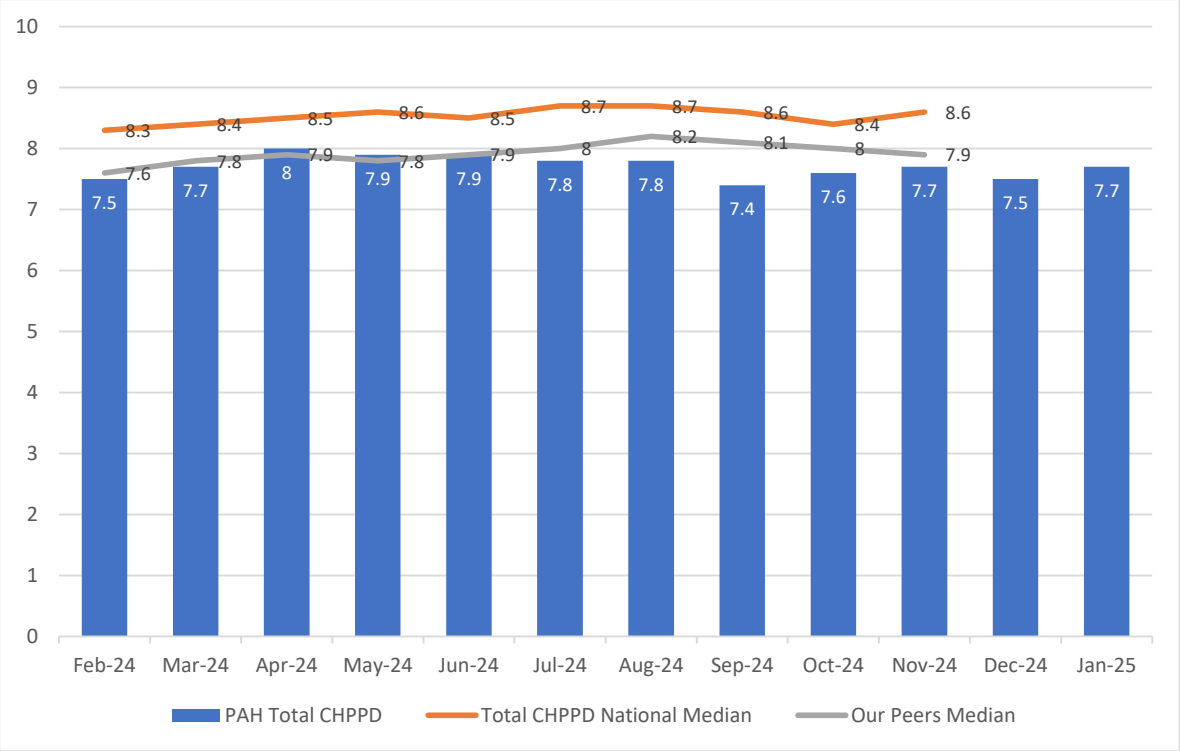
Table 3. Overall Care Hours Per Patient Day (CHPPD) January 2025

Registered CHPPD	Unregistered CHPPD	Total CHPPD
4.9	2.8	7.7

The Model Hospital data for November 2024 shows the Trust with a CHPPD of 7.7 against the national median of 8.6**.** Table 4 also 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 January 2025

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, the number of occasions when registered staffing fell below 75% of the standard template and trend and the number of Red Flags raised in SafeCare. Currently, this information cannot be monitored for all nursing red flags on the DATIX system and a system has been implemented to capture these in SafeCare.

5.2 Quality indicators (Falls, pressure ulcers and complaints, PALS and compliments)

Nursing quality indicators have been reviewed and there is no correlation between these, fill rates or red flags which are a cause of concern. A review of quality indicators can be found in Appendix 4

6.0 Conclusion

The Trust continues to achieve a sustained overall registered fill of > 95%. The increase in overall fill rates are primarily due to enhanced care needs. The Trust is part of an enhanced care collaborative working group supported by NHS England that is reviewing the provision of enhanced care including the workforce and training requirements to sustainably manage this demand. Outputs from this working group will be available during quarter one.

7.0 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 and narrative: fill rates January 2025 *(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	90.2%	130.7%	111.4%	143.3%	98.9%	136.7%	112.6%
Henry Moore	132.5%	151.5%	183.0%	183.2%	152.7%	166.7%	158.8%
ITU & HDU	96.1%	69.8%	104.5%	100.0%	100.3%	84.9%	98.9%
John Snow	109.8%	42.3%	106.5%	82.8%	108.2%	55.1%	85.3%
Penn	109.7%	123.9%	121.0%	210.8%	114.5%	156.9%	129.7%
Saunders	96.4%	119.0%	126.2%	212.8%	107.5%	154.6%	125.3%
Surgery Total	102.5%	111.5%	117.9%	168.0%	109.3%	135.0%	117.0%
Fleming	92.2%	92.6%	100.7%	126.7%	95.8%	108.9%	99.8%
Harold	89.6%	89.9%	103.8%	114.0%	95.8%	101.4%	97.6%
Kingsmoor	85.3%	113.8%	108.1%	132.1%	94.0%	122.5%	104.6%
Lister	92.8%	107.0%	104.0%	134.9%	97.6%	120.3%	106.6%
Locke	90.5%	103.7%	100.0%	132.1%	94.5%	117.3%	103.6%
Nightingale	110.6%	81.6%	111.5%	206.5%	111.0%	120.8%	115.3%
Opal	105.5%	94.1%	102.8%	125.7%	104.2%	109.2%	106.2%
Ray	96.7%	101.7%	102.8%	176.9%	99.3%	130.2%	110.4%
Tye Green	96.6%	103.2%	103.9%	143.6%	99.8%	119.7%	107.5%
Winter	95.2%	94.7%	107.3%	110.9%	100.3%	102.4%	101.2%
Medicine Total	93.7%	99.4%	104.1%	134.7%	98.2%	115.3%	104.6%
AAU	87.1%	140.3%	95.4%	158.0%	90.8%	148.8%	103.0%
Charnley	94.9%	108.0%	105.9%	135.0%	100.1%	120.9%	106.1%
UEC Total	90.1%	124.1%	99.8%	146.5%	94.5%	134.8%	104.3%
Birthing	83.9%	83.5%	81.1%	86.8%	82.5%	85.1%	83.4%
Chamberlen	90.9%	52.2%	85.0%	87.1%	88.1%	68.9%	83.3%
Dolphin	92.8%	73.4%	95.8%	88.6%	94.2%	78.5%	90.2%
Labour	84.9%	96.0%	91.0%	80.8%	87.8%	88.7%	88.0%
Neo-Natal Unit	91.7%	93.9%	95.6%	77.4%	93.6%	85.6%	92.3%

Samson	98.2%	95.8%	92.4%	85.5%	95.4%	90.9%	92.8%
CHAWS Total	90.0%	86.6%	91.4%	84.3%	90.7%	85.5%	89.1%
Total	94.7%	101.5%	103.9%	132.1%	98.8%	115.2%	104.2%

John Snow Ward - continues to have fluctuating capacity and has not consistently been sending 1 of the 2-day HCSW shifts to NHS Professionals (NHSP). The HCSW night shift is being filled, though depending on overnight patient numbers and acuity these staff may be redeployed to other areas. During January these factors continued to impact on the number of HCSW shifts being redeployed from the ward, and to impact on the HCSW fill rate for day and night. The ward template is being adjusted.

Henry Moore Ward - if the Level one bay is not required then this is available for all patients to ease site pressures and additional staff booked if required via additional duties.

Critical Care - it has been identified in the divisional roster reviews that critical care are not consistently sending all HCSW shifts out to NHSP, the division is currently reviewing the critical care establishment. An improvement plan has been requested and a recruitment campaign for support workers will commence centrally in February, for surgery and critical care.

Maternity - the service continues to robustly review staffing through twice weekly staffing reviews and the use of Birthrate Plus. Safety is maintained by daily staffing huddles and staff deployment according to acuity, support continues to be provided by specialist midwives and matrons being redeployed as required. A Maternity Support Worker (MSW) recruitment event took place in January 2025 with 10.60 WTE vacancy being offered to 11 successful candidates. New MSW staff will cover vacancies throughout all maternity areas including community. Midwifery vacancies are now at zero with newly qualified midwives joining gradually and commencing their preceptorship period

The next interim establishment review (which underpins the rota templates) is due to commence in March 2025. This is for adult and paediatric inpatient wards and assessment units along with main and paediatric emergency departments.

Appendix 2: Ward level data: CHPPD January 2025

Care Hours Per Patient Day (CHPPD)			
Ward	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total	***4.9***	***2.8***	***7.7***
Harvey Ward	4.0	3.2	7.2
Henry Moore Ward	3.4	2.9	6.3
ITU & HDU	19.5	1.6	21.1
John Snow Ward	5.0	2.0	7.0
Penn Ward	4.3	3.3	7.6
Saunders Unit	3.7	3.2	7.0
Surgery Total	***5.5***	***2.9***	***8.4***
Fleming Ward	3.9	2.0	5.8
Harold Ward	4.5	2.2	6.7
Kingsmoor General	3.4	2.7	6.1
Lister Ward	3.7	3.0	6.7
Locke Ward	3.6	3.0	6.6
Nightingale Ward	3.0	2.5	5.5
Opal Unit	5.0	3.5	8.4
Ray Ward	3.7	2.7	6.5
Tye Green Ward	4.2	3.2	7.4
Winter Ward	3.8	2.6	6.4
Medicine Total	***3.9***	***2.7***	***6.6***
AAU	6.0	2.6	8.6
Charnley Ward	4.4	2.1	6.5
UEC Total	***5.2***	***2.4***	***7.5***
Birthing Unit	13.4	6.9	20.3
Chamberlen Ward	7.2	1.9	9.1
Dolphin Ward	9.3	2.6	11.9
Labour Ward	28.5	8.2	36.7
Neo-Natal Unit	10.4	1.9	12.3
Samson Ward	2.6	3.3	5.9
CHAWS Total	***8.2***	***3.3***	***11.5***

Appendix 3. Nursing Red Flags (NICE 2014) and trend data

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.

Staffing red flags and trend data

The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards is available in Table 1. This decreased by 14 occasions in January 2025 to 85. The majority of these shortfalls were in Maternity, which had 59. Table 2 shows the trend for when registered staffing fell below 75% of standard template.

Table 1. Occasions when registered staffing fell below 75% of standard template

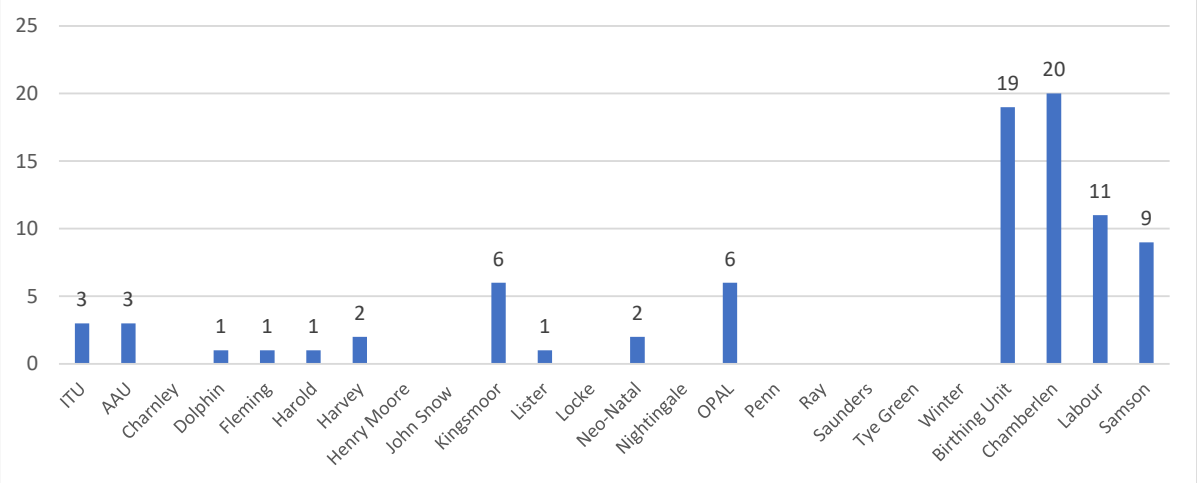
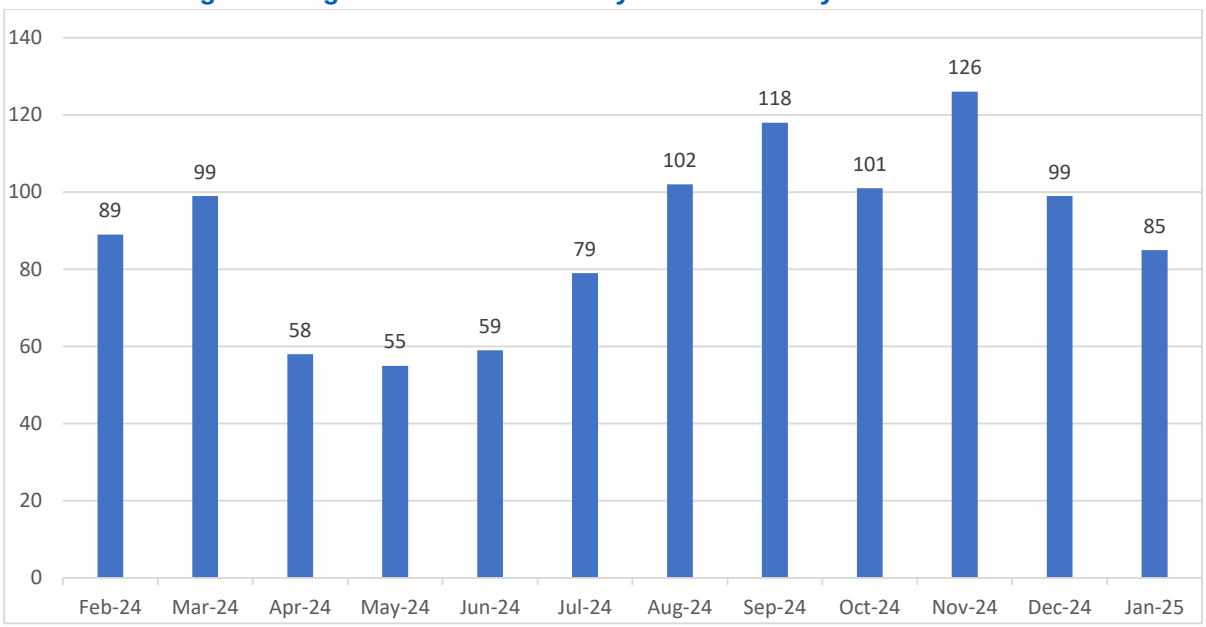


Table 2. Staffing Red Flags Trend Data February 2024 – January 2025



Going forward all adult inpatient areas will be capturing staffing shortfalls on SafeCare by raising a Red Flag on the system. Table 3a shows the Red Flags raised through SafeCare in January 2025. Table 3b shows the number of Red Flags raised for adult inpatient wards has decreased with 82 raised in January against 86 for December.

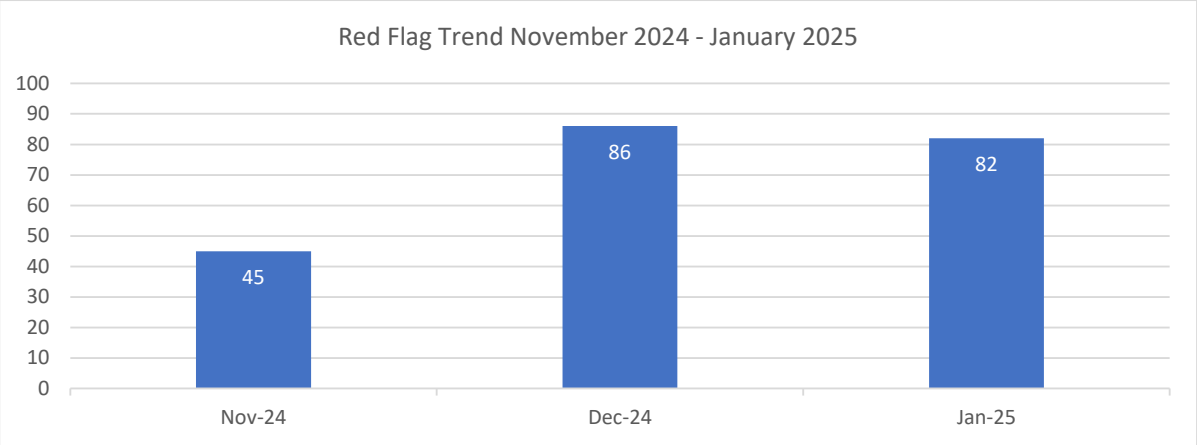
To improve oversight into how many incidents relating to when Enhanced Care could not be provided, the Trust has also added a local Red Flag highlighting when this occurs in SafeCare. This and the addition of Enhanced Care Level 3 Patient task will also enable the Trust to provide data to the Enhanced Care Collaborative and ensure staffing is appropriately deployed. These have now been rolled out across all adult inpatient wards.

There needs to be robust validation of the red flags by managers and matrons to understand which have been mitigated and closed, which is not demonstrated in Table 3a below. This will be a focused aspect of work with the divisions.

Table 3a. Red Flags raised via SafeCare January 2025

Row Labels	Missed 'intentional rounding'	Shortfall in RN time	Unable to provide Enhanced Care	Grand Total
AAU		1	6	7
Charnley Ward	2	7	2	11
Fleming Ward		1	4	5
Henry Moore			1	1
Kingsmoor General		2	3	5
Lister Ward			1	1
Locke Ward			1	1
OPAL Unit		1		1
Penn Ward		3	13	16
Ray Ward	1	2	4	7
Saunders Unit			1	1
Tye Green Ward	1		16	17
Winter Ward	2	7		9
Grand Total	**6**	**24**	**52**	**82**

Table 3b. Red Flags raised via SafeCare Trend



Redeployment

Redeployment of staff continues to be undertaken to support safe staffing as part of the daily staffing huddles. Table 4 details the trend in January 2025 with Tye Green redeploying the highest number of substantive staff with ITU and AAU being the next highest. The highest net receiver of staff was Nightingale followed by A&E and Saunders Ward. Table 5 demonstrates the number of substantive staff redeployments per month trend

Table 4. Hours of sunstantive staff redeployed January 2025

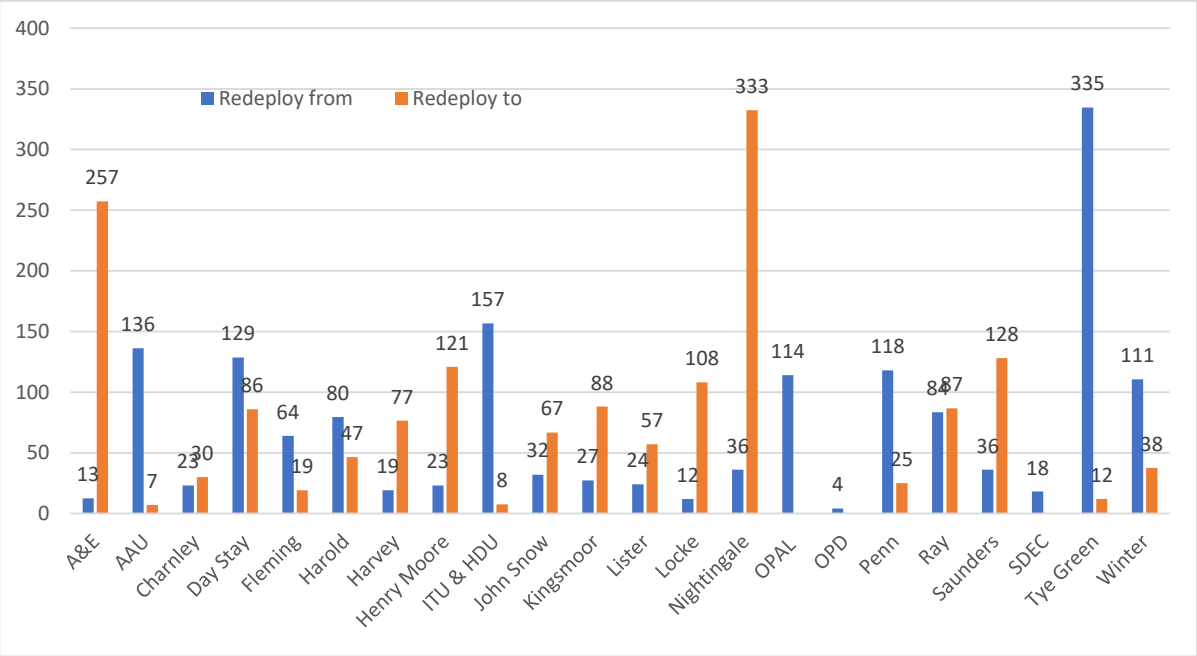


Table 5. Substantive staff redeployment trend

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.

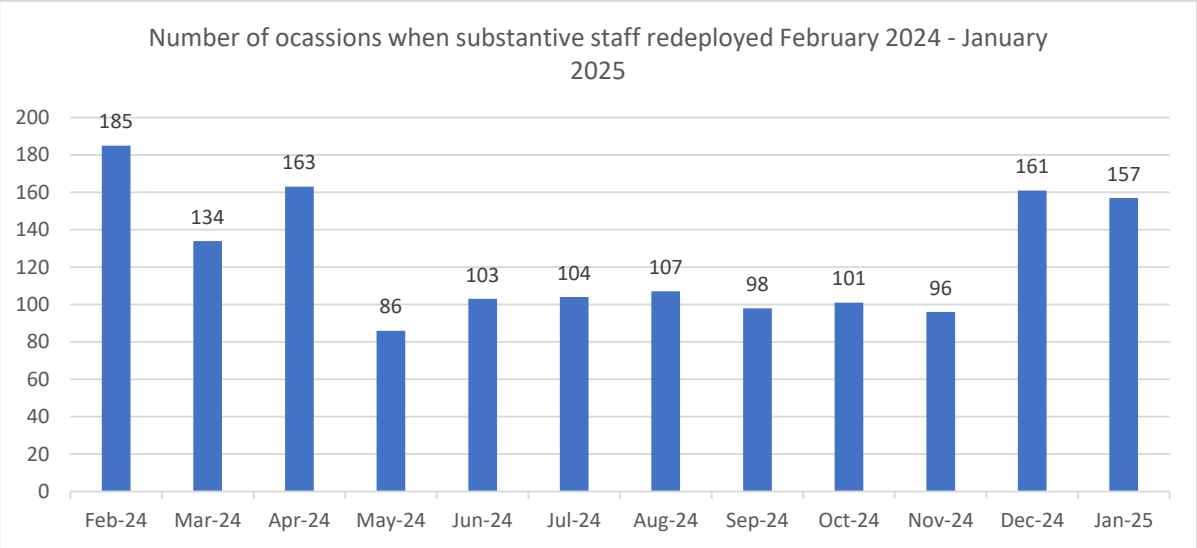


Table 6 shows the hours of substantive staff moved as a percentage of total hours worked.

Table 7 shows the hours of all staff including bank and agency, excluding the Enhanced Care Team, Bank Pool and Rapid Response Pool staff.

Table 6. % 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
1592	143074	1.1%

Table 7. % 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)
3539	143074	2.47%

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

Appendix 4: Nursing quality indicators

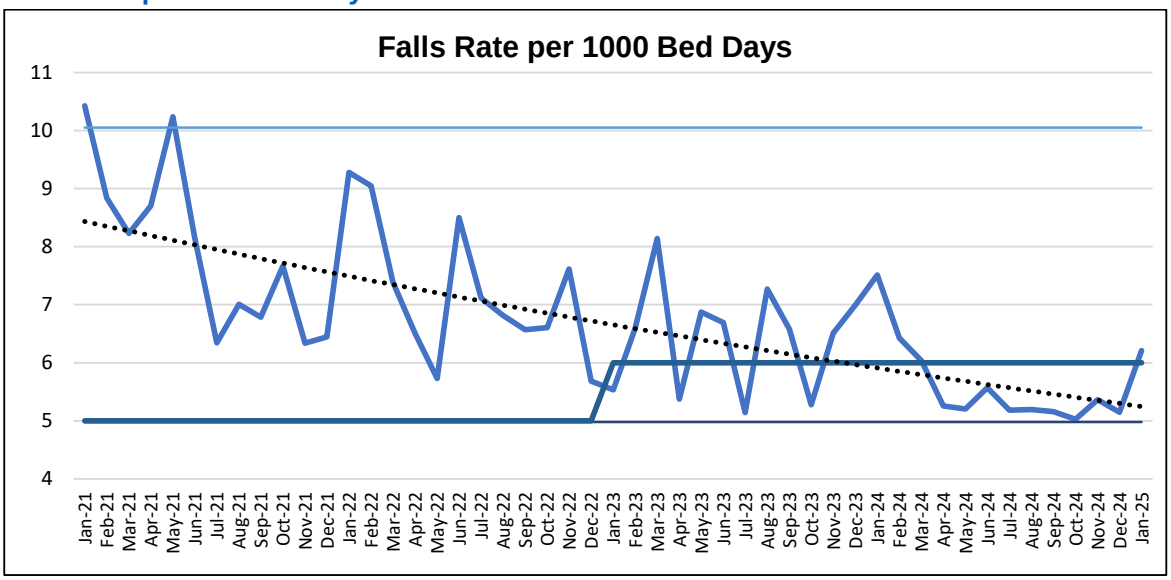
Table 1. Number of falls, unwitnessed falls and falls with harm in January 2025, with the top 3 wards being highlighted

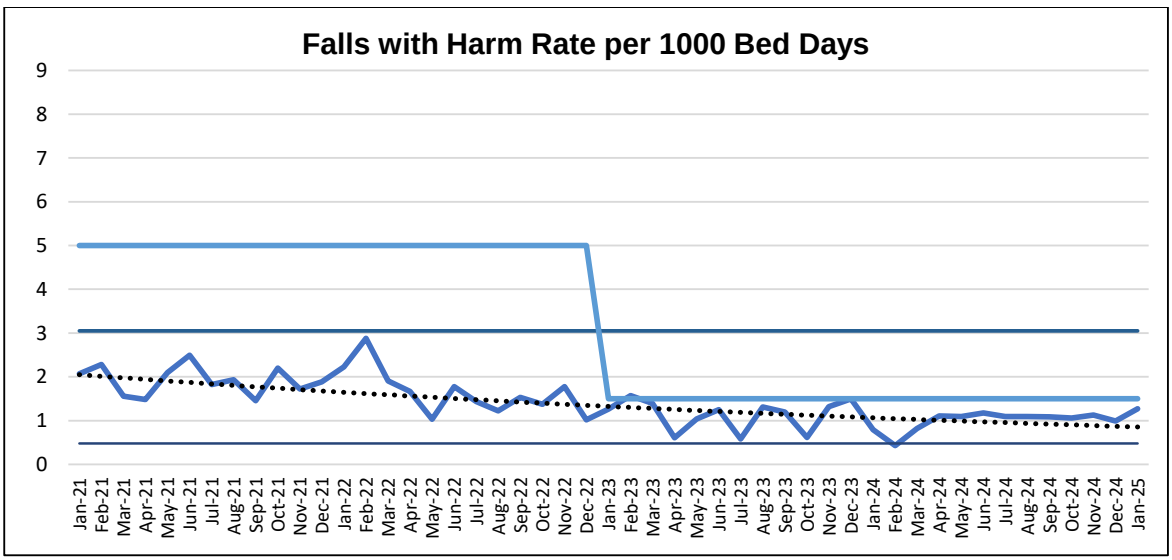
	Total falls in month	Top 3 wards		
Total falls	102	Kingsmoor 15	Tye Green 10	AAU 9
Unwitnessed falls	84	Kingsmoor 13	Tye Green 8	Saunders 8
Falls with harm *	16	AAU 2	Charnley 2	Ray 2

**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 97%.

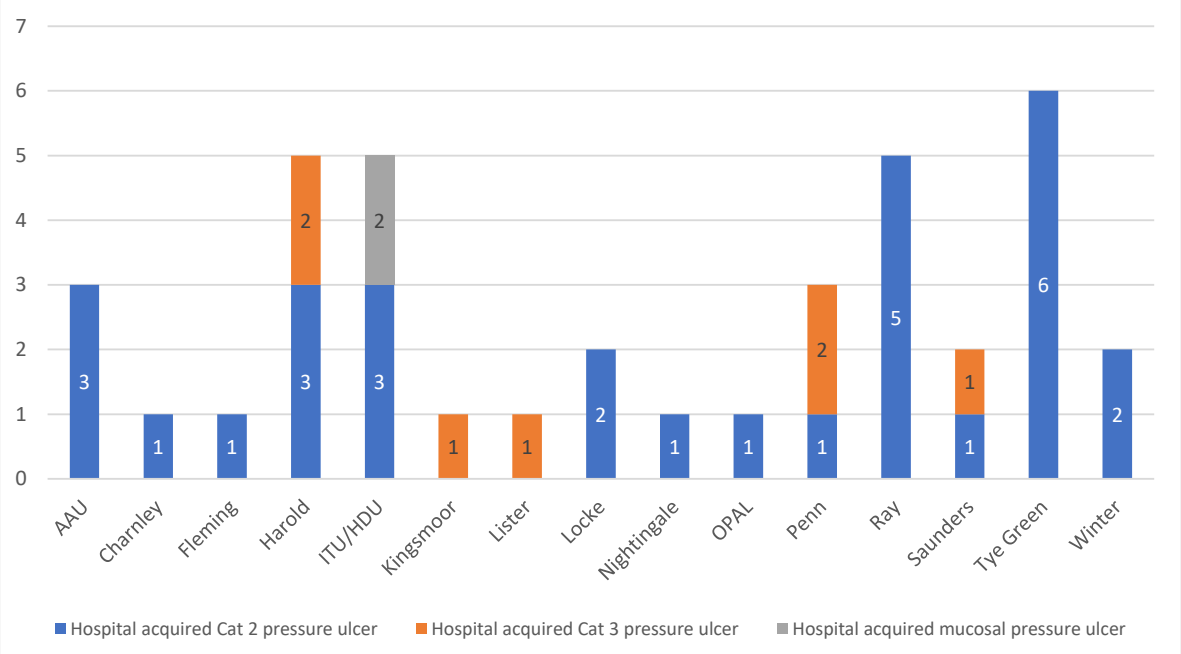
Falls Rate per 1000 bed days





Pressure Ulcers

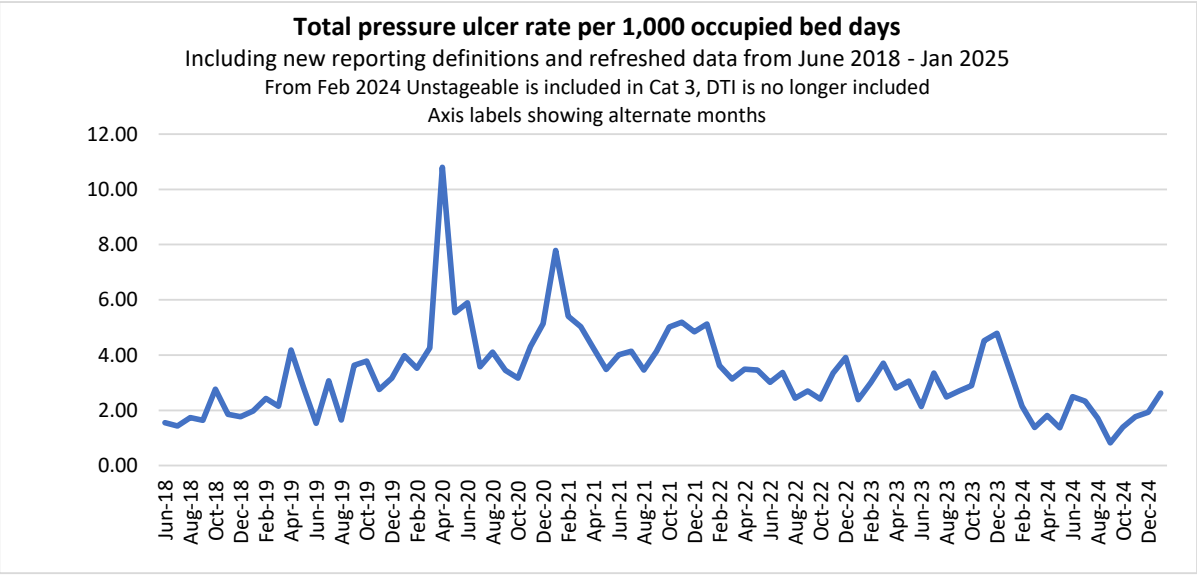
Table 2. Number of Hospital Acquired Pressure Ulcers (HAPU) Cat 2 and Cat 3 Pressure Ulcers (including unstageable)

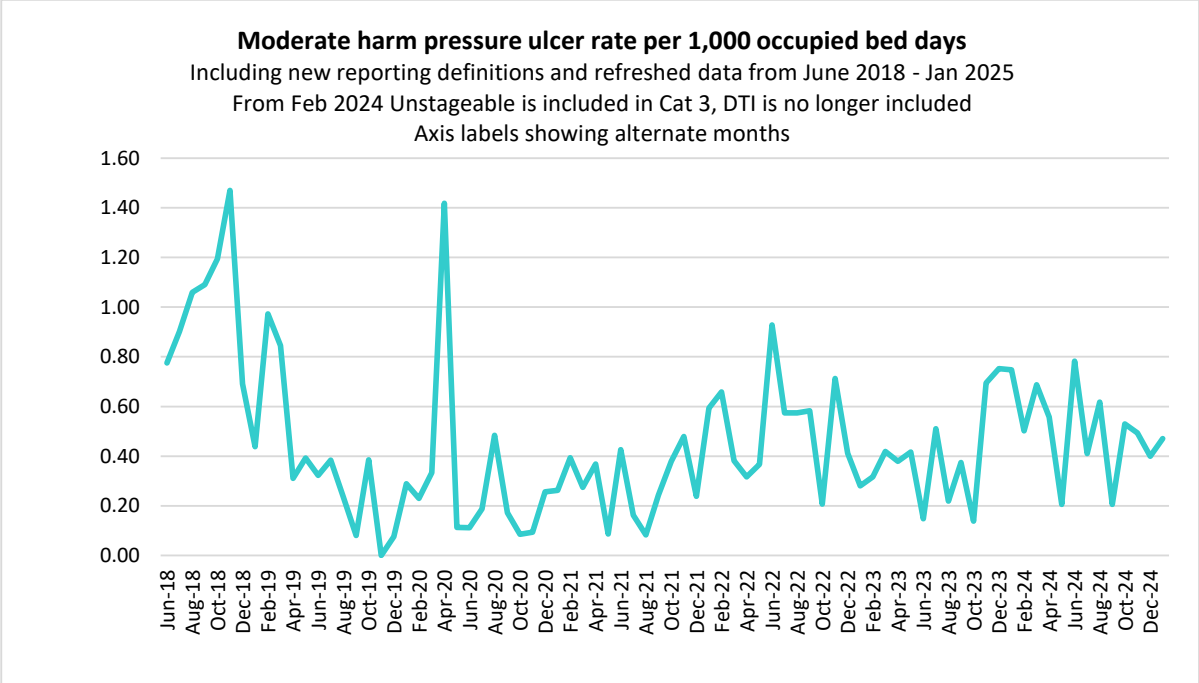


In January 2025 there was an increase in HAPU, with 39 HAPU's in month compared to 29 in December.

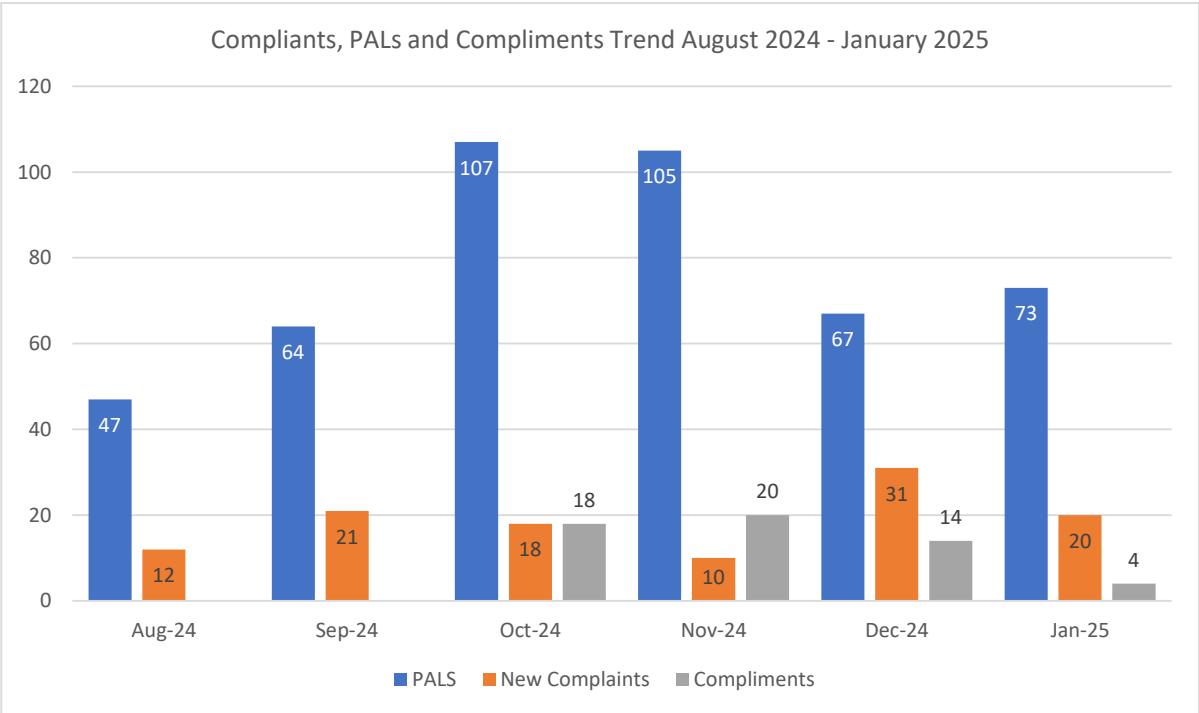
Total in month	Top 3 wards	
39	Tye Green 6	Harold, ITU & Ray 5 each

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





Complaints, PALS and Compliments Trend Data August 2024 – January 2025



Complaints, PALS and Compliments

Table 3. Number of new Complaints, PALS and Compliments in January 2025 with top three wards highlighted

	Total in month	Top 3 wards		
New complaints	20	A&E 5	Lister 3	Dolphin, Henry Moore & Kingsmoor 2 each
PALs	73	A&E 19	Ray 6	Tye Green 5
Compliments	4	Henry Moore, Labour Ward, Saunders and Tye Green 1 each		

The 3 main PALS themes for January were:

- Delay – 34.7%, Communication – 26.8%, Cancellations – 9.8%

Complaints themes for January were as follows

- Communication – 22.3%, Medical care – 16% and Delay – 14.3%

The Princess Alexandra Hospital NHS Trust

Learning from Death and Mortality Paper for Quality and Safety Committee 28 March 2025

Agenda item:	4.4							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team Fay Gilder | Medical Director							
Date prepared:	19th March 2025							
Subject / title:	Learning from deaths and Mortality Paper							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This paper provides assurance on the learning from death process and highlights key pieces of learning and updates on the current programme of work to improve clinical practice and patient outcomes.							
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.							

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

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

The Princess Alexandra Hospital NHS Trust

1.0 Purpose

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

3.1 Background

Telstra provide an in-hospital mortality report for all inpatient admissions. This report covers the 12-month time period Nov 2023 - Oct 2024.

3.2 Analysis

Hospital standardised mortality ratio (HSMR) overview

Figure 1 – HSMR Monthly Trend Nov 23 - Aug 24 HSMR for Oct 24 is 'within expected'

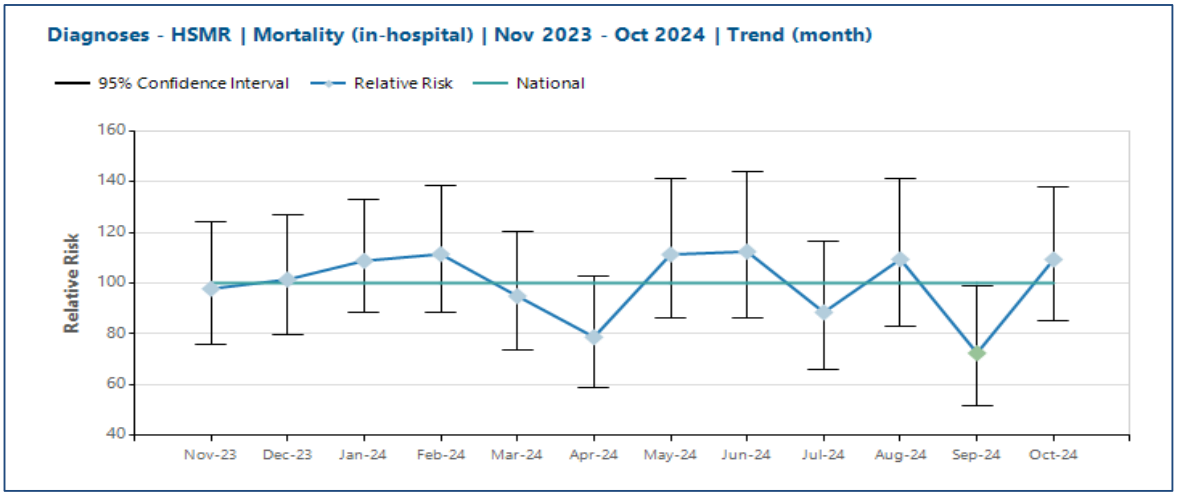
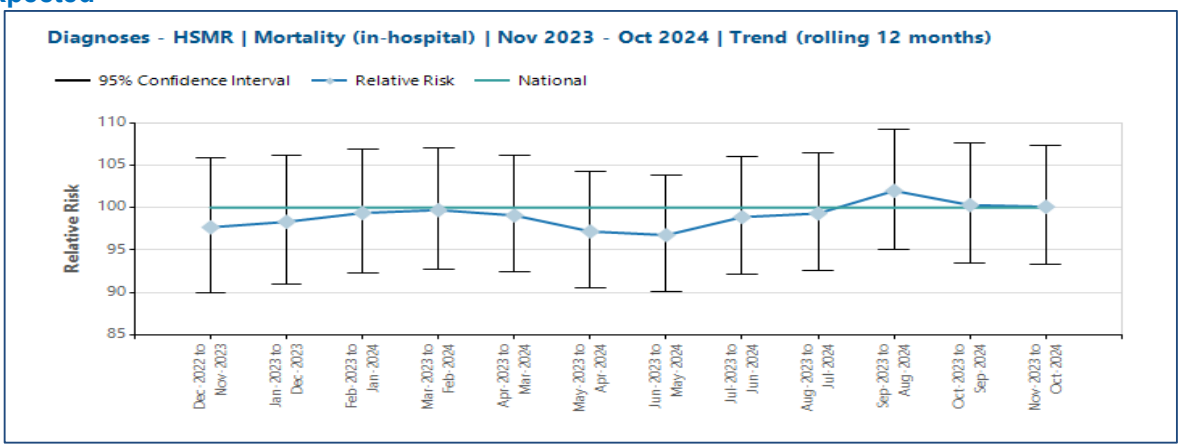


Figure 2 – HSMR 12 month rolling trend Nov 23 – Oct 24 (excluding Jun 24) which is 'within expected'

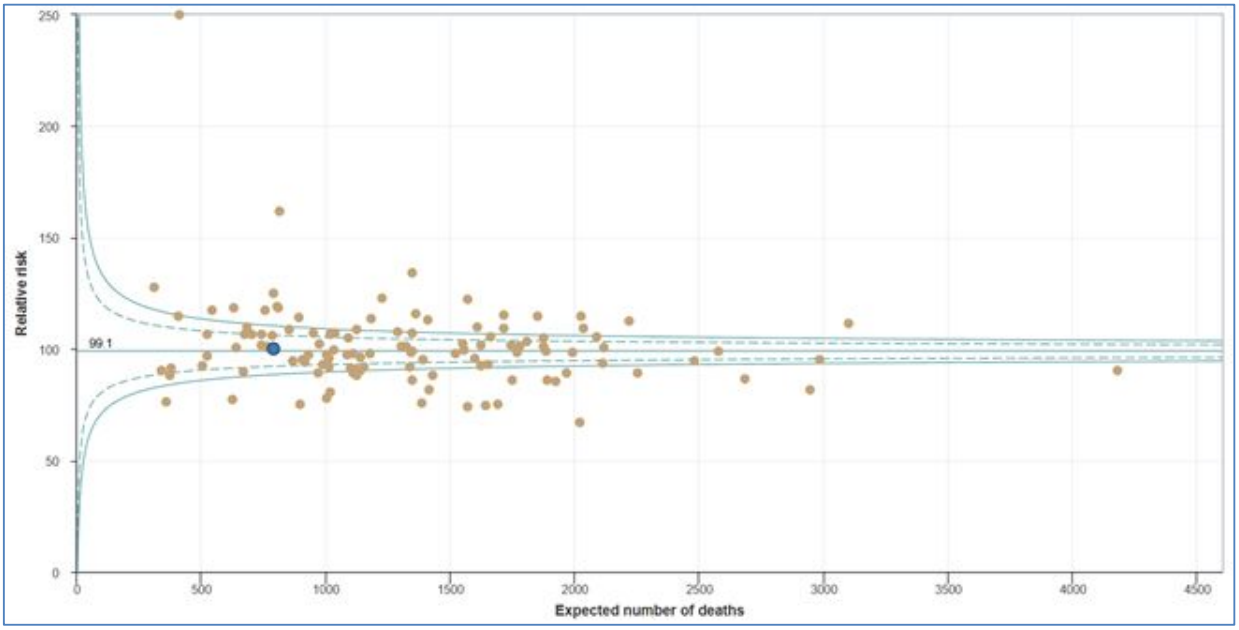


The Princess Alexandra Hospital NHS Trust

The rolling 12 month HSMR (figure 2) for the period Nov-23 to Oct-24 is 100.09 **'within expected'** based on 21,488 superspells and 791 deaths (crude rate 3.68%).

Figure 3 – HSMR+ National Peer Comparison (Last 12 Months)

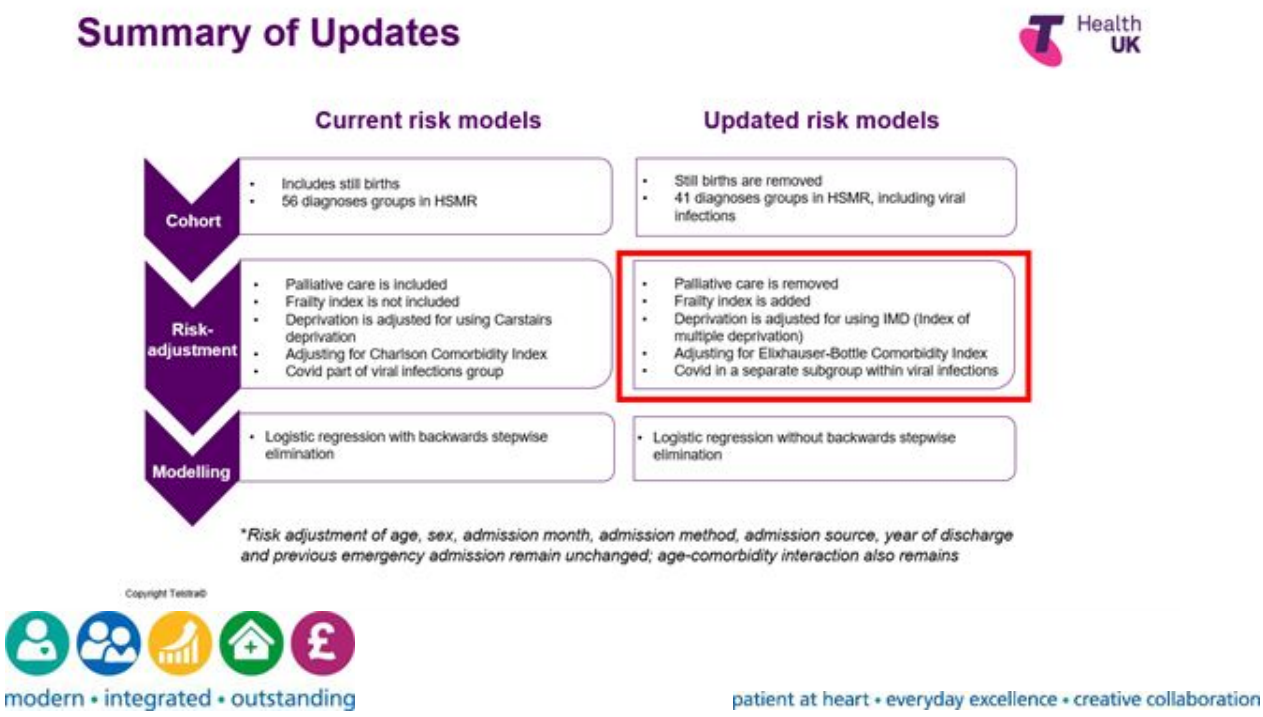
(PAH = blue; all other acute, non-specialists = brown)



What is HSMR+?

HSMR+ is the new risk model being used by Telstra. It replaces HSMR as the mortality index for Trusts they work with.

Figure 4 shows the differences between HSMR ('current risk model) and HSMR+ (updated risk model).



Critically important to our understanding is how frailty is accounted for. See Figure 5 for the codes that support the HSMR+ frailty index. This has been shared with the coding team.

Figure 5

Appendix - Frailty indicators

Health UK

Group	ICD-10 code	Description (ICD-10)
1. Dementia and Delirium	F00	Dementia in Alzheimer's disease
	F01	Vascular dementia
	F02	Dementia in other diseases classified elsewhere
	F03	Unspecified dementia
	F05	Delirium not induced by alcohol and other psychoactive
	G30	Alzheimer's disease
	G311	Senile degeneration of brain, not elsewhere classified
	G310	Circumscribed brain atrophy
	F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
	R41	Other symptoms and signs involving cognitive functions and awareness
2. Mobility Problems	R26	Abnormalities of gait and mobility
	R298	Other and unspecified symptoms and signs involving the nervous and musculoskeletal systems
3. Falls and Fractures	S32	Fracture of lumbar spine and pelvis
	S33	Dislocation, sprain and strain of joints and ligaments of lumbar spine and pelvis
	S42	Fracture of shoulder and upper arm
	S43	Dislocation, sprain and strain of joints and ligaments of shoulder girdle
	S52	Fracture of forearm
	S53	Dislocation, sprain and strain of joints and ligaments of elbow
	S62	Fracture at wrist and hand level
	S63	Dislocation, sprain and strain of joints and ligaments at wrist and hand level
	S72	Fracture of femur
	S73	Dislocation, sprain and strain of joint and ligaments of hip
	W0-W1	Falls
	M80	Osteoporosis with pathological fracture
	M81	Osteoporosis without pathological fracture
	R296	Tendency to fall, not elsewhere classified
	R55	Syncope and collapse
	R54	Senility
	M966	Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate
4. Pressure Ulcers and Weight Loss	L89	Decubitus ulcer and pressure area
	R634	Abnormal weight loss
	R636	Insufficient intake of food and water due to self neglect
	Z724	Inappropriate diet and eating habits
5. Incontinence	R32	Unspecified urinary incontinence
	R15	Faecal incontinence
6. Dependence and Care	Z74	Problems related to care-provider dependency
	Z75	Problems related to medical facilities and other health care
7. Anxiety and Depression	F38	Other mood [affective] disorders
	F41	Other anxiety disorders
	F43	Reaction to severe stress, and adjustment disorders
	F44	Dissociative [conversion] disorders
	F064	Organic anxiety disorder
	F32	Depressive episode
	F33	Recurrent depressive disorder
	F204	Post-schizophrenic depression
	F251	Schizoaffective disorder, depressive type
	F31	Bipolar affective disorder
	F341	Dysthymia
	F412	Mixed anxiety and depressive disorder
	F432	Adjustment disorders

References Soong JTY, Gammall J, Liew D, et al (2019) Dr Foster global frailty score: an international retrospective observational study developing and validating a risk prediction model for hospitalised older persons from administrative data sets BMJ Open 2019;9:e026759. doi: 10.1136/bmjopen-2018-026759 https://bmjopen.bmj.com/content/9/6/e026759

This is an evidence based improvement in the accuracy of mortality indices for organisations supported by NHSE.

Standardised Mortality Ratio (SMR) overview

Figure 6 – SMR for Oct 24 – which is 'within expected'

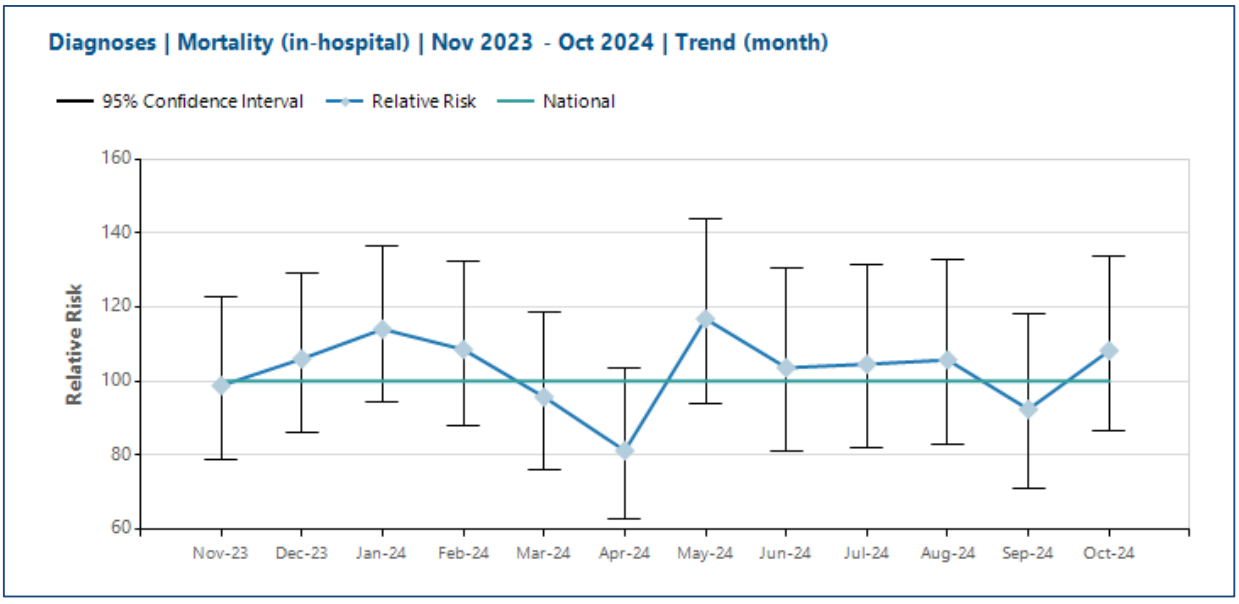


Figure 7 – 12 month rolling SMR Nov 23 – Oct 24 which is 'within expected'

3.3 Summary

The data presented highlights the stability of the trusts HSMR and SMR position, currently sitting as 'within expected'.

There are no new diagnosis groups with CUSUM alerts, however the group 'medical examination/evaluation' has now triggered a second alert for the last 12-month period.

This will be reviewed as part of the clinical coding monthly audit.

4.0 Mortality Programme Updates

The Strategic Learning from Deaths Group (SLfDG) did not go ahead in March 2025 due to minimal attendance and lack of representation from 3 divisions. An update will be provided in the May 2025 paper.

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 93 deaths in February 2025
14 cases referred for Structured Judgment Reviews (SJRs)
There are 152 outstanding SJRs (over 6 weeks of the patients' death).
The Medical Division continues to work on the backlog of SJRs as well as new referrals.
The Surgical and Critical Care Division have made a start on SJR's. Critical care are working on a plan and trajectory to clear the backlog.
The Divisional Directors receive a monthly report with the breakdown of outstanding SJR's.

5.2 Deaths Investigated Under the Patient Safety Incident Response Framework

Figure 5 – Avoidable Deaths (June 2024)

- Nil

5.3 Cases awaiting the second review panel

- PAweb125454 – multidisciplinary second review panel held March 2025.

5.4 Themes and Issues Identified from Reviews and Investigation

- Issues with anticoagulation prescribing – this has been logged as an incident and will be reviewed through the Trust incident management process.

5.5 Actions Taken in Response to Avoidable Deaths

- Nil required

6.0 Medical Examiner (ME) Headlines

6.1 Scrutiny Update

100% were scrutinised by 7 Medical Examiners.
21 cases were referred to the Coroner.
14 Post-mortems were requested.
There were no independent post-mortems.
1 inquest

National MCCDs issued within 72 hours: (National Target)
The 21 coroners' referrals are exempt from Trust Statistics
76 of the remaining 82 were issued on time.
6 failed national target due to delays in doctors attending to complete the MCCD.
This resulted in 92.7% of MCCDs being issued within 72 hours in December 2024. This falls below the National target of 95%.

6.2 Ongoing Developments

- SMART training continues to be provided for new junior doctors across many specialities
- SMART – ongoing work to develop the system to enhance the trusts learning from deaths.
- A project has started on the improvement of MCCD national target compliance

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
NHS Trust

BOARD OF DIRECTORS: Trust Board - Public 3 April 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 31 March 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 Medical Workforce Review – Interim update	Yes	Yes	No	A review of budgets for resident doctors was discussed. alongside bank and agency spend. The outstanding areas; CSS and Surgery, will be completed by May 2025 The consultant medical workforce review is ongoing and is being informed by the 24/25 job planning round. Team job planning will be introduced 25/26 and be supported with the data from the transformation nous work. This will enable a comprehensive review of the medical workforce requirement. The committee agreed that updates on the medical workforce will be added to the workplan.
2.2 GMC Enhanced Monitoring Group Assurance Report	Yes	Yes	No	There were no items for escalation. It was noted the name of the group is likely to change to 'Improving Working Lives for Resident Doctors'. It was agreed Non-Executive Director attendance at the group would no longer be required as the Committee will receive assurance reports from the group.
2.3 Staff Survey including Cultural Assessment	Yes	Yes	No	The 2024 Staff Survey results were discussed. New priorities had been agreed for 2025/26: 1. People Promise: Compassionate and inclusive 2. People Promise: We are a team 3. People Promise: We are recognised and rewarded The Committee were assured on the plans in place to develop and deliver action plans and further updates will be presented to May's meeting.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - Public 3 April 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 31 March 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 Appraisals	Yes	Yes	No	• The Committee noted the updated approach to appraisals, which included removal of the cascade approach and the simplified and digitalised appraisal form. • Compliance has improved to 78%. • Managers with a number of appraisees have the option to delegate the appraiser responsibility.
2.5 Annual Equality Report 2023 – 2024	Yes	No	No	The Equality Report 2023 -2024 provides assurance that the Trust is meeting its statutory duties under the Equality Act 2010. The report outlines the progress made towards delivering the Trust's annual equality objectives, provides a snapshot of staff diversity data as at 31 March 2024, and highlights the breadth of equality, diversity and inclusion activity taking place across the Trust. The Committee recommended the report to Board
2.6 Gender & Ethnicity Pay Gap Report Action Plan 2025	Yes	Yes	No	Further to the Gender and Ethnicity pay gap reports and recommendations, the Committee noted the action plans which provided tangible interventions to progress inclusivity and counteract workplace inequality. The Committee acknowledged the national requirement but discussed the possibility to explore actions that are specific to the Trust's position.
2.7 NHS disability toolkit implementation	Yes	Yes	No	The Committee was assured on the actions following an internal review of processes against the recommendations in the Disabled NHS Directors Network (DNDN) Good

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - Public 3 April 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 31 March 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				Practice Toolkit for the Recruitment and Retention of Disabled People in the NHS.
2.8 People Report	Yes	Yes	No	The Committee noted the good progress on the people metrics with the majority rated as green. The vacancy rate is 6.9% and the sickness level was just above target (4.5%) at 4.56% and rolling sickness at 4.43%. Bank and agency expenditure remain a key focus and on a downward trajectory with only 12.75WTE over establishment. Flu vaccine uptake has increased to 40.38%. Voluntary turnover is at the lowest it has been since 2013 at 9.49%. Stability rate is reported at 87% which is just below Trust target of 90%.
2.9 Learning and OD Update	Yes	Yes	No	Statutory and mandatory training compliance is at 88% with 3 divisions reaching the 90% target and appraisals at 77.5% with Medicine reaching the 90% target. National Apprenticeship week launched a number of new apprenticeships and the Trust has reached 100 apprentices.
2.10 Apprenticeships	Yes	Yes	No	The Committee supported the strategic recommendations for apprenticeships, levy expenditure and gifting: •To attract, recruit, develop and retain both clinical and non-clinical apprentices •Building a workforce fit for the future •Maximise the spend of £2million levy •Strengthen the Trusts presence as an anchor organisation by providing training and employment opportunities

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - Public 3 April 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 31 March 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.11 Annual Fit and Proper Person Checks Compliance	Yes	Yes	No	This Committee noted the progress made, however there remained a number of outstanding checks, particularly at the Board level and sub-Board level. The Committee supported the contingency planning efforts to ensure all checks are completed by the end of Q1. The submission was required by the 30th June 2025.
2.12 Nursing, Midwifery and Allied Health Professionals strategy 2024-2027	Yes	Yes	No	The strategy had been refreshed and will be launched to coincide with the international celebrations of nursing and midwifery on the 16 May 2025.
2.13 Safer Nurse Staffing Report	Yes	No	No	There has been a sustained Registered Nurse fill rate of > 95%. No wards achieved < 75% overall fill rate in month. The increase in overall fill rates is multifaceted with a combination of enhanced care needs and supernumerary time driving this.
2.14 BAF Risk 2.3 Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust	Yes	Yes	No	The score was reviewed and remained at 16. A deep dive into vacancies was being conducted to evidence improvement.
2.15 AHP Workforce Modelling – deep dive	Yes	Yes	No	The committee noted that there is no nationally recognised tool for modelling the AHP workforce. PAHT therapies has collaborated with the business school at the University of Hertfordshire in a proof of concept pilot for a web-based decisions support tool to assist in the future development of the AHP workforce at PAHT. Various interventions over the

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - Public 3 April 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 31 March 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				past 6-9 months have addressed the high turnover rate in AHPs with vacancy rates dropping significantly from 25% in October 2023 to 7% in October 2024 which is below the Trust target of 8%. The modelling for PT and OT has concluded and has identified a deficit in the workforce based on the multiple factors considered as part of the tool. The work now focusses on contextualising the outputs and analysing the opportunities to work differently across the workforce. Further updates on outcomes would be brought to the Committee in due course.
2.16 Horizon Scanning	Yes	Yes	No	The following items were discussed: • Employment Rights Bill update • Workforce planning & NHSE announcements - final workforce plan submission required neutral growth. • Data protection: new guidance on keeping employment records - no changes to Trust polices required • Updates noted on the level of people team involvement in the CDC and surgical hub.
3.1 Communications Update	Yes	No	No	An update on the activity of the Communications team was noted including; the development of the new website and recent communications in relation to the New Hospital Programme.

Trust Board (Public) – 3 April 2025

Agenda item:	5.2								
Presented by:	Giovanna Leeks, Interim CPO								
Prepared by:	Denise Amoss, associate director of organisational development and learning								
Date prepared:	03-03-25								
Subject / title:	NHS Annual Staff Survey 2024: national benchmarking scores								
Purpose:	Approval	x	Decision		Information	x	Assurance		
Key issues:	This paper sets out the results for the Annual Staff Survey 2024, benchmarked against all other acute/acute and community combined Trusts. It defines our next steps in using this data to drive improvement. It does not contain Trust and divisional actions as they are now being devised (month of April & May) and will be reported back to this committee at the May meeting.								
Recommendation:	Review and discuss results, endorse the proposed top three improvement priorities, and support Feedback to Action 2.0.								

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

Previously considered by:	
Risk / links with the BAF:	2.3 Inability to recruit and retain our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC - KLOE well led
Appendices:	Appendix 1: Responses rates by division and staff group Appendix 2: Detailed benchmarked results *(emailed separately)* Appendix 3 - Cultural assessment

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

NHS Annual Staff Survey 2024: national benchmark scores

1.0 Introduction

This paper sets out our Annual Staff Survey 2024 results benchmarked nationally and proposes a timeline for communication and action planning.

2.0 Background

The benchmark report shows our results against the national average and aligns them with the NHS People Promise, i.e. the seven elements that would most improve working life as chosen by NHS employees.

People Promise results provide an easily understood, consistent, and standardised way of talking about, measuring, and improving Employee Experience in PAHT.

The results enable us to compare our progress with NHS organisations nationally but crucially assess our own progress from previous years.

3.0 Guidance on the national benchmark report

- PAHT is benchmarked against 122 trusts (acute, and acute and community combined).
- Most questions are aligned (where possible) with the NHS People Promise and/or ‘staff engagement’ and ‘morale’.
- Some questions are not benchmarked because of incomparable data.
- The results comprise best, average and worst scores for similar organisations.

4.0 Benchmarked response rate

PAHT response rate **(49.33%)** is:

- Equal to the median response rate of the comparison group (49%).
- Less than 1% lower than our 2023 response rate (49.7%).
- Due to our increase on workforce, despite a slightly lower response rate we had an increase of **6.6%** of our staff engaging with the NSS24 (equivalent of 275 staff).

Highest response rates (divisions):

- **70.6%** corporate services
- **68.4%** estates and facilities – a **32%** increase on 2023

Highest response rates (staff groups):

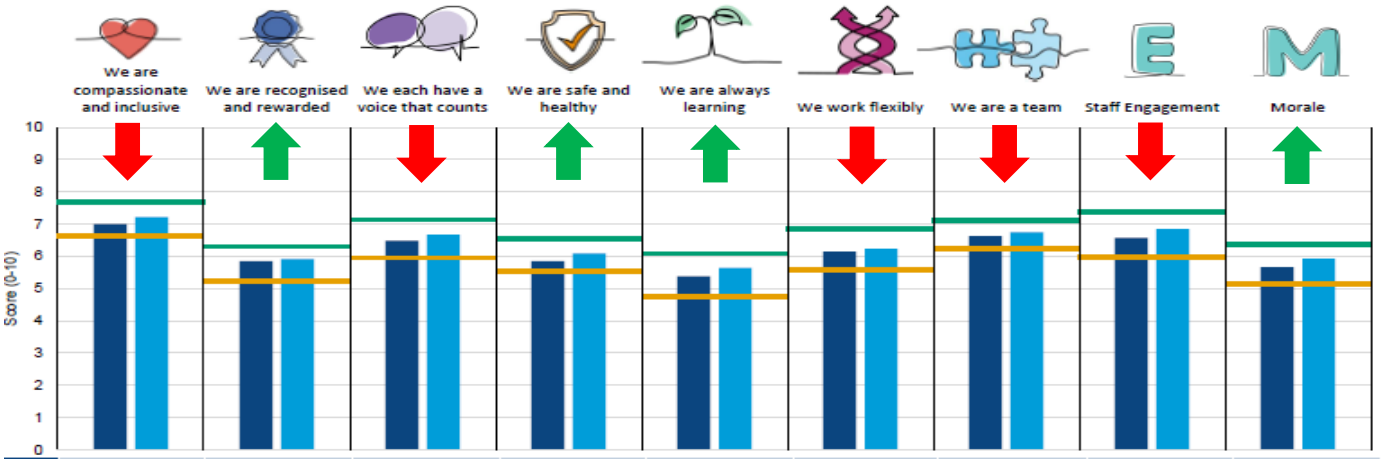
- **65.1%** administrative and clerical
- **63.7%** estates and ancillary

Response rates by division and staff group can be found on Appendix 1.

5.0 Results headlines

the below picture provides the overview comparison for PAHT NSS24 results compared to NSS23. It is evident that PAHT have improved on four of the domains with some further work to improve on the remaining.

It is worth noting that PAHT scores are closer to the average for similar organisations, so although scores have declined for some of the domains PAHT is not an absolute outlier.



6.0 Detailed benchmarked results (Appendix 2)

Locally staff engagement and morale scores remain stable, and there are no statistically significant changes to scores across the NHS People Promise compared with 2023.

It should be noted that there were significant impacts, heard from ad hoc conversations and on the ground insight, on our ability to improve engagement scores in 2024 and action some of the plans devised in 2023. Those perceived barriers were named as the Alex Health roll-out, triple-lock constraints, budget pressures, increased service demands and changes in the executive team. To remain stable against this backdrop should be regarded as positive.

6.1 Cultural assessment (Appendix 3)

We have also produced a cultural assessment based on the staff survey and generated ideas that will feed into the Trust and divisional plans to deliver on our 25/26 staff survey outcome goals.

7.0 Priorities from previous year (2024-25)

Through discussion at senior leadership level, 3 priorities were set to support the 24/25 trust- wide strategic operational and people objectives outcomes:

1. **People Promise: We are always learning**
2. **People Promise: We are safe and healthy**
3. **This is Us management Practices and leadership promise**

8.0 Setting priorities for upcoming year (2025-26)

The data from the NSS24 survey has been presented in multiple formats and analysed internally yielding differing focus areas, based on a slightly different set of outcome data than last year's. Through engagement with the senior leadership at PAHT the below priority areas were identified. This was done by collectively considering common themes from the national report, executive Picker presentation, Picker data, free-text thematic analysis and internal culture dashboard.

The analysis of the output the recommendations for key areas of focus are as follows:

1. **People Promise: Compassionate and inclusive**
2. **People Promise: We are a team**
3. **People Promise: We are recognised and rewarded**

8.1 Compassionate and inclusive

Given the challenges in the NHS is facing the need for nurturing a **compassionate and inclusive** culture has never been more important. The focus on this is reflected in;

- The CQC single assessment framework, launched in April 2024, placing more focus on capable, compassionate and inclusive leaders in the well-led guidance for NHS Trusts
- Priority 2 in our PAHT2030 strategy is about "fostering and nurturing an inclusive environment that champions diversity and equality, and where our people are engaged, supported and helped to learn and grow"

- Recommendations in Lord Darzi's report include re-engaging staff and inclusive leadership.

In PAHT we now need to place a focus on management and leadership development ensuring that all managers reflect the competencies required by the NHS to lead a team and deliver on our leadership promise.

External

		2021	2022	2023	2024	Acute Orgs	PAHT 2024
q9f	Immediate manager works with me to understand problems	65%	63%	66%	66%	69%	66%
q9g	Immediate manager listens to challenges I face	67%	67%	70%	69%	71%	69%
q9h	Immediate manager cares about my concerns	66%	65%	68%	67%	70%	67%
q9i	Immediate manager helps me with problems I face	62%	61%	65%	63%	67%	63%

The below inserts are from the free text comments from our staff:

"Managers not listening, not being visible, not showing interest in understanding the experience of being on the front line. Until this changes and people are valued and appreciated in equal standing outside of hierarchy, I fear that engagement will continue to decrease…."

"If your manager doesn't listen, then raising it to higher management, again nothing happens, what's the point in having a manager"

8.2 We are a team

We are a team, a large, diverse and growing team. United by a desire to provide the very best care. We learn from each other, support each other and take time to celebrate successes. There are many complex challenges within the PAHT environment that requires all staff to pull in the same direction through teamwork, by breaking down silos, respecting diverse contributions, working towards the same overall objectives and thereby increasing organisational performance and effectiveness.

External

		2021	2022	2023	2024	Acute Orgs	PAHT 2024
q7a	Team members have a set of shared objectives	70%	70%	71%	70%	73%	70%
q7b	Team members often meet to discuss the team's effectiveness	54%	55%	60%	58%	61%	58%
q7d	Team members understand each other's roles	68%	68%	70%	68%	71%	68%
q8a	Teams within the organisation work well together to achieve objectives	42%	44%	47%	50%	54%	50%

Free text from the survey:

"Work with some amazing people and amazing teams, BUT, communication between certain teams is very challenging and unproductive."

"I feel over the last 6 months there has been more tension between staffing groups…"

8.3 Recognised and rewarded

Fundamentally, employees want to look forward to coming to work, be treated with dignity and respect, to make a difference and be appreciated for their efforts. The mechanism to be **recognised and rewarded** involves a robust appraisal process. When done correctly, employee satisfaction and motivation is high.

On our scores our people told us that when they have meaningful appraisals it helps them to improve how they do their jobs, it helps by setting clear objectives and leave our people feeling valued – all of those questions have scored on our top 5 Picker results against national benchmark.

The issue is that while this is so positive, 71% of our respondents said they have not had an appraisal on the last 12 months.

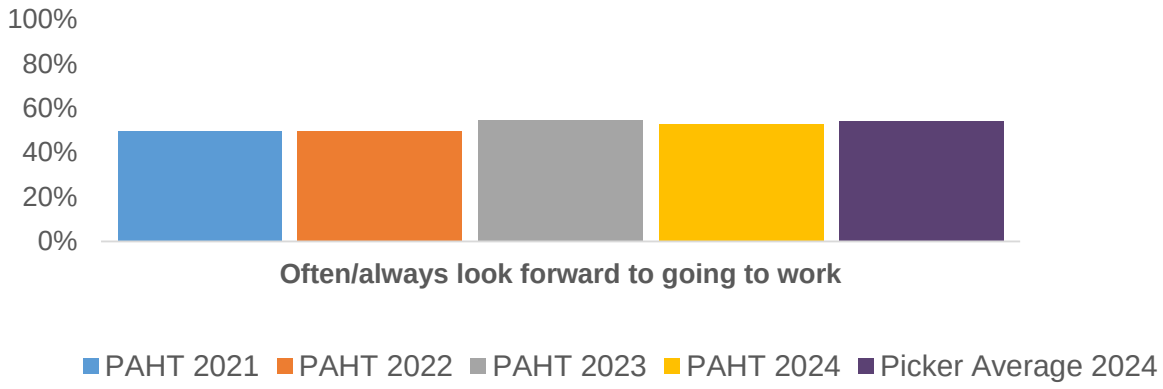
		PAHT Overall	Child Health & Women's Services	Clinical Support Services	Corporate Services	Estates & Facilities	Medicine	Surgery & Critical Care	Urgent and Emergency Care
Q	Description	n = 2029	n = 252	n = 474	n = 367	n = 242	n = 238	n = 274	n = 182
PP5_2	Appraisals sub-score	4.3	3.5	4.5	4.5	3.5	5.2	4.3	4.5

Free text form the survey:

"I am concerned that having started here in June 2021 I have never had a one to one, never had an appraisal and never had any training."

"I am given no feedback on my performance, but I feel I am doing well, if I wasn't I think I would have been told by now.."

Approximately half of our respondents look forward to coming to work, greater emphasis by managers on 'intrinsic reward' (not linked with remuneration) is required such as appreciation, recognition, development, autonomy and flexibility.



9.0 Net promotor score questions

The below two questions is the measure utilised nationally to gauge satisfaction from our staff, it is how we are measured.

We will be now tracking progress on the two net promotor score questions through quarterly pulse surveys on key themes. Specifically:

- Q25c: **Would recommend organisation as place to work** – remained the same as 2023 at 50% but is 9% lower than the Picker average
- Q25d: **If a friend / relative needed treatment, I would be happy with the standard of care provided by the organisation** – has gone down from 47% to 46% in 2024 and is 15% below the Picker average

10.0 Responding to the results

March 25	Receive national results; submit Executive Cabinet paper
	Executive cabinet confirm top improvement priorities, communicate trust-wide and incorporate into managers appraisal goals
	Divisions schedule results workshops for all managers
April 25	Divisional leads bring together managers in the division alongside representatives across roles, professions and levels to share the Trust-wide priorities and key themes arising in the divisional / departmental survey findings Divisional leads define divisional priorities on the engagement plan
May 2025	Divisions begin monthly updates at DRMs and through local governance
June 25 – ongoing	Action improvements outlined in divisional engagement plan; discuss, update and prioritise actions at monthly board meetings
	Share positive change stories for communication ahead of NSS25
October 25	Annual Staff Survey 2025 opens

11.0 Recommendation

Board is asked to receive, discuss and accept this level of assurance.

Appendix 1 - Response rates by division and staff group

Comparison of 2023 and 2024 response rates by division			
	Response rate 2023	Response rate 2024	Variance 2023-24
Urgent & Emergency Care	34.9%	45.0%	10.1%
Surgery & Critical Care	39.4%	32.2%	7.2%
Medicine	48.3%	41.5%	6.8%
CHaWS	54.1%	48.2%	5.9%
Estates and Facilities	36.8%	68.4%	31.6%
Corporate Services	74.7%	70.6%	4.1%
Clinical Support Services	54.7%	53.4%	1.3%
Trust wide	50.0%	49.3%	0.7%

Comparison of 2023 and 2024 response rates by staff group			
Staff group	Response rate 2023	Response rate 2024	Variance 2023-24
ADD PROF SCIENTIFIC AND TECHNIC	52.9%	52.80%	0.1%
ADDITIONAL CLINICAL SERVICES	40.30%	40.60%	0.3%
ADMINISTRATIVE AND CLERICAL	69%	65.10%	3.9%
ALLIED HEALTH PROFESSIONALS	54.3%	50.00%	4.3%
ESTATES AND ANCILLARY	36.3%	63.70%	27.4%
HEALTHCARE SCIENTISTS	58.4%	52.10%	6.3%
MEDICAL AND DENTAL	32.8%	28.50%	4,3%
NURSING AND MIDWIFERY REGISTERED	50.5%	47.90%	2.6%

Appendix 2 – Detailed benchmarked results – *(emailed separately as large file)*

RQW-benchmark-2024.pdf

Appendix 3 – Cultural assessment

3.1 Culture Dashboard: Local and National questions mapped to PAHT This is Us

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

3.2 Culture Dashboard: Staff Survey responses mapped to This is Us by Division

This is Us element	Related behaviour	Overall	Clinical Support Services	Corporate Services	Estates & Facilities	Child health & women's services	Medicine	Surgery & Critical Care	Urgent and Emergency Care
Patient at heart	We put patients first in all that we do: ensuring the goal of our work is always to enable high quality patient care	69%	69%	72%	69%	68%	76%	62%	66%
Patient at heart	We are compassionate and respectful, responding with kindness to our patients' needs	69%	73%	74%	65%	61%	73%	63%	63%
Patient at heart	We feel safe and confident to speak up when we believe we can do things better	66%	66%	63%	58%	72%	74%	58%	70%
Patient at heart	We ensure our places of work are safe for our patients and our people	59%	59%	62%	45%	54%	70%	57%	56%
Everyday excellence	We embrace change by understanding the need to improve and grow	58%	57%	61%	44%	52%	69%	56%	58%
Everyday excellence	We recognise, thank and value our colleagues for excellence in their work	44%	44%	54%	47%	29%	55%	34%	39%
Everyday excellence	We are committed to challenging ourselves to being the best that we can be	55%	54%	67%	52%	47%	63%	48%	48%
Everyday excellence	We are always learning and developing to be more effective in our work	58%	53%	66%	47%	55%	66%	60%	61%
Creative collaboration	We support each other as one team: working together to create a great place to work	41%	41%	38%	29%	36%	59%	36%	47%
Creative collaboration	We support each other as one team: working together to create a great place to work	50%	52%	48%	51%	47%	55%	41%	56%
Creative collaboration	We learn from each other, by creatively combining our skills and knowledge	53%	52%	50%	35%	49%	71%	51%	55%
Creative collaboration	We ask for people's views and suggestions both internally and externally, making better decisions together	55%	57%	66%	43%	49%	66%	51%	45%
Creative collaboration	We are inclusive, ensuring everyone feels they are an important part of their team	68%	71%	76%	61%	63%	76%	62%	63%
Creative collaboration	We are inclusive, ensuring everyone feels they are an important part of their team	67%	69%	72%	64%	61%	75%	61%	64%
Management practices	We prioritise health and wellbeing, ensuring our people feel safe, rested and have access to support	66%	70%	76%	54%	61%	72%	60%	59%
Management practices	We are approachable: encouraging people to feel free to speak to us openly and honestly	72%	74%	79%	63%	69%	76%	65%	64%
Management practices	We are approachable: encouraging people to feel free to speak to us openly and honestly	56%	53%	61%	56%	57%	61%	49%	51%
Management practices	We share feedback: giving praise, offering suggestions and celebrating success	64%	68%	75%	54%	56%	76%	55%	59%
Management practices	We are visible and part of the team, being there when our team face challenges, and supporting individuals through 1-1s and team meetings	71%	70%	80%	62%	64%	78%	65%	67%
Management practices	We enable people to develop, through coaching and learning opportunities	54%	52%	65%	44%	51%	61%	49%	52%
Management practices	We take accountability for our teams' work and support individuals to achieve their goals	66%	69%	75%	58%	55%	72%	60%	57%
Leadership promise	We lead by listening to our people with compassion, seeking to understand their experiences and challenges	69%	71%	77%	61%	64%	79%	61%	61%
Leadership promise	We lead inclusively, seeking the views and input of others to inform our decisions and progress	66%	68%	76%	54%	58%	71%	58%	55%
Leadership promise	We lead by empowering our people, trusting their judgement and giving assurance that we treat all outcomes as learning opportunities	71%	69%	77%	65%	69%	80%	66%	72%
Leadership promise	We lead by inspiring people to help shape and be a part of our future vision	59%	60%	68%	50%	49%	67%	53%	54%
Leadership promise	We lead by championing culture: we act on staff feedback to create a culture of trust, respect and inclusivity	62%	60%	58%	59%	66%	73%	54%	63%
Leadership promise	We lead by championing culture: we act on staff feedback to create a culture of trust, respect and inclusivity	64%	65%	72%	54%	58%	72%	57%	57%
Leadership promise	We lead by championing culture: we act on staff feedback to create a culture of trust, respect and inclusivity	42%	41%	43%	48%	38%	50%	34%	45%

Key

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

0% - 24%	Very bad
25% - 49%	Poor
50% - 69%	Medium
70% - 79%	Good
80% - 100%	Excellent

3.3 'This is Us' culture analysis based on NSS24 Data

'This is Us' data shows a culture with a string foundation of patient-centred care but also highlight areas that need improvement in staff morale, facilities and workplace support.

Highlights

- Leadership and management commitment – engagement scores in management and leadership suggest that teams recognise string leadership efforts, particularly in corporate services.
- Teamwork and collaboration – high engagement in the divisions of medicine and CSS reflects strong teamwork and shared learning locally.

Areas for improvement

- Openness to speaking up – there is evidence that our people feel only somewhat comfortable raising concerns, this is an area that needs to be strengthened.
- Teamwork and collaboration – whilst there are positive scores in a couple of divisions, there is a general perception that the organising works in silos with low scores across the board.
- Disparity between service areas - similar to teamwork, engagement had positive scores in a couple of divisions, but further work needs to be done for the Trust overall.
- Workforce environment and morale – low scores related to our estates and infrastructure suggests challenge sin workplace conditions, which directly and indirectly impacts on job satisfaction.
- Urgent and emergency care pressures – some of the scores relating to emergency and critical care suggests our people are experiencing burnout and/or stress related challenges
- Variability in engagement levels – as per some of the comments above, engagement scores are not consistent across all teams/organisation wide. This suggests we have pockets of string culture alongside areas needing targeted support and management training.
- Need for stronger recognition and inclusion – according to the scores, gaps are identified in how our people feel valued, included and supported on their roles.

4.4 Practical improvement ideas and benefits of each

Some ideas that will support strengthen PAHT culture and improve the working lives of our people.

Strengthen leadership unit

1. Recognise competing agendas, timelines and priorities amongst the leadership teams
2. Run a three-horizon session to start clarifying the value of each priorities, i.e. short term operational actions, innovation and long term transformation, with the commitment that each agenda item will have full support of leaders as a united team.
    - Executive board team to lead by example and role model the value of teamwork
    - It will improve the score/perception of 'across the organisation, we work together as a team.'

Strengthen leadership visibility and support

1. Encourage PAHT leaders to engage directly with front line teams through regular check-ins and shadowing shifts
2. Implement a quarterly all hands hospital update and Q&A session with the Executive team
3. Implement 'Ask the leader' session within the divisions where staff can voice concerns and get direct responses
4. Provide structured leadership training focused on inclusivity, coaching and psychological safety
    - It will build trust and accountability
    - Will support with further strengthening the leadership understanding of day-to-day challenges
    - Will support our people to feel heard and valued

Improve workplace conditions and facilities

1. Address concerns around our infrastructure by looking into plans for improving staff spaces/rest areas and equipment inventory.
2. Conduct quarterly staff wellbeing audits (pulse survey) to identify pain points.
3. Further communicate flexible working options, make the process easier to access and understand and ensure breaks are protected (time protected)
    - These actions if carried out properly will improve staff morale and support retention
    - It will also reduce burnout and improve job satisfaction
    - And will demonstrate commitment to our people in regards to their wellbeing

Empower teams to innovate and share best practice

1. Implement 'Bright ideas' sessions where our people pitch solutions to workplace challenges.
2. Encourage cross-department collaboration days to share best practices.
3. Recognise and reward staff-driven improvements through divisional and trust wide awards incentives.
    - These will encourage a culture of innovation and continuous improvement
    - Will create a sense of ownership and engagement
    - Will help break silos and improves team morale

Strengthen psychological safety and speaking up culture

1. Reinforce communication around confidential reporting
2. Cascade clear communication on escalation pathways
3. Strengthening of the training for managers on how to handle concerns fairly and sensitively
4. Build up on closing the loop on feedback across the organisation
5. Share positive examples of what happened as a result of staff speaking up in order to normalise transparency
    - These will increase trust and staff confidence in leadership
    - It will help prevent issues before they escalate
    - It will strengthen a fair and inclusive workplace culture

Targeted support for high risk areas

1. Further focus on wellbeing and support initiatives on hot spots areas
2. Introduce peer support network to provide emotional support
3. Offer resilience-building workshops to all our people
    - It will support with reduction of burnout and improve retention on high-pressure areas
    - It will foster a culture of support and teamwork
    - Indirectly, it will ensure patient care remains high-quality

Enhance recognition and career progression

1. Expand staff recognition programmes beyond awards night, e.g. monthly ‘thank yous’
2. Provide clear development pathways for all staff groups
3. Implement ‘Employee Spotlights’ to celebrate contribution from all teams
    - These actions will support with increase motivation and loyalty
    - Will ensure our people feel valued and invested in
    - Will support with retention

In addition we have linked how our ‘This is Us’ culture initiatives link with the NHS People Promise. (Appendix 5)

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 April 2025:

Agenda item:	5.3
Presented by:	Giovanna Leeks, Interim CPO
Prepared by:	Arleen Brown, Head of Equality, Diversity & Inclusion
Date prepared:	27 February 2025
Subject:	EDI Annual Equality Report 2023 – 2024

Purpose:	**Approval**		**Decision**	x	**Information**		**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Equality Report 2023 -2024 provides assurance that the Trust is meeting its statutory duties under the Equality Act 2010. The report outlines the progress made towards delivering the Trust's annual equality objectives, provides a snapshot of staff diversity data as at 31 March 2024, and highlights the breadth of equality, diversity and inclusion activity taking place across the Trust. To note this is a retrospective report and compliant with the national requirements.							
Recommendation:	The People Committee is asked to: • Note the contents of this report • Approve so it can be published in line with national requirements							

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:	
Risk / links with the BAF:	Robust performance in relation to equality, diversity and inclusion helps mitigate against risks of service/policy gaps that put protected groups at a disadvantage.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Equality Act 2010 Public Sector Equality Duty CQC Well Led Framework Equality Delivery System
Appendices:	Appendix 1 Workforce information (workforce and recruitment data; patient demographics for the report period; employee relations cases; non-mandatory training & CPD)

The Princess Alexandra Hospital NHS Trust

Annual Equality Report 2023- 2024

1.0 Purpose and background to the report

The Princess Alexandra Hospital NHS Trust (PAHT) publishes diversity data annually as statutory requirement and as an enabler to meeting its general and specific duties under the under the Equality Act 2010.

The Trust has a general Public Sector Equality Duty (PSED) to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by the Equality Act 2010;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Trust also has specific duties under the Equality Act 2010 to:

- Publish equality information at least once a year to show how we have complied with the equality duty;
- Prepare and publish equality objectives at least every 4 years.

The general duty applies to the protected characteristics set out under Section 4 of the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief (including no belief)
- Sex
- Sexual orientation

2.0 Introduction

We are committed to equality, diversity, and inclusion (EDI) because we are passionate about creating an inclusive culture, for the benefit of our staff, patients, visitors, service users and the community that we serve. In the course of this, it helps us to comply with our legal and statutory obligations, for example, through the Workforce Race Equality Standard (WRES), Disability Equality Standard (WDES), the Gender Pay Gap reporting and the NHS Equality Delivery System (EDS).
Our ambition is that every person who comes through our doors, feels safe, free from fear of discrimination and where they are their authentic selves, able to access our services freely and safely, for the right treatment at the right time.

This annual equality report is a valuable reflection of our commitment to our vision and achievements against this, and our programme of work as we look forward to continuing to make a difference to the lives our people, our patients, and our community.

Appendix 1 contains our Workforce Information and Appendix 2 contains our Patients Demographics.

Our EDI Reports are published on our public website once approved via our internal governance route. https://www.pah.nhs.uk/equality-and-diversity

3.0 Key activity during 2023 -2024

Outlined below some of the key successes the Trust has made in the year 2023/24 on EDI.

On 5 October 2023, our Trust Board approved our new EDI strategy, setting out our vision, principles, goals and focus areas for the next seven years, as well as our journey to this point.

Staff and patients' voices were at the heart of the design of the new EDI strategy (objective 1 - 4). It was important to staff that our colleagues are prioritised alongside our patients and service users, and that they feel their voices are heard and their views matter.

Overwhelmingly, staff believed that EDI can no longer be an add on – inclusivity must be central to everything we do in the healthcare system. Together they formed the vision:

With fundamental aims of

And with strategic goals to achieve our EDI vision

The Trust engaged with staff through 2023 and the EDI Strategy was published in February 2024. To monitor activity through 2023, the four strategic goals continued to be the focus.

An EDI Delivery Group has been established to drive forward strategic priorities for EDI across clinical divisional and corporate departments. Each division and department have been tasked with:

- Cascade of briefing throughout each level of management/supervision until all teams have received a team brief
- Review of clinical strategies, care models and delivery plans with an EDI lens
- Define objectives, determine outcomes and list actions that are needed for 2024/25 as part of established business planning process

Widening participation	Training	Staff networks	Culture and belonging
We implemented an inclusive career development Project Search provided employment opportunities for 7 young adults with a learning disability or autism spectrum conditions, or both. We achieved our Menopause friendly employer status We continue to recruit and welcome International nurses', providing welcome events, induction and specific practice development support.	EDI awareness as part of corporate induction which is undertaken by all new staff. Ready to Manage Inclusive management training continues which provides managers with the skills and knowledge to manage in an equitable and inclusive way Inclusive recruitment training for hiring managers continues Disability training for staff in the People department covering legal principles and ways to promote disability inclusion. LGBTQ+ training sessions held to explore ways to be more inclusive in service delivery.	The Race Equality & Cultural Heritage (REACH) rebranded and relaunched with leadership development support for its leaders. REACH Cultural Festival success. Over 350 people attended. REACH series of events in person and online to mark Black History Month. Diwali event Marked National Day for Staff Networks with session on finding your voice and being heard. Women's network was investigated and the purpose scoped alongside lively debate on membership and allyship. Spiritual network conversations and	Signed up to UNISON Antiracism Charter Implemented NHS Rainbow Badge scheme  Continued to support and grow the Disability Champions Diversity goal /objective embedded in appraisal framework Schwartz Rounds with a focus on neurodiversity, race and menopause Marked the following diversity days with social media posts and additional internal communications: World Mental Health Day; Inclusion Week; International Day for the

		meetings took place and an inaugural spiritual conference took place with a variety of speakers demonstrating the important of spiritual care for both patients and staff.	Remembrance of the Slave Trade and its Abolition; Black History Month; Pride Month and Eid ul-Adha

4.0 Our Equality Objectives - April 2023 to March 2024

We set out interim equality objectives in February 2023 for 2023/24 outline below:

1. Ensure that our services promote and improve the health and wellbeing of staff, volunteers, patients, and visitors
2. Ensure all future and current staff and volunteers are supported to make the most of their skills and talents
3. Create a more inclusive culture where all staff, volunteers, patients and visitors feel engaged
4. Engage with our senior leaders to ensure that equality and inclusion is a central trait of the organisation
5. Champion the concept of zero tolerance to the fear of violence, abuse, harassment and intolerance
6. Champion and enable all of our staff, volunteers, patients, and visitors to have the freedom to speak up
7. Encourage our partner organisations and suppliers to acknowledge and support our commitment to diversity as a core value
8. Engage with more of our diverse communities to effectively inform, develop and deliver our strategies, services and initiatives
9. Services will be accessible to more people, with consistent quality that meets the needs of all staff, volunteers, patients, and visitors
10. Ensure that all staff, volunteers, patients, and visitors will have access to the information they need to make the most of the services provided at PAHT
11. Improve the accessibility of our infrastructure to enable everyone to access PAHT (physically, emotionally, developmentally, and virtually)

For 2024/25, we are planning to develop our EDI Delivery Plan and Governance framework to meet our regulatory reporting responsibilities.

We are committed to improving the quality and extend our data and information in relation to protected characteristics and this will inform the development of equality actions and activity.

4.1 (Objective 1 & 9) Health and wellbeing

During 2023-2024 the staff health and wellbeing team have continued to support people through Covid-19. Along with providing in house occupational health services, the team continues to support the mental health first aiders and the health and wellbeing champions.

Work undertaken by Staff Health and Wellbeing team included:

- Continued Financial wellbeing offer
- Self-referrals and management referrals
- Outbreak monitoring
- NHS health checks
- Travel immunisations
- Access to Physiomed (physiotherapy services)
- Referrals to physiological support services
- Support to staff networks
- Flu vaccinations
- Change of Employee Assistance provider with greater access to podcasts, blogs And a wide range of self-help CBT workbooks.
- Nutrition and hydration steering group with a focus on staff
- Working in partnership with FTSU Guardian.
- Review of all clinical and non-clinical processed to support submission for SEQOHS accreditation.
- Achieving gold level for working well accreditation - the accreditation recognises our robust health and wellbeing strategy and commitment to providing a varied programme to support and develop our people further.

4.2 (Objective 2 & 10) Learning and development

The Trust has rolled out different types of training ranging from EDI awareness as part of corporate induction, inclusive management training for managers and bespoke disability training for colleagues working in the People department all aimed at building understanding and embedding a culture of equality, diversity and inclusion across the Trust.

The new learning management system provided links to more e-learning modules and guidance on EDI, free and accessible events are promoted through membership to NHS Elect.

4.3 (Objective 3) Staff networks

The Trust currently has three staff networks, which are the Disability and Wellbeing Network (DAWN), the Race Equality & Cultural Heritage (REACH) staff network and the Alex Pride (LGBTQ+) staff network.

The **REACH** has supported the organisation to move forward on race equality with a focus on its three primary objectives:

1. The promotion of *Psychological Safety*
2. Support for *Continuing Professional Development*
3. Achieving our goals through Allyship with other networks.

The network is committed to creating an inclusive working environment where individuals from the global majority are respected, supported and valued in the workplace. The network is a safe place for people to discuss the issues they face and share experiences.

However, we have noticed a decline in attendance and we are actively trying to understand why this has happened and see how we can address this and improve attendance and support our staff as a voice and any changes needed within the Trust.

The **DAWN** has been operating for just over 1 year and formed in response to feedback from staff and review of staff survey findings. The purpose of the network is to be an independent and effective voice for staff with long term health conditions and disabilities and to ensure that the organisation recognises and responds to the needs of all its staff, thereby increasing staff morale and improving the patient experience.

The **LGBTQ+** staff network re-established its name to **Alex Pride** and is running virtually. The network has invited members of the LGBTQ+ community to meetings to share learning and as an opportunity to inform trust policies and practices. The network is linked in with the East of England LGBTQ+ network.

4.4 (Objective 4) Equality impact assessments

Equality Impact Assessments (EIAs) are an anticipatory process that support the Trust to predict possible issues, and take appropriate action such as removing or mitigating any negative impacts, where possible, and maximising any potential for positive impact. An EIA assesses against our legal duties and ensures that the impact is assessed in a structured and robust way, which can be evidenced if challenged. We will be improving our EDI Guidance and process for 2025.

In order for this tool to support our objectives we have engaged with senior leaders and supported decision making into our policies, guidance etc.

4.5 (Objective 5) Zero tolerance campaign

The organisation is at its early stages in creating a ‘zero tolerance to violence against our staff’ group. Chaired by our Deputy Chief Nurse we anticipate that this work will take form and shape for the 24/25 year and we will be updating the trust via our future annual delivery plan.

4.6 (Objective 6) Freedom to Speak Up (FTSU)

The Trust provides various ways in which staff can speak up and raise their concerns within the Trust which includes:

- Datix / incident reporting
- Line management and team leader channels
- Trades unions
- People Team
- Occupational health
- Chaplaincy
- Staff support
- Staff networks
- Health and Wellbeing Champions (who offer signposting and general support)

The Trust has introduced FTSU ambassadors to strengthen the avenues for people to raise concerns with. The ambassadors are a self-nominated role and come from a cross section of staff groups within the organisation.

4.7 (Objective 7 & 8) Partnership working

In February 2024 we have published our new EDI strategy that will support our engagement with external partners to adhere to our commitment to diversity as a core value.

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

4.8 (Objective 9) Accessibility

In addition to accessibility for staff already mentioned under 4.1 section, a plan was developed by the patient engagement team alongside the patient panel and other stakeholders to improve the required access to service by patients. Some of the examples of work being put in place is a recognition that parents visiting our NICU are often experiencing stress so to support the organisation made the decision to make parking as easy as possible by not charging those visitors, in addition to welcome siblings and allowing them to spend as much time as possible with our patients, in line with policy. Another example is the placement for a diabetes specialist nurse that is now available to support patients and families, even outside appointment times.

Further work is being done in partnership with our volunteers. Progress will be reported on the 24/25 annual delivery plan.

4.9 (Objective 10) Accessibility of information

In addition to the points already mentioned on 4.2 section, the trust is working further with the communications team to devise a plan for all year round and improvements already being made in terms of ‘This is Us’ briefings, ‘Up to Date’ emails, urgent pop-us.

Further plans are being devised and will be implemented on the year to come (24/25).

4.10 (Objective 11) Accessibility of our infrastructure

Plans are being devised alongside our Estates and Facilities team, taking into account our New Hospital Plans and PAHT2030 strategy, to support the improvement of accessibility for all.

5.0 Governance

5.1 Equality, diversity and inclusion steering group

The group consists of a diverse range of representation from teams and departments across the Trust. The main aim of the group is to help shape the organisation’s strategies and policies to improve the experience of staff and patients with protected characteristics.

The steering group meets on a bimonthly basis and regularly reports progress to the People committee, as a sub-committee of the board, to ensure visibility and scrutiny of all interventions.

5.2 Workforce Race and Disability Equality Standard

The national data submissions for the Workforce Race Equality Standard, and the Workforce Disability Standard have been reviewed and an action plan has been developed in response to the finding. Reports can be viewed at the link: Our reports | Princess Alexandra Hospital

5.3 Gender and Ethnicity Pay Gap reporting.

The annual Gender Pay Gap Report 2024 has been audited and published. This is the first year that we have also completed an audit and publication on our Ethnicity Pay Gap Report 2024. Both Reports can be viewed at the link: Our reports | Princess Alexandra Hospital

5.4 Equality Delivery System

The Equality Delivery System (EDS) is designed to help NHS providers improve the services we provide for our local communities and provide better working environments, free from discrimination, for the whose who work in the NHS thereby helping to meet the requirements of the Equality Act 2010. Since April 2014, EDS has been mandated in the NHS Standard Contract and is cited as a key implementation requirement.

PAHT embraces reporting used each year to provide an independent assessment of the organisation's progress against the 3 EDS domains. Our 2024 report is available on our website Our reports | Princess Alexandra Hospital

6.0 Assurance

The People committee receives regular assurance that the Trust is meetings its statutory and regulatory requirements by way of seeing and approving all reports.

7.0 Recommendation

The Committee is asked to receive and note this report.

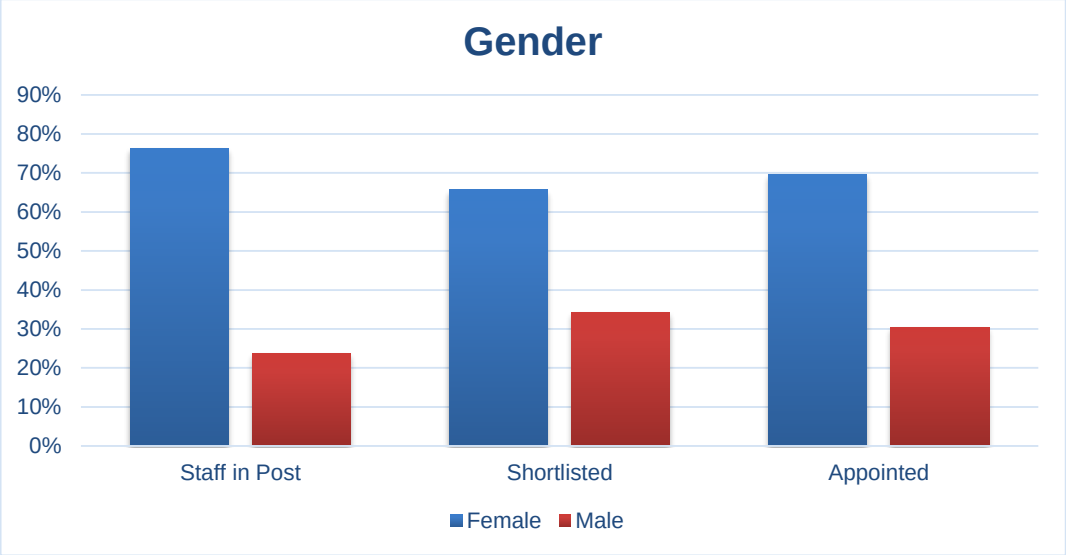
The Princess Alexandra Hospital NHS Trust

APPENDIX 1 WORKFORCE INFORMATION

Data in this report is as at March 2024

Workforce and recruitment data

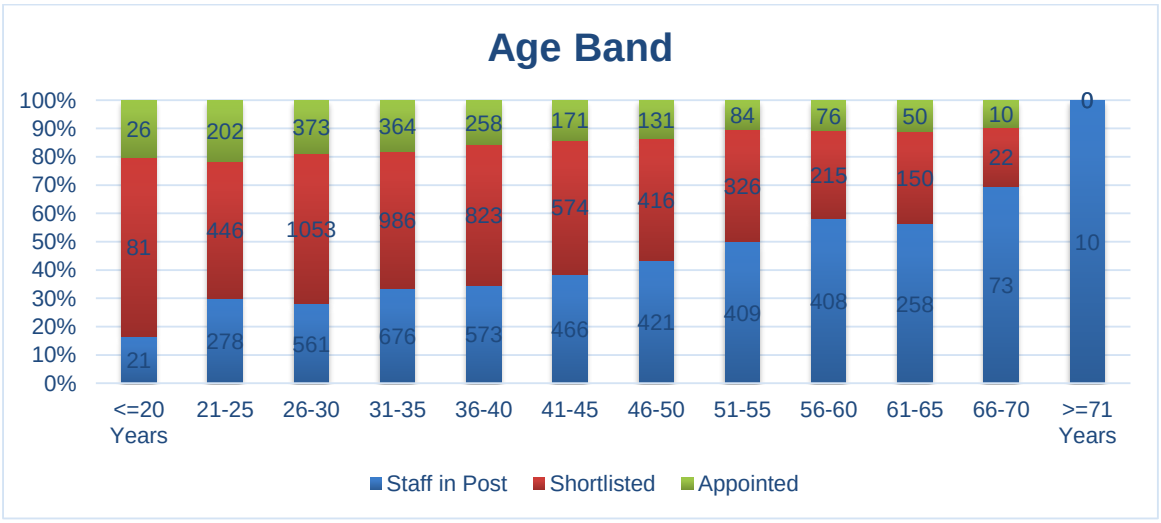
Gender



The Trust workforce is 76% female and 24% male. Whilst this is not comparative to the local population of Hertfordshire and Essex, it is comparative to the rest of the NHS, of which the majority of employees are female.

The proportion of male applicants versus female applicants from shortlisting's to appointed is broadly representative of the current Trust profile.

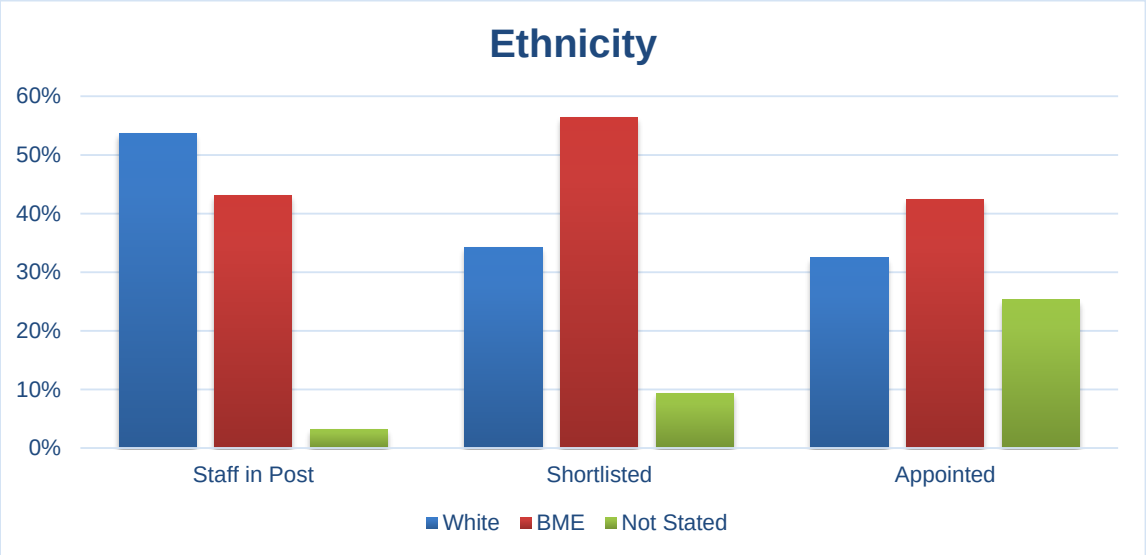
Age Band



The Trust employs staff across all age bands, with a significantly reduced number of employees aged less than 20 years old (21) and aged over 71 (10). The smaller number of staff aged less than 20 could correlate to having a minimum entry age into some professions due to health and safety restrictions,

and a large proportion of the population in this age band still being in full-time education. The 31-35 is the largest age band (676) followed by the 26-30 group (561).

Ethnicity



The current ethnic make-up of the workforce is 54% White and 43% Black, Asian and minority ethnicity.

The Trust has a range of robust selection methods that focus on strict objective criteria such as skills, knowledge, behaviour and values which inform decision makers regarding selection of candidates. Managers are taught, through advanced recruitment and selection training, the importance of using objective criteria and reasoning.

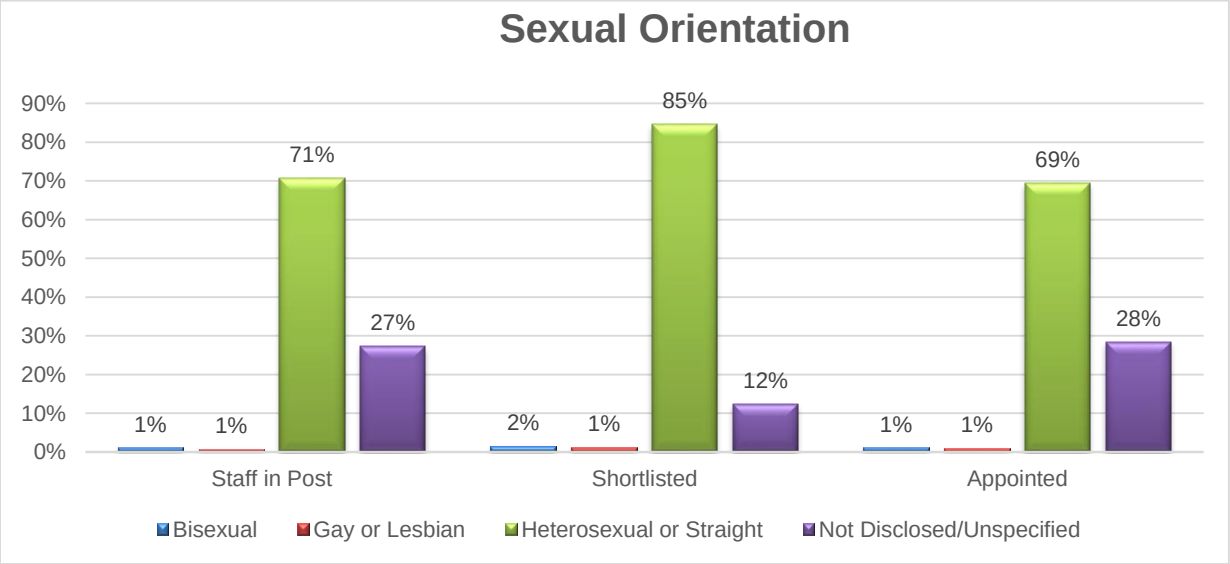
Disability

4% of the workforce is recoded as disabled, 84% not disabled and 12% of staff not declared.

The figures below show the proportion of applicants with a declared disability and their progress through the recruitment process.

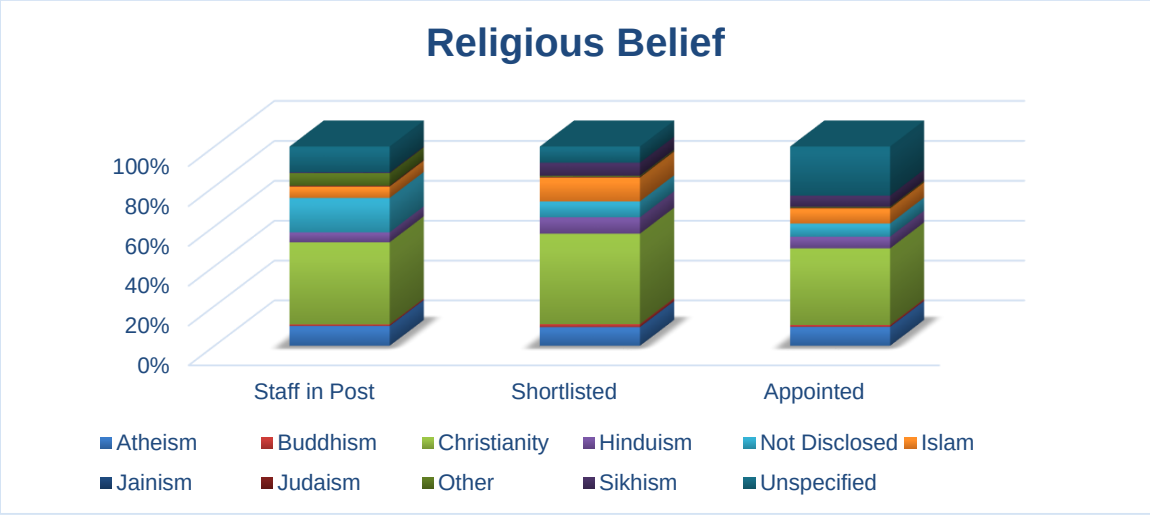
Where an applicant has a stated disability and meets the criteria for the role they are guaranteed an interview. The Trust has signed up to the Government's Disability Confident Scheme, and is currently on tier 2 of this scheme as a Disability Confident Employer. Tier 3 is the highest level of the scheme and is something which the Trust is working towards.

Sexual Orientation



Within the overall staff in post, 2% identify as gay, lesbian or bisexual, and 71% identify as heterosexual and 27% as not declared.

Religious Belief



Christians staff make up the largest category in the Trust religious belief. 1716 members of staff have identified themselves as Christian. Unspecified and Atheism, is the second largest category in the Trust. 714 Trust employees have not disclosed their religious beliefs.

Employee Relations Cases (ER)

ER Cases 1st April 2023 – 31st March 2024

The following data analyses the total number of staffs entering a formal employee relations process from April 2023 to March 2024 broken down by ethnicity, gender, disability and age group.

All ER case type

Case Type	Closed	Live	Total	% of Total Cases
Capability Ill – Health	7	1	8	7.48%
Dignity at Work	6	0	6	5.61%
Disciplinary	38	0	38	35.51%
ET	3	0	3	2.80%
MHPS	9	0	9	8.41%
Grievance	24	0	24	22.43%
Performance Management	6	2	8	7.48%
Probation	11	0	11	10.28%
Grand Total	**104**	**3**	**107**	**100%**

All ER case type by Ethnicity

Ethnicity	Closed	Live	Total	% of Total Cases
White	64	2	66	61.68%
BME	35	1	36	33.64%
Not Stated	5	0	5	4.67%
Grand Total	**104**	**3**	**107**	**100%**

All ER case type by Disability

Disability	Closed	Live	Total	% of Total Cases
Disabled	18	1	19	17.76%
Not Declared	22	1	23	21.50%
Not Disabled	64	1	65	60.75%
Grand Total	**104**	**3**	**107**	**100%**

All ER case type by Gender

Gender	Closed	Live	Total	% of Total Cases
Female	72	2	74	69.16%
Male	32	1	33	30.84%
Grand Total	**104**	**3**	**107**	**100%**

All ER case type by Age Range

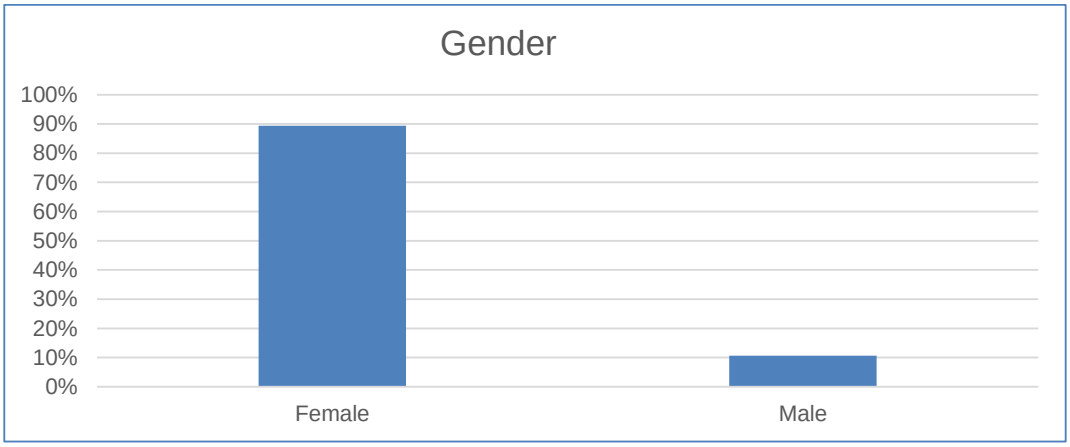
Age Band	Closed	Live	Total	% of Total Cases
16-20	1	0	1	0.93%
21-25	2	0	2	1.87%
26-30	7	0	7	6.54%
31-35	9	0	9	8.41%
36-40	12	0	12	11.21%
41-45	10	0	10	9.35%
46-50	18	0	18	16.82%
51-55	19	2	21	19.63%
56-60	12	1	13	12.15%
61-65	10	0	10	9.35%
66-70	3	0	3	2.80%
71-75	1	0	1	0.93%
Grand Total	**104**	**3**	**107**	**100%**

Support is provided to all staff entering into a formal ER process, including staff identifying with a disability. Measures such as Occupational Health (OH) support, health assessments, reasonable adjustments are explored with staff. The overall percentage of staff identifying as disabled will be impacted by any staff who have “Not Declared” but would be identified as having a disability.

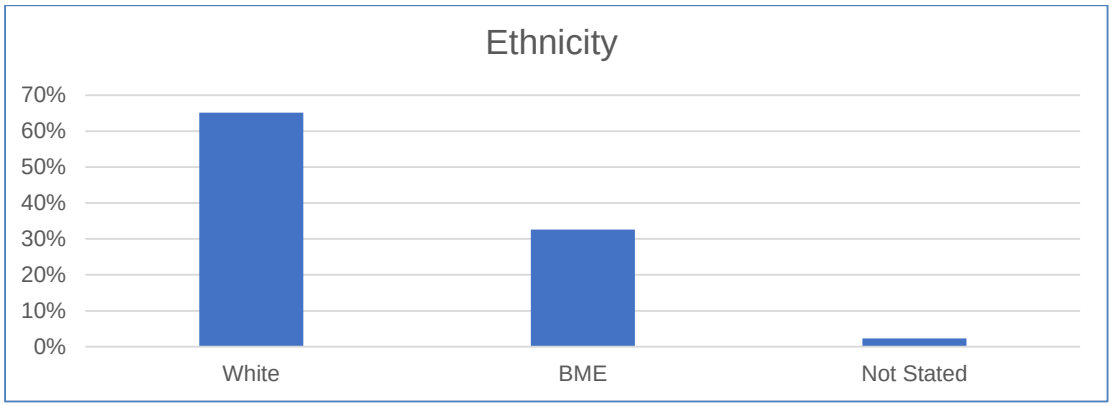
Non -Mandatory Training & Continuous Professional Development (CPD)

The analysis shows a snapshot of staff that has undertaken Non-Mandatory Training and CPD in 2023/24

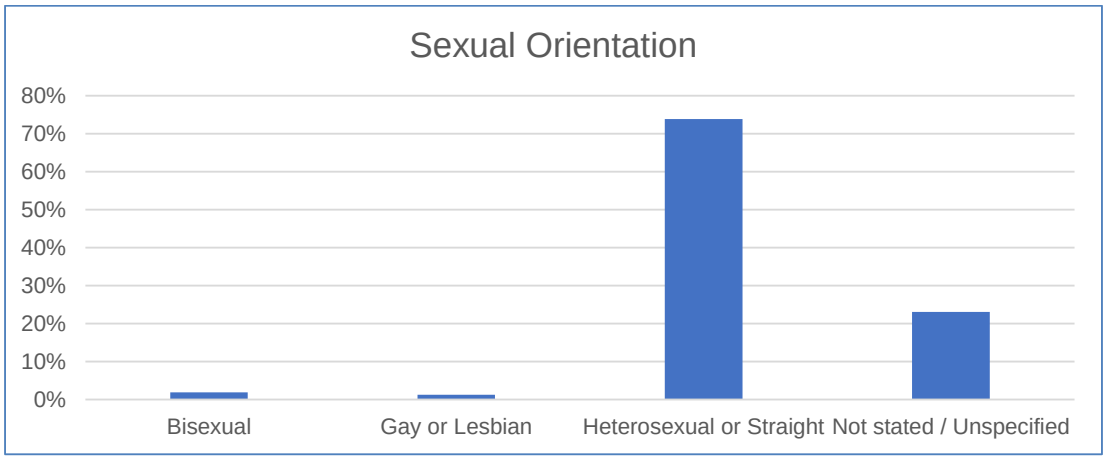
Non-Mandatory Training & CPD by Gender



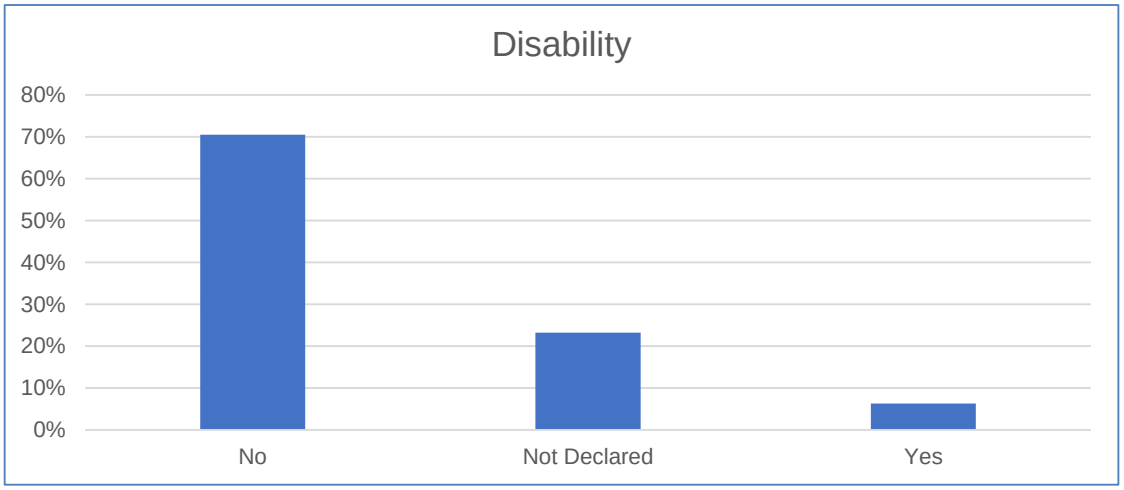
Non-Mandatory Training & CPD by Ethnicity



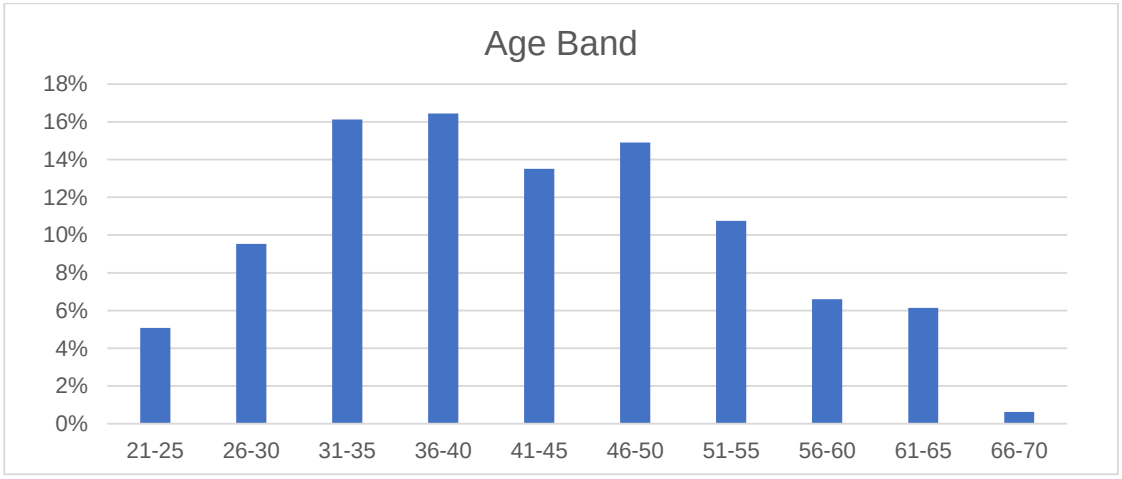
Non-Mandatory Training & CPD by Sexual Orientation



Non-Mandatory Training & CPD by Disability



Non-Mandatory training & CPD by Age Band



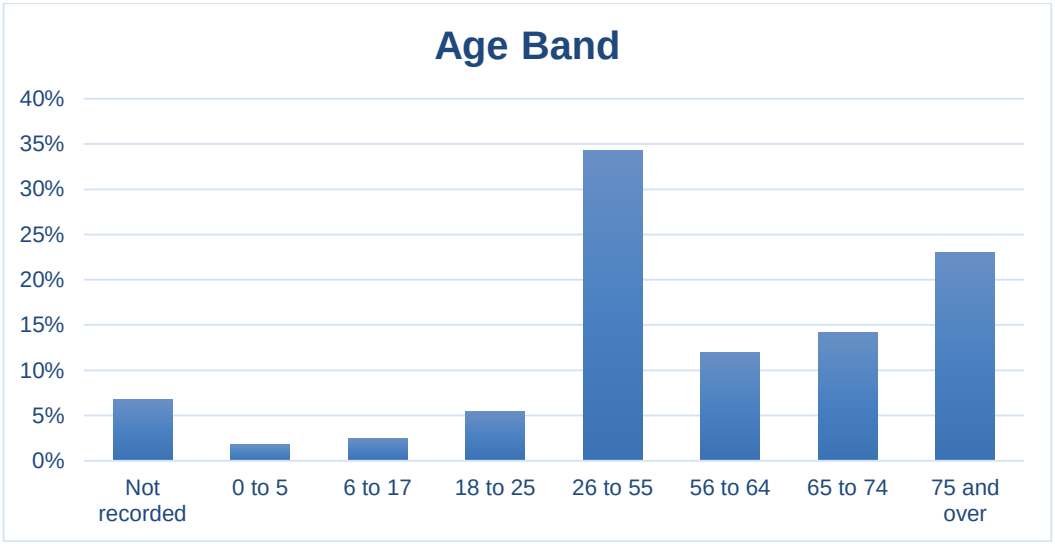
Staff have many opportunities in the Trust to continue personal and professional development. There are several streams which support education and training provision enabling staff to continue their personal development as well as supporting those staff seeking to develop a clinical career in the Trust.

The Princess Alexandra Hospital NHS Trust

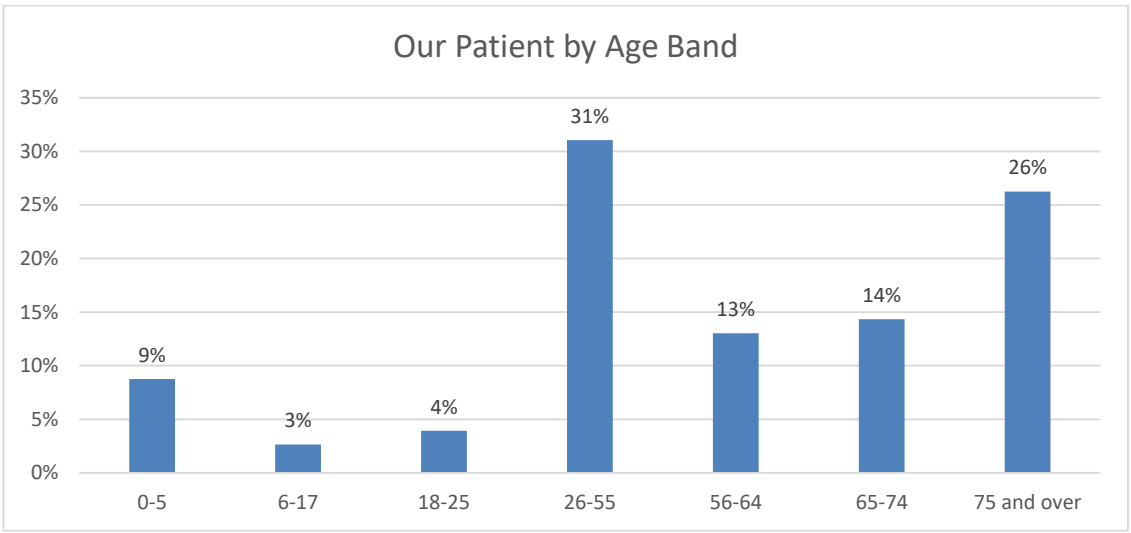
Appendix 2 – Patient Information

Informatics Patient Demographics

Our Patient by Age March 2023



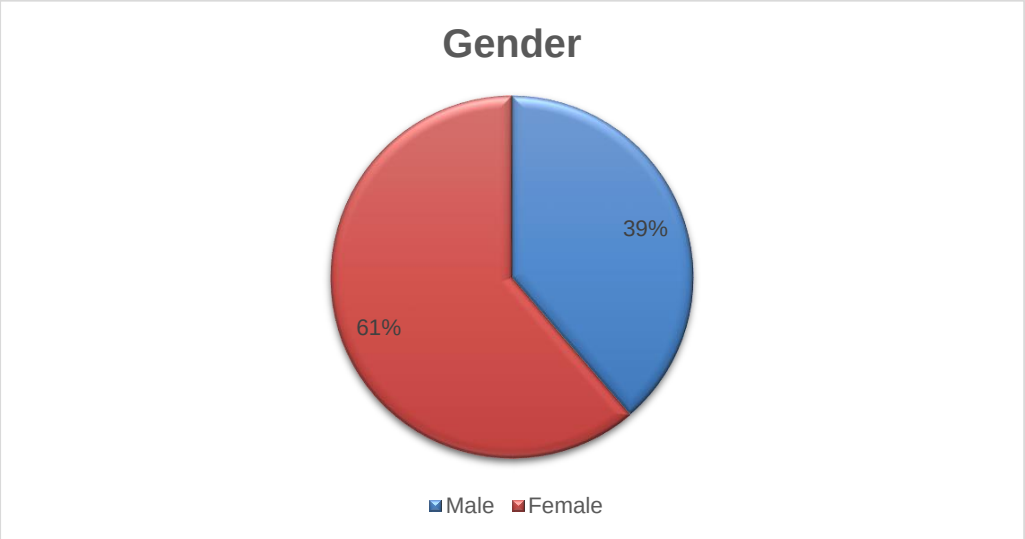
Our Patient by Age March 2024



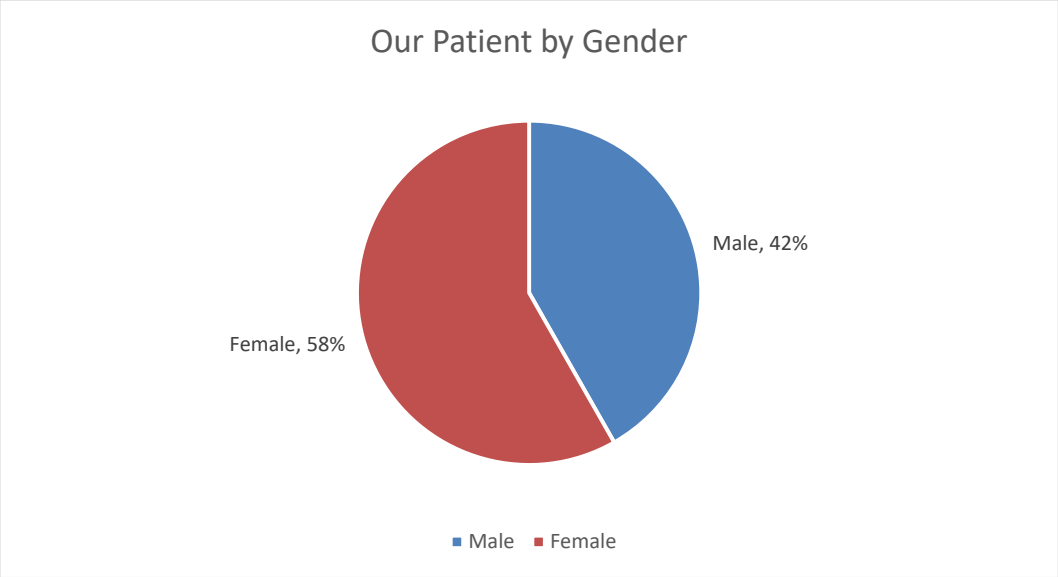
In 2024 a significant portion of our patients consists of the elderly (65 years and older) who make up 40% of the total patient population, with a slight decrease of 3% from 2023 in elderly 75 and over.

In 2024 there has been an increase in children patients representing 12% of the total patient population, compared to 4% in 2023.

Our Patient by Gender March 2023

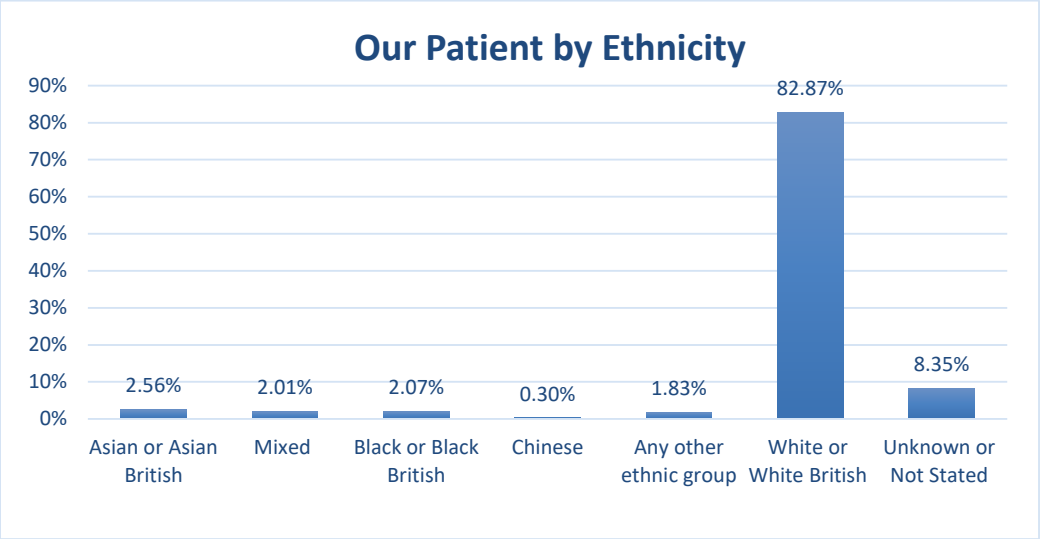


Our Patient by Gender March 2024

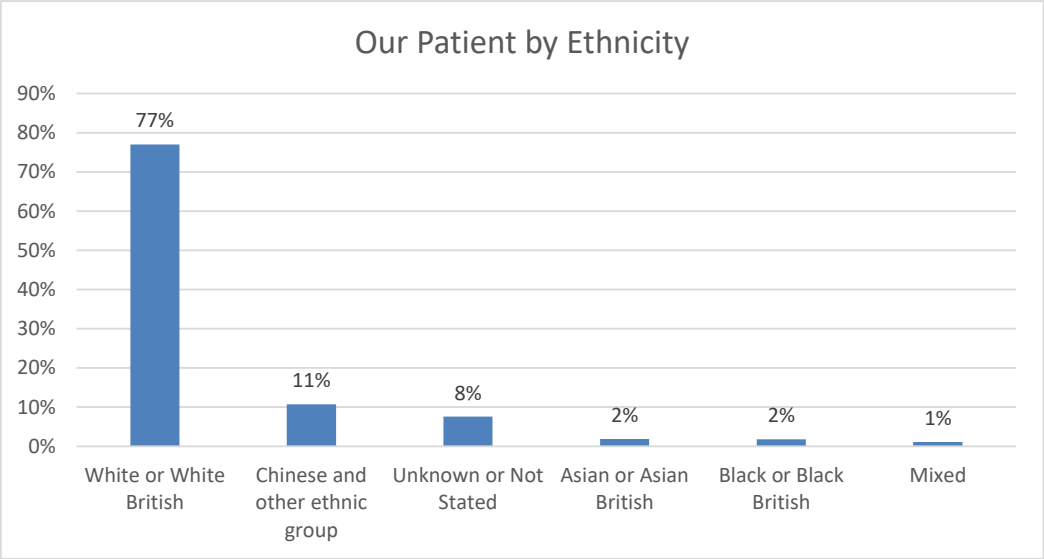


Overall the population has a higher proportion of females, however there has been a slight increase of 3% in male patients over the last year.

Our Patients by Ethnicity March 2023



Our Patients by Ethnicity March 2024



The main change in the ethnicity of the patient population is in the white or White British which was 82.87% in 2023 and has reduced to 77% in 2024. In addition, the Chinese and any other group has increased from 2.13% in 2023 to 11% in 2024.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Lead/Host Provider Model	Y	Y	N	In line with the recommendation, PAF endorsed: • The draft proposed Delegation Framework and HCP terms of reference. • The route to decision with the aim of launching the host provider arrangements from May 2025. • The lead provider requirements based on the current position. Timescales for PAHT becoming a host and lead provider were discussed. The Board will receive an update on the current position in the public session.
2.3 Health & Safety Update	Y	Y	N	The scale of risk the organisation is carrying in terms of its aging estate was noted along with the absolute requirement in 25/26 to secure additional funding to address this risk and invest in the estate. Attention was drawn to an incident involving an accident which had resulted in the hospitalisation of a PAH estates electrical craftsman which had been reported to the HSE under RIDDOR. Stringent controls had since been put in place to minimise reoccurrence which would impact the Estates team's reactive response to electrical failures/repairs and capital programmes.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 Estates & Facilities Quarterly Update	Y	Y	N	The Trust has assessed its key infrastructure risks. To mitigate these risks continued upgrades are recommended to electrical, water, drainage, lifts, ventilation, and UPS systems, along with enhancing fire compartmentation measures. Improved communication and registration processes will support better management of estate issues. A risk assessment is underway in regard to the lack of authorised persons and in the interim external suppliers are providing support in these roles.
2.5 Quarterly New Hospital Update	Y	Y	N	Confirmation had been received that the Trust's New Hospital team would continue to be funded until at least Q2 25/26. Work on the review of the clinical model and associated impact on infrastructure/estate continued. The site development control plan is being developed.
2.6 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.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.1 Ophthalmology Progress Update	Y	Y	N	Key headlines were: • Cataract waiting list down from 675 in August 2024 to 225 in March 2025. • Difficulties with Alex Health introduction have been addressed and it is now possible to identify sub-speciality patients. This work has allowed colleagues to ascertain that 53% of the waiting list was made up of cataracts and 50% of those were suitable for HVAC (high volume any complexity) lists (through a risk stratification process). • Activity has been increasing over the last few months – 92 (Nov), 102 (Dec), 129 (Jan), 139 (Feb). • 3 HVAC lists per week for cataracts. • PGD finalised and nurses giving eye drops or patients administering themselves which has reduced consultant time.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.2 M11 Integrated Performance Report (IPR)	Y	Y	N	Key headlines were: • **6 week diagnostics:** Work continued in conjunction with Oracle Health to address the issue of missing data. Diagnostics performed within 6 weeks of referral had increased for February to 67.42% from 62.70% however validation was still ongoing and the finalised position was likely to be slightly better. MRI remained at 100% performance with no waits over 6 weeks and CT at almost 95%. There were recovery plans in place for the other modalities however Echos, NOUS and Audiology were dependent on recruitment drives. • **ED 4 hour constitutional standard:** Performance is now at 67% and the best since December 2021. There has been a huge change in non-admitted patient performance which is now at 77% month-to-date.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.3 Reporting Against Operating Plan	Y	Y	N	• The 28 day faster diagnosis performance standard was 66.4% in January, with February's unvalidated position currently at 75.5%. The 62 day finalised performance for January was 50.0% against a trajectory of 64%. • 18 week performance had deteriorated for November and December to 41.8% due to Alex Health implementation and reduced activity, migration and post migration DQ and a reduction in validation. Positively, this had increased to 44.3% for January and 44.5% for February. For February, the Trust achieved 0 x 78+ week breaches and 51 x 65+ week breaches (34 choice). • The Trust remained under Tier 2 monitoring with fortnightly performance meetings on cancer and routine elective standards.
3.4 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.
3.5 BAF Risk 1.3 (Recovery Programme)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
3.6 BAF Risk 4.2 (4 Hour Emergency Department Constitutional Standard)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
3.7 BAF Risk 1.5 (Cyber)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.1 M11 Finance Update	Y	Y	N	The Trust was reporting an in-month surplus of £0.9m against a £4.3m surplus plan. The YTD position was a deficit of £1.4m against a deficit plan of £4.1m thus reporting a £2.7m improvement to plan. The YTD position included the system support funding planned for M11 but received in prior months and £1.7m on non-recurrent benefit. In addition, the Trust received confirmation of an additional unplanned system support of £5.3m for the year of which £4.9m was included in the M11 position. The cash balance at the end of February was £22.9m with forecast cash balances at the year-end of £16.6m. The increase in cash at the end of December was largely due to capital PDC receipts of £11.5m. It was believed therefore no additional cash support would be required before year end.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.2 Capital Update	Y	Y	N	The Trust total funding for 24/25 was £39.5m and included within this was £25.2m of external funding for specific projects (i.e. New Hospital, CDC, UEC and EHR). The Trust reported at M10 a deficit, of c.£0.6m which had now moved to a surplus of £0.4m. This was largely due to the New Hospital Programme which would underspend by £0.4m in year and for which any underspends must be returned to the centre. Alex Health remained overspent and had largely consumed the majority of additional capital over the last year. This was being offset with other underspends within nationally funded schemes.
4.3 Annual Operating Plan Update	Y	Y	N	The operational, financial and workforce plans had been submitted to the ICB for submission to NHSE on 27.03.25. It was expected that this would be the final submission. The financial plan had been submitted as breakeven with a PQP target of 5.8% aligned to the national average. This was driving an efficiency program of £26.15m. To achieve a breakeven submission there was £24.7m of system support funding to match that received in 2024/25 along with a further temporary £15.8m of system support funding whilst the ICS collectively identified the savings/efficiencies/transformation to deliver a sustainable ICS breakeven position.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 3 April 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**27.03.25**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.4 PQP Report	Y	Y	N	M11 produced PQP savings of £1.36m in-month and £16.2m YTD. Whilst the programme value and delivery YTD remained below target, assurance was provided that the full year target of £18.5m would be achieved or would be within £100k of that full target.
4.6 BAF Risk 5.1 (Finance/Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

Other items discussed:

- Recent Changes to NHS
- Update from Business Case Review Group

The Princess Alexandra Hospital NHS Trust

Trust Board – 3 April 2025

Agenda item:	6.2
Presented by:	Tom Burton, Chief Finance and Infrastructure Officer
Prepared by:	Beth Potton, Deputy Director of Finance
Date prepared:	17 March 2025
Subject / title:	Month 11 Financial Performance

Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Trust is reporting an in-month surplus of £0.9m against a £4.3m surplus plan. The YTD position is a deficit of £1.4m against a deficit plan of £4.1m thus reporting a £2.7m improvement to plan. Within the YTD position is the system support funding planned for M11 but received in prior months and £1.7m on non-recurrent benefit. In addition, the Trust received confirmation of an additional unplanned system support of £5.3m for the year of which £4.9m is included in the M11 position.								
Recommendation:	The Committee is asked to note the month 11 financial 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 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 M10 the ICB has allocated £5.3m of additional system support funding to the Trust with £4.9m included in the M11 position. This funding is to support the system achieving its control total of breakeven and has been allocated based on M8 forecast positions.

- The in month adverse position of £3.4m to plan, is due to having a plan for system support funding of £4.6m in M11 which has been recognised in prior months, partially offset by additional unplanned £0.4m system support funding. The underlying in month position is therefore £0.6m favourable to plan.

- The cash position at the end of February 2025 (M11) was £22.9m. The Trust has received capital PDC receipts of £11.5m. Cash remains under constant review, and we are anticipating holding a cash balance on 31st March 2025 of £16.6m. This includes cash relating to the £5.3m system support.

- Capital spend YTD is £28.1m against a YTD plan of £39.8m and a full year plan of £40.2m. The year end forecast is to meet plan with some movements between schemes.

Table 1: M11 24/25 reported position including system support

	FY Budget	Feb-25			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS & non-NHS Income	376.0	36.0	32.9	(3.1)	345.2	360.0	14.8
Pass through Income	19.2	1.6	1.5	(0.1)	17.6	18.7	1.1
Income Total	395.2	37.6	34.4	(3.2)	362.8	378.7	16.0
Pay							
Substantive	(257.2)	(21.5)	(19.4)	2.1	(235.8)	(214.2)	21.6
Bank	(7.7)	(0.6)	(2.3)	(1.7)	(7.1)	(27.0)	(19.8)
Agency	(6.8)	(0.5)	(0.7)	(0.2)	(6.3)	(8.9)	(2.6)
Pay Total	(271.7)	(22.5)	(22.4)	0.2	(249.2)	(250.1)	(0.9)
Non-Pay							
Drugs & Medical Gases	(11.1)	(0.9)	(0.9)	0.1	(10.1)	(10.2)	(0.0)
Pass through expenditure	(19.4)	(1.6)	(1.5)	0.1	(17.7)	(18.5)	(0.7)
Supplies & Services - Clinical	(16.2)	(1.3)	(1.8)	(0.5)	(14.8)	(16.7)	(1.9)
Supplies & Services - General	(5.6)	(0.5)	(0.4)	0.1	(5.1)	(4.9)	0.2
All other non pay costs	(54.9)	(4.6)	(4.4)	0.1	(50.3)	(59.2)	(8.9)
Non-Pay Total	(107.1)	(9.0)	(9.0)	0.0	(98.1)	(109.5)	(11.4)
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.8)	(0.4)	(15.1)	(16.7)	(1.6)
PDC & Interest	(5.2)	(0.4)	(0.4)	0.1	(4.8)	(4.1)	0.7
Financing & Depn Total	(21.7)	(1.8)	(2.2)	(0.4)	(19.9)	(20.8)	(1.0)
Total	(5.3)	4.3	0.9	(3.4)	(4.3)	(1.7)	2.7
Technical Adjustment	0.3	0.0	0.0	0.0	0.3	0.3	0.0
Grand Total	(5.0)	4.3	0.9	(3.4)	(4.1)	(1.4)	2.7

Trust Board

The Princess Alexandra Hospital NHS Trust

February - Month 11

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a surplus of £0.9m in month 11 of 24/25 against a planned surplus of £4.3m. Year to date the planned deficit was £4.1m with actual performance now delivering a £1.4m deficit, however there is £4.9m of system support funding in the position to date which was not planned, therefore there is an underlying adverse YTD variance to plan of £2.2m.

- The in month adverse position of £3.4m to plan, is predominantly due to having a plan for system support funding of £4.6m in M11 which has been recognised in prior months, partially offset by additional unplanned £0.4m system support funding. The underlying in month position is therefore £0.6m favourable to plan.

- In month 11, the Trust has reported an unfavourable income position of £3.2m against plan driven by:
    - Unwinding £4.6m of Income support recognised in earlier months, planned for in month 11
    - £442k of additional income support
    - £229k Cancer Alliance funding
    - £477k Education Income

- The reported ERF position include the block arrangement to mitigate impacts of Electronic Health Records (EHR) implementation.

- The Trust had a PQP target of £1.5m in month 11 of which £1.3m was delivered, the YTD position shows delivery of £16.2m versus a plan of £17.0m. Delivery remains behind plan YTD. To deliver the financial plan at the year end, robust recovery actions are required.

- Areas of overspend contributing to the underlying adverse variance to plan (once accounting for the system support income), are predominantly within non pay with high outsourcing and clinical consumable costs.

Summary financial results

The Princess Alexandra Hospital NHS Trust

	FY Budget £'m	Feb-25 Budget £'m	Feb-25 Actual £'m	Feb-25 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	376.0	36.0	32.9	(3.1)	345.2	360.0	14.8
Pass through Income	19.2	1.6	1.5	(0.1)	17.6	18.7	1.1
Income Total	**395.2**	**37.6**	**34.4**	**(3.2)**	**362.8**	**378.7**	**16.0**
Pay							
Substantive	(257.2)	(21.5)	(19.4)	2.1	(235.8)	(214.2)	21.6
Bank	(7.7)	(0.6)	(2.3)	(1.7)	(7.1)	(27.0)	(19.8)
Agency	(6.8)	(0.5)	(0.7)	(0.2)	(6.3)	(8.9)	(2.6)
Pay Total	**(271.7)**	**(22.5)**	**(22.4)**	**0.2**	**(249.2)**	**(250.1)**	**(0.9)**
Non-Pay							
Drugs & Medical Gases	(11.1)	(0.9)	(0.9)	0.1	(10.1)	(10.2)	(0.0)
Pass through expenditure	(19.4)	(1.6)	(1.5)	0.1	(17.7)	(18.5)	(0.7)
Supplies & Services - Clinical	(16.2)	(1.3)	(1.8)	(0.5)	(14.8)	(16.7)	(1.9)
Supplies & Services - General	(5.6)	(0.5)	(0.4)	0.1	(5.1)	(4.9)	0.2
All other non pay costs	(54.9)	(4.6)	(4.4)	0.1	(50.3)	(59.2)	(8.9)
Non-Pay Total	**(107.1)**	**(9.0)**	**(9.0)**	**0.0**	**(98.1)**	**(109.5)**	**(11.4)**
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.8)	(0.4)	(15.1)	(16.7)	(1.6)
PDC & Interest	(5.2)	(0.4)	(0.4)	0.1	(4.8)	(4.1)	0.7
Financing & Depn Total	**(21.7)**	**(1.8)**	**(2.2)**	**(0.4)**	**(19.9)**	**(20.8)**	**(1.0)**
Total	**(5.3)**	**4.3**	**0.9**	**(3.4)**	**(4.3)**	**(1.7)**	**2.7**
Technical Adjustment	0.3	0.0	0.0	0.0	0.3	0.3	0.0
Grand Total	**(5.0)**	**4.3**	**0.9**	**(3.4)**	**(4.1)**	**(1.4)**	**2.7**

Summary financial results

The Princess Alexandra Hospital NHS Trust

Position excluding system support funding and internal non recurrent benefits	FY Budget £'m	Feb-25 Budget £'m	Feb-25 Actual £'m	Feb-25 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	356.6	28.2	29.3	1.1	326.9	336.8	10.0
Pass through Income	19.2	1.6	1.5	(0.1)	17.6	18.7	1.1
Income Total	**375.8**	**29.8**	**30.8**	**1.0**	**344.4**	**355.5**	**11.1**
Pay							
Substantive	(257.2)	(21.5)	(19.9)	1.6	(235.8)	(214.7)	21.1
Bank	(7.7)	(0.6)	(2.6)	(2.0)	(7.1)	(27.2)	(20.1)
Agency	(6.8)	(0.5)	(0.7)	(0.2)	(6.3)	(8.9)	(2.6)
Pay Total	**(271.7)**	**(22.5)**	**(23.1)**	**(0.6)**	**(249.2)**	**(250.8)**	**(1.6)**
Non-Pay							
Drugs & Medical Gases	(11.1)	(0.9)	(0.9)	0.1	(10.1)	(10.2)	(0.0)
Pass through expenditure	(19.4)	(1.6)	(1.5)	0.1	(17.7)	(18.5)	(0.7)
Supplies & Services - Clinical	(16.2)	(1.3)	(2.5)	(1.2)	(14.8)	(17.8)	(2.9)
Supplies & Services - General	(5.6)	(0.5)	(0.4)	0.1	(5.1)	(4.9)	0.2
All other non pay costs	(54.9)	(4.6)	(4.4)	0.1	(50.3)	(59.2)	(8.9)
Non-Pay Total	**(107.1)**	**(9.0)**	**(9.7)**	**(0.7)**	**(98.1)**	**(110.5)**	**(12.4)**
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.8)	(0.4)	(15.1)	(16.7)	(1.6)
PDC & Interest	(5.2)	(0.4)	(0.4)	0.1	(4.8)	(4.1)	0.7
Financing & Depn Total	**(21.7)**	**(1.8)**	**(2.2)**	**(0.4)**	**(19.9)**	**(20.8)**	**(1.0)**
Total	**(24.7)**	**(3.5)**	**(4.1)**	**(0.7)**	**(22.7)**	**(26.6)**	**(3.9)**
Technical Adjustment	0.3	0.0	0.0	0.0	0.3	0.3	0.0
Grand Total	**(24.4)**	**(3.4)**	**(4.1)**	**(0.6)**	**(22.4)**	**(26.3)**	**(3.9)**

System Support Comprises of 3 elements:

- System support funding - £6.7m – all planned for in M11 (Feb 25). This improved the plan for the June plan submission from £24.4m to £17.7m.
- System Deficit Support given to the ICS to move the system from a £20m deficit plan to a break-even plan. PAH received £12.7m. This moved the plan in M6 from £17.7m deficit to £5m deficit.
- An additional £5.3m given to PAH in M10, of which £0.4m has been recognised in M11 – this has not been amended in the plan

Internal non recurrent benefits relating to release of prior year provisions, in M9 improving the position by £1.0m, and in M10 further improving the position by £0.7m on non pay.

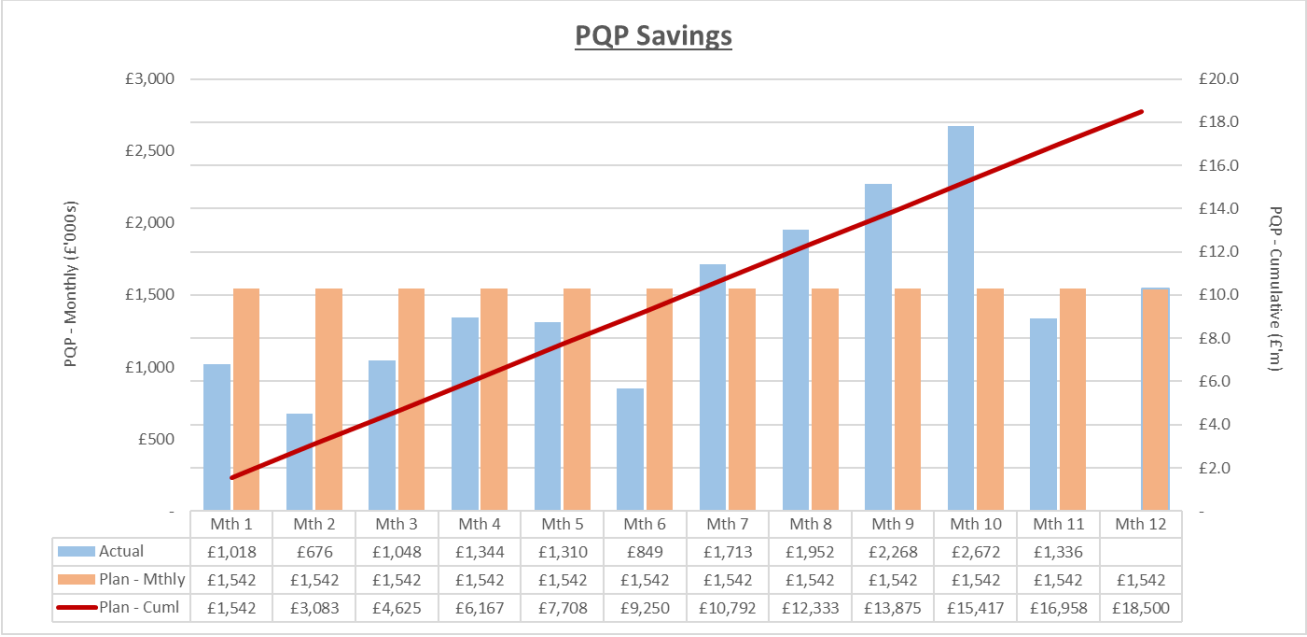
PQP

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 11, the Trust delivered £1.3m PQP against a plan of £1.5m. YTD delivery is £16.2m against a plan of £17.0m. Whilst some divisions are delivering PQP this financial year, delivery is behind plan, and to deliver the financial position at the year end, robust recovery actions are required. PQP is being delivered in some divisions this financial year (Surgery, Corporate, Estates & Facilities, CHAWS and CSS) but there are some divisions that are not delivering, and in addition to this have exceeded their budgets.

Work has begun on identification of PQP schemes for 25/26.



	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	£849	£1,713	£1,952	£2,268	£2,672	£1,336	
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

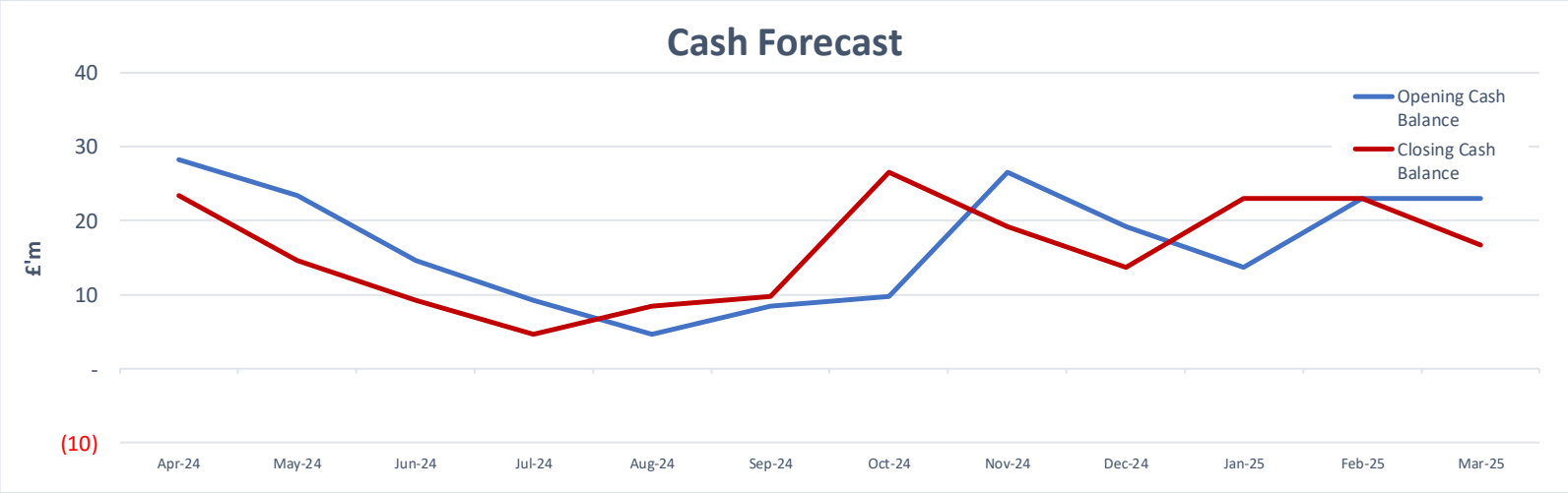
Statement of Financial Position	Mar-24 £'m	Jan-25 £'m	Feb-25 £'m	Movement In Month £'m	Movement YTD £'m
Non-current assets					
Property, plant & equipment	179.1	175.8	177.9	2.1	(1.2)
Right of use assets	41.7	43.6	43.3	(0.2)	1.6
Intangible assets	20.1	33.0	35.1	2.1	15.0
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**242.0**	**253.4**	**257.4**	**4.0**	**15.4**
Current assets					
Inventories	5.0	5.0	5.0	-	-
Trade & other receivables	15.0	29.4	24.8	(4.7)	9.8
Cash & cash equivalents	28.2	23.0	22.9	(0.1)	(5.3)
Current assets	**48.2**	**57.5**	**52.7**	**(4.8)**	**4.5**
Total assets	**290.3**	**310.9**	**310.2**	**(0.8)**	**19.9**
Current liabilities					
Trade & other payables	(51.5)	(52.5)	(43.7)	8.8	7.8
Provisions	(0.9)	(0.7)	(0.9)	(0.2)	0.0
Borrowings	(2.4)	(2.2)	(2.2)	-	0.2
Current liabilities	**(54.8)**	**(55.4)**	**(46.7)**	**8.6**	**8.0**
Net current assets/ (liabilities)	**(6.6)**	**2.1**	**6.0**	**3.9**	**12.6**
Total assets less current liabilities	**235.5**	**255.5**	**263.4**	**7.9**	**27.9**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(0.9)	(0.8)	(0.8)	-	0.1
Borrowings	(39.2)	(41.1)	(40.8)	0.3	(1.6)
Total non-current liabilities	**(40.2)**	**(41.9)**	**(41.7)**	**0.3**	**(1.5)**
Total assets employed	**195.3**	**213.6**	**221.8**	**8.1**	**26.4**
Financed by:					
Public dividend capital	356.3	377.1	384.4	7.3	28.1
Income and expenditure reserve	(172.4)	(174.9)	(174.0)	0.9	(1.7)
Revaluation reserve	11.4	11.4	11.4	-	-
Total taxpayers' equity	**195.3**	**213.6**	**221.8**	**8.1**	**26.4**

- Non Current Assets PPE has increased by £2.1m and is mainly due to reclassifications of assets. A decrease of £0.2m in ROU assets is mainly due to ROU accumulated depreciation during the year. An increase of £2.1m in intangible assets relates to additions to the development expenditures.
- Trade and Other Receivables has decreased by £4.7m, and this is due to reduction in accrued income of £3.4m to NHS Hertfordshire & West Essex ICB for Variable ERF, and £0.1m to NHSE for Education Uplift. A £1.2m reduction in prepayment of NHS Resolution - CNST 24-25
- Cash balances has decreased by £0.1m and this is largely due to a payment made to Lee Baron Ltd for electricity Recharge
- Trade and Other Payables The decrease of £8.8m is due to payment of £7.2m to Oracle Corporation, £0.9m to Morgan Sindall, £0.4m to Accenture (UK) Ltd, and £0.3m to Vanguard Health.
- Borrowings decrease representing payment of ROU lease repayment & Interest charge

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	9,755	26,495	19,258	13,639	23,031	22,934
Closing Cash Balance	23,358	14,653	9,261	4,701	8,401	9,755	26,495	19,258	13,639	23,031	22,934	16,647



A marginal decrease of £0.1m is due to payment made to Lee Baron Ltd for electricity Recharge

Capital Analysis 24/25

The Princess Alexandra Hospital NHS Trust

	Month 11			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
Estates									
Dispensing Robot (Pharmacy)	83	51	33	867	241	626	1,000	925	75
New UPS/IPS to critical areas - Phase 1 Main theatres/ED/ITU/HDU	130	(52)	182	1,314	239	1,075	1,559	1,042	517
Estates	21	43	(22)	229	99	130	250	380	(130)
Estates BLM									
Drainage - Internal and external works	-	6	(6)	201	86	115	125	201	(76)
Sitewide building management system upgrade installation works	29	26	3	321	80	241	350	69	281
Statutory Fire	50	64	(14)	830	520	310	600	830	(230)
HVAC	63	31	31	738	275	463	750	675	75
Environmental - localised refurbishment works & asbestos removal	800	105	695	1,300	484	816	500	1,265	(765)
Fleming Ward	14	-	14	86	0	86	100	95	5
EHR, ICT & Info									
ICT & Information Schemes									
EHR	-	1,153	(1,153)	10,869	11425	(556)	7,738	11,418	(3,680)
Computer Hardware Purch - ICT	-	-	-	-	103	(103)	-	776	(776)
Corporate									
Corporate schemes	1	24	(22)	17	46	(29)	17	143	(126)
Medical Equipment									
Medical Equipment (Surgery)	23	6	17	173	207	(35)	90	656	(566)
Medical Equipment (CSS)	13	21	(7)	147	202	(55)	160	242	(82)
23-24 schemes	-	(71)	71	-	386	(386)	-	386	(386)
Medical Equipment (Medicine & UEC)	5	-	5	53	21	32	58	79	(21)
Medical Equipment (CHAWS)	8	5	3	92	9	83	100	238	(138)
CRL to be allocated to plan	-	-	-	-	-	-	1,600	-	1,600
YTD Total	**1,240**	**1,411**	**- 170**	**17,235**	**14,423**	**2,812**	**14,997**	**19,420**	**(4,423)**
New Hospital (OBC)	178	218	(39)	1,813	1,510	303	2,141	1,741	400
CDC	705	1,065	(360)	8,864	4,507	4,357	8,460	6,800	1,660
CDC Substation	-	-	-	-	-	-	-	-	-
EHR	1,709	2,638	(929)	6,836	6,836	-	6,836	6,836	-
ICS East Imaging	56	77	(21)	332	300	32	355	355	-
UTC Works	11	4	7	1,846	151	1,695	3,664	1,300	2,364
Tye Green Lift	-	-	-	1,250	-	1,250	1,500	187	1,313
IMS Storage	-	-	-	100	53	47	30	53	(23)
Digital Funding	-	350	(350)	1,200	350	850	1,600	1,600	-
Cyber Improvement Programme	-	-	-	23	-	23	45	45	-
Future Connectivity	-	-	-	17	-	17	34	34	-
Diagnostics Digital Capability	-	-	-	65	-	65	130	130	-
Energy Efficiency Fund	-	-	-	216	-	216	431	431	-
YTD spend on External Schemes	**2,660**	**4,351**	**- 1,692**	**22,561**	**13,707**	**8,854**	**25,226**	**19,512**	**5,714**
Total - Internal and External	**3,900**	**5,762**	**- 1,862**	**39,796**	**28,130**	**11,666**	**40,223**	**38,932**	**1,291**

The Princess Alexandra Hospital NHS Trust

Trust Board – 3 April 2025

Agenda item:	6.3							
Presented by:	Tom Burton, Chief Finance and Infrastructure Officer							
Prepared by:	Beth Potton, Deputy Director of Finance							
Date prepared:	27 March 2025							
Subject / title:	2025/26 Operational Plan							
Purpose:	**Approval**	**X**	**Decision**		**Information**	**X**	**Assurance**	**X**
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Trust has submitted the financial, operational workforce plan for 2025/26 in line with national timescales and guidance. The Herts & West Essex ICS have submitted a breakeven plan with PAH submitting a breakeven financial plan. Included within the PAH plan is a PQP target of 5.8% aligned to the national average which equates to £26.15m. The operational plan is set to deliver all performance targets aligned to the national requirement by March 2026. The workforce plan is aligned to the key national directives on reductions in bank and agency and the key Trust strategic projects.							
Recommendation:	The Board is asked to approve the 2025/26 operational 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:	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 Operational Plan report attached

The Princess Alexandra Hospital NHS Trust

Summary

- The operational, financial and workforce plans have been submitted to the ICB for submission to NHSE on 27th March 2025. It is expected that this is the final submissions.

- The operational plan is set to deliver all performance targets aligned to the national requirement by March 2026. This is an aspirational planning assumption which will require transformational change to deliver it.

- There are several risks to delivery of the performance targets including the condition of the estate, availability of workforce and the impacts on both activity delivery and reporting following the implementation of Alex Health

- The financial plan is submitted as breakeven with a PQP target of 5.8% aligned to the national average. This is driving an efficiency program of £26.15m.

- To achieve a breakeven submission there is £24.7m of system support funding to match that received in 2024/25 along with a further temporary £15.8m system support funding whilst the ICS collectively identify the savings/efficiencies/transformation to deliver a sustainable ICS breakeven position.

- The workforce plan is aligned to the key national directives on reductions in bank and agency and the key Trust strategic projects. This translates into 30% reduction in agency and a 15% reduction in bank usage.

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25/26 Operational Plan Submission

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Headlines

The Princess Alexandra Hospital NHS Trust

- The operational, financial and workforce plans have been submitted to the ICB for submission to NHSE on 27th March 2025. It is expected that this is the final submissions.
- The plans have been triangulated with the expectation that the operational performance targets are met requiring some additional costs whilst improving productivity.
- The financial plan is submitted as breakeven with a PQP target of 5.8% aligned to the national average. This is driving an efficiency program of £26.15m. To achieve a breakeven submission there is £24.7m of system support funding to match that received in 2024/25 along with a further temporary £15.8m system support funding whilst the ICS collectively identify the savings/efficiencies/transformation to deliver a sustainable ICS breakeven position.
- The workforce plan is aligned to the key national directives on reductions in bank and agency workforce (15% reduction in bank and 30% reduction in agency). It includes the movements for strategic projects including CDC, Surgical Hub and Alex Health sustainment.
- Next Steps:
  - Embed action plans/task and finish groups to ensure delivery of operational performance.
  - Continue to review and reduce the funding support of £15.87m through reviews of key pressures.
  - Further development of PQP schemes to reduce the unidentified value.
  - Review current internal grip and control measures and ensure clarity to the organisation on measures/expectations in particular on EVCP.

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Operational Performance

The Princess Alexandra Hospital NHS Trust

25/26 Operational Performance	Baseline Dec-24	Planning Assumption Mar-26
General and Acute overnight bed occupancy		
Number of overnight G&A beds occupied - available and occupied	98.6%	97.4%
NEL Average length of stay - acute trusts		
NEL Average length of stay - acute trusts	7.60	7.60
Cancer 28 day waits (faster diagnosis standard)		
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following	72.2%	80.0%
Cancer 62-day pathways. Total patients seen, and of which those seen within 62 days		
Percentage of patients seen within 62 days	60.9%	75.0%
Cancer 31 day performance		
Percentage of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat/earliest clinically appropriate date	95.4%	96.6%
PIFU	Apr 2024 - Dec 2024	Mar-26
PIFU as percentage of total outpatient attendances	1.7%	3.0%
A&E	Apr 2024 - Jan 2025	Mar-26
Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	60.4%	78.0%
Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours.	47.9%	71.0%
Percentage of attendances at Type 2 and 3 A&E departments, departing in less than 4 hours	100.0%	100.0%
Percentage of attendances at type 1 A&E departments where the patient spent more than 12 hours	0.0%	6.5%
Outpatients	Jan-25	Mar-26
Percentage of patients waiting for first attendance who have been waiting less than 18 weeks	42.0%	56.3%
RTT	Nov-24	Mar-26
Percentage of patients waiting no longer than 18 weeks for treatment	45.5%	60.0%

The Operational Plan will deliver all performance targets aligned to the national requirement by March 2026.

The table highlights key metrics from the operational plan submission showing the baseline data and the planning assumption included to be achieved by March 2026.

This is an aspirational planning submission which will require transformational change to deliver it.

There are a number of risks to delivery including the condition of the estate, availability of workforce and the impacts on both activity delivery and reporting following the implementation of Alex Health.

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Financial Plan 25/26 – movement from previous submission

The Princess Alexandra Hospital NHS Trust

PAH - Bridge	£000
2025/26 Plan - 1st Submission (27th February)	**(13,323)**
Remove convergence error	(2,544)
Elective Recovery Funding Adjustments	(400)
Additional Advice & Guidance	992
PDC Funding Removed as agreed with ICB	(1,200)
Movement in unavoidable cost pressures	(546)
2025/26 Plan - 2nd Submission (14th March)	**(17,021)**
Additional PQP to align to National Average of 5.8%	3,325
Reduce Alex Health Sustainment	500
Increase Inflation on HEE Contract	233
Reduce cost pressures (not yet identified)	1,000
Increase income for additional non-recurrent funding (not yet identified)	1,000
2025/26 - Plan Submission Excluding Pathology Adjustments	**(10,963)**
Pathology pressure	(2,368)
Pathology Income Assumed Previously to cover pressure	(2,585)
2025/26 - Final Plan Submission before System Efficiency Support	**(15,916)**
System Efficiency Support - to be identified by ICS	15,916
2025/26 - Final PAH Plan	**0**

For completeness, the movements between submissions are shown in the bridge.

The Trust undertook a number of steps to improve the deficit position including moving to 5.8% efficiency, reduced Alex Health sustainment costs and further movements in costs/income to support.

The Trust continues to work with the ICB to review the pressure from Pathology.

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Final Workforce Submission 21.03.25

The Princess Alexandra Hospital NHS Trust

Total Establishment (WTE)			Mar-25 Plan Workforce (WTE)				Mar-26 Plan Workforce				Mar-25 vs Mar-26 Growth %			
Plan Establishment as at Mar-25	Plan Establishment as at Mar-26	Total Increase/ (Decrease)	Total Workforce	Total Substantive	Plan Bank	Plan Agency	Total Workforce	Total Substantive	Plan Bank	Plan Agency	Total Workforce	Total Substantive	Plan Bank	Plan Agency
4,097.77	4,097.77	0.00	4,235.14	3797.62	386.79	50.73	4,203.92	3,841.05	328.05	34.82	-1%	1%	-15%	-31%

High level Assumptions :

- Total establishment excludes pathology
- Total substantive staff in post excludes pathology, staff on career break and staff out to external secondment
- EHR benefit realisation in plan will phase out some post commencing Nov-25 (28.15 WTE substantive & 20.07 WTE bank & agency)
- EHR sustainment business case **option 2** included from Nov-25 (53.30 WTE)
- Increase to the establishment include approved business cases for CDC, surgical centre and vanguard (56.73 total WTE)
- Increase to substantive staff in post through, increase recruitment, staff retention and reducing temporary staffing
- To reduce spend on temporary staffing, plan bank and agency usage worked up using NHSE operational guidance of 30% reduction in agency and 15% reduction in bank usage. (average bank & agency run rate 495.33 wte)
- Streamline the recruitment process to move bank to substantive, any long lines of work over 10 weeks will be offered if covering a vacancy

PQP

The Princess Alexandra Hospital NHS Trust

PQP Themes	£000
Temporary Staffing - Bank & Agency	5,610
Procurement	518
Alex Health Benefits	2,629
Pathology Testing Reduction	541
Corporate Services	986
Additional Sessions linked to Productivity	1,492
International Nurse Recruitment	500
Estates Schemes	441
Central non-recurrent schemes	2,000
Nursing paid at shift rather than grade	570
Non Pay (excl procurement schemes)	800
Drugs cost reduction	187
Contract changes / Income Review	653
Private Patient Income	13
Legal & Professional Fees	150
Other	102
Unidentified PQP	8,958
Total PQP Target 25/26	**26,150**
% of PQP unidentified	**34%**

The Operational Plan assumes the following with regards to efficiency for 25/26:

- Total target is £26.15m which is equivalent to 5.8% of total expenditure. This is in line with the national average.
- Currently work is underway to identify the opportunities and to allocate the PQP target across Divisions and Corporate Services based on opportunity rather than a blanket 5.8% reduction.
- The expectation is that **£16.6m** will be achieved recurrently. This is 63% of the total target.
- Divisions and corporate teams are working to ensure schemes are included on PM3 and

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Board Assurance

The Princess Alexandra Hospital NHS Trust

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	Prioritisation of business cases and cost pressures undertaken with clinical, operational and financial executive input.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes	All PQP schemes will have completed quality and equality impact assessments.
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes	

Board Assurance

The Princess Alexandra Hospital NHS Trust

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	Review of plans against the national priorities has taken place throughout the planning process with the use of benchmarking data from within the Trust and provided by NHSE.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Partly	The Trust has an efficiency target of 5.8% which is equivalent to £26.15m. This has not all been identified to date. Work continues to review productivity and efficiency opportunities.
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	Yes	
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes	Risk as identified include delivery of ICS efficiency to support additional funding to breakeven, PQP delivery and income risk on ERF due to Alex Health. For performance the risks include Alex Health reporting, condition of the estate and availability of workforce.

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The Princess Alexandra Hospital NHS Trust

Trust Board Public – 3 April 2025

Agenda item:	6.4
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Antoinette Woodhouse – Head of Information
Date prepared:	27th March 2025
Subject / title:	Integrated Performance Report

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	NA	No KPIs reporting by exception this month.
People		
	Appraisal - non medical	10% Increase in compliance from January to February 2025. Further increase expected in March 2025 to close the 14% gap to achieve the 90% target.
	Statutory & Mandatory training	Increase in spend due to winter pressures including additional staff requirements due to critical incident.
Performance		
Performance	Referral Elective Standards	Our submitted 18 week performance deteriorated for November and December to 41.8% due to Alex Health implementation and reduced activity, migration and post migration DQ and a reduction in validation. Positively, this increased to 44.3% for January and we are now including ASIs in the RTT monthly submission. For December, the trust achieved 0 x 78+ week breaches and 61 x 65+ week breaches (20 choice). For January the trust achieved 0 x 78+ week breaches and 97 x 65+ week breaches (26 choice) and for February the trust achieved 0 x 78+ week breaches and 51 x 65+ week breaches (34 choice). We continue to work hard to secure diagnostic, outpatient and treatment activity ahead of the breach date in order to continue the recovery momentum and move toward the new expectations set out in the Elective Reform paper. ASIs are also being monitoring closely, validated and sent for bookings on a twice weekly basis.
	Cancer standards	The 28 day faster diagnosis performance standard was 66.4% in January, with Februarys unvalidated position currently at 75.5%, validations are on-going. The 62 day finalised performance for January was 50.0% against a trajectory of 64%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics. The service teams are working on recovery plans improve performance and clearance of our backlog remains an area of focus, but whilst we continue to make progress with the backlog this will impact our 62-day performance.
	Diagnostics	Diagnostics performed within 6 weeks of referral has increased slightly for January to 62.70% from 57.82%. MRI remain at 100% performance with no waits over 6 weeks and CT at almost 95%. There are recovery plans in place for the other modalities however Echo's, NOUS and Audiology are dependent on recruitment drives. Insourcing and validation is continuing to support improving performance and OPCS code issues with Alex Health have been escalated that are currently affecting Endoscopy and other areas.
Pounds		
Pounds	Income\Activity	The Trust put in Elective Recovery Fund weighted value of 117.85% of 2019/20 baseline . The Trust's ERF performance is above plan as at the end of February. Block ERF funding agreed with the NHSE to mitigate any impact of Alex Health implementation from M8-12. The overall ERF forecast outturn is 120% of 2019/20 weighted value. Excess depreciation over plan has been accrued to the position (YTD £1.5m). Additional system support income notified in January has been reflected in the position (£442k in month) and YTD (£4.9m).
	Capital Spend	The Trust total Capital resourcing for 2024/25 is £40.2m, 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 surplus of £0.9m in month 11 against a planned surplus of £4.3m. The YTD position is now a deficit of £1.4m which is £2.7m ahead of plan. The in month position predominantly relates to the fact some system support funding was planned for in M11, but has been recognised twelfths throughout the year. The YTD favourable variance to plan relates to an additional £5.3m (over 12 months), system support funding received in M10 and M11.
	Cost Improvement Plan	The 24/25 PQP target is £18.5m. The YTD PQP plan is £17.0m, of which £16.2m has been delivered, this is predominantly within Corporate, Surgery, Estates and Facilities and some within CSS and CHAWS.
	Cash	The Trust's cash balance is £22.9m. 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 day BPPC performance.
Places		
Places	Estates	Estates Responsiveness (Priority 1 - Emergency) and Estates Responsiveness (Priority 2 - Urgent). BMS controls upgrade works in Main theatre 3 and 4. SCBU internal walls cladding and decoration. Tye green lift lobby paint works. Theatre 2 operation lights replaced.
	Capital	Completion of BLM with additional funding and other capital funded streams - briefing documents awaited from Estates team/end users via SHofE for full year end completion based on risk. Supporting ED team on UEC funding spend by year end - full approval awaited from Project Team for in year spend. Supporting Pharmacy team with turnkey works for new dispensing robot for year end spend. Supporting CHAWS division on urgent works in Maternity areas for year end spend with SSOC. Supporting Medicine division on urgent works in Maternity areas for year end spend with SSOC. Supporting Strategy team on delivery of new CDC at SMH offsite location for December 2025 completion. Supporting Medicine division on urgent minor works in Fleming Ward for year end spend with SSOC. Supporting sitewide divisions on creation of SSOC or BC for proposed schemes for 2025/26 year. Supporting Strategy team with regards to site DCP project
	Facilities	Five Stars in our EHO visit. Initiated Catering staffing consultation. Implementation of patient and staff parking charges. Retail Price increasing. Removal of provision from Kao Park. Trial of waste on ED. Roll out of cleaning scheduler and HER improvements.

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:	n/a
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:	M11 IPR

Integrated Performance Report:

February 2025

As at 27/03/2025

Executive Summary

The Princess Alexandra Hospital NHS Trust

Patients

Patients

NA	No KPIs reporting by exception this month.

Pounds (November's data and summaries)

Capital Spend	The Trust total Capital resourcing for 2024/25 is £40.2m, 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.
Cost Improvement Plan (PQP)	The 24/25 PQP target is £18.5m. The YTD PQP plan is £17.0m, of which £16.2m has been delivered, this is predominantly within Corporate, Surgery, Estates and Facilities and some within CSS and CHAWS.
Income / Activity	The Trust put in Elective Recovery Fund weighted value of 117.85% of 2019/20 baseline . The Trust's ERF performance is above plan as at the end of February. Block ERF funding agreed with the NHSE to mitigate any impact of Alex Health implementation from M8-12. The overall ERF forecast outturn is 120% of 2019/20 weighted value. Excess depreciation over plan has been accrued to the position (YTD £1.5m). Additional system support income notified in January has been reflected in the position (£442k in month) and YTD (£4.9m).
Surplus / Deficit	The Trust reported a surplus of £0.9m in month 11 against a planned surplus of £4.3m. The YTD position is now a deficit of £1.4m which is £2.7m ahead of plan. The in month position predominantly relates to the fact some system support funding was planned for in M11, but has been recognised twelfths throughout the year. The YTD favourable variance to plan relates to an additional £5.3m (over 12 months), system support funding received in M10 and M11.
Cash	The Trust's cash balance is £22.9m. 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 day BPPC performance.

People

Appraisal - non medical	10% Increase in compliance from January to February 2025. Further increase expected in March 2025 to close the 14% gap to achieve the 90% target.
Statutory & Mandatory training	2% under compliance target. Continued discussions with divisions with target support for staff groups with lowest compliance. Continued escalations through to divisional review meetings.

Performance

Referral Elective Standards	Our submitted 18 week performance deteriorated for November and December to 41.8% due to Alex Health implementation and reduced activity, migration and post migration DQ and a reduction in validation. Positively, this increased to 44.3% for January and we are now including ASIs in the RTT monthly submission. For December, the trust achieved 0 x 78+ week breaches and 61 x 65+ week breaches (20 choice). For January the trust achieved 0 x 78+ week breaches and 97 x 65+ week breaches (26 choice) and for February the trust achieved 0 x 78+ week breaches and 51 x 65+ week breaches (34 choice). We continue to work hard to secure diagnostic, outpatient and treatment activity ahead of the breach date in order to continue the recovery momentum and move toward the new expectations set out in the Elective Reform paper. ASIs are also being monitoring closely, validated and sent for bookings on a twice weekly basis.
Cancer Standards	The 28 day faster diagnosis performance standard was 66.4% in January, with Februarys unvalidated position currently at 75.5%, validations are on-going. The 62 day finalised performance for January was 50.0% against a trajectory of 64%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics. The service teams are working on recovery plans improve performance and clearance of our backlog remains an area of focus, but whilst we continue to make progress with the backlog this will impact our 62-day performance.
Diagnostics	Diagnostics performed within 6 weeks of referral has increased slightly for January to 62.70% from 57.82%. MRI remain at 100% performance with no waits over 6 weeks and CT at almost 95%. There are recovery plans in place for the other modalities however Echo's, NOUS and Audiology are dependent on recruitment drives. Insourcing and validation is continuing to support improving performance and OPCS code issues with Alex Health have been escalated that are currently affecting Endoscopy and other areas.

Places

Capital

Completion of BLM with additional funding and other capital funded streams - briefing documents awaited from Estates team/end users via SHofE for full year end completion based on risk.	Estates
Supporting ED team on UEC funding spend by year end - full approval awaited from Project Team for in year spend. Supporting Pharmacy team with turnkey works for new dispensing robot for year end spend. Supporting CHAWS division on urgent works in Maternity areas for year end spend with SSOC.	Estates
Supporting Medicine division on urgent works in Maternity areas for year end spend with SSOC. Supporting Strategy team on delivery of new CDC at SMH offsite location for December 2025 completion. Supporting Medicine division on urgent minor works in Fleming Ward for year end spend with SSOC. Supporting sitewide divisions on creation of SSOC or BC for proposed schemes for 2025/26 year.	Facilities

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Section summaries

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**
NA	No KPIs reporting by exception this month		

Section summaries

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 increased slightly for January to 62.70% from 57.82%. MRI remain at 100% performance with no waits over 6 weeks and CT at almost 95%. There are recovery plans in place for the other modalities however Echo's, NOUS and Audiology are dependent on recruitment drives. Insourcing and validation is continuing to support improving performance and OPCS code issues with Alex Health have been escalated that are currently affecting Endoscopy and other areas.		
RTT Elective standards	Our submitted 18 week performance deteriorated for November and December to 41.8% due to Alex Health implementation and reduced activity, migration and post migration DQ and a reduction in validation. Positively, this increased to 44.3% for January and we are now including ASIs in the RTT monthly submission. For December, the trust achieved 0 x 78+ week breaches and 61 x 65+ week breaches (20 choice). For January the trust achieved 0 x 78+ week breaches and 97 x 65+ week breaches (26 choice) and for February the trust achieved 0 x 78+ week breaches and 51 x 65+ week breaches (34 choice). We continue to work hard to secure diagnostic, outpatient and treatment activity ahead of the breach date in order to continue the recovery momentum and move toward the new expectations set out in the Elective Reform paper. ASIs are also being monitoring closely, validated and sent for bookings on a twice weekly basis.		
Cancer Standards	The 28 day faster diagnosis performance standard was 66.4% in January, with Februarys unvalidated position currently at 75.5%, validations are on-going. The 62 day finalised performance for January was 50.0% against a trajectory of 64%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics. The service teams are working on recovery plans improve performance and clearance of our backlog remains an area of focus, but whilst we continue to make progress with the backlog this will impact our 62-day performance.		

Section summaries

The Princess Alexandra Hospital NHS Trust

People Summary	Board Sub Committee: People Committee		
Focus Area	**Description and Action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Appraisals non-medical	10% Increase in compliance from January to February 2025. Further increase expected in March 2025 to close the 14% gap to achieve the 90% target.	For recognition	Mar-25
Statutory & Mandatory training	2% under compliance target. Continued discussions with divisions with target support for staff groups with lowest compliance. Continued escalations through to divisional review meetings.	For increased visibility and awareness	Mar-25

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

Key Performance Indicators of Interest

The Princess Alexandra Hospital NHS Trust

5P Section	KPI	SPC Status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	Total grade 3, 4 & unstageable pressure Ulcers		9	1.1	16	12
	Serious Incidents		2	1.1	16	12
	Falls per 1000 bed days		4.5	1.1	16	12
People	Appraisals - non-medical		76%	2.3	16	8
	Statutory & Mandatory training		88%	2.3	16	8
	Vacancy Rate		7%	2.3	16	8
	Voluntary turnover		9.5%	2.3	16	8
Performance	RTT over 78 week waits		0	1.3	16	12
	Proportion of Ambulance Handovers Between 15 & 30 mins		43%	1.3	16	12
	Patient seen within 6 weeks		63%	1.3	16	12
	4 hour standard		53.0%	4.2	16	12

Patients section measures of interest

SPC for C.15 - Total grade 3, 4 & unstageable pressure Ulcers

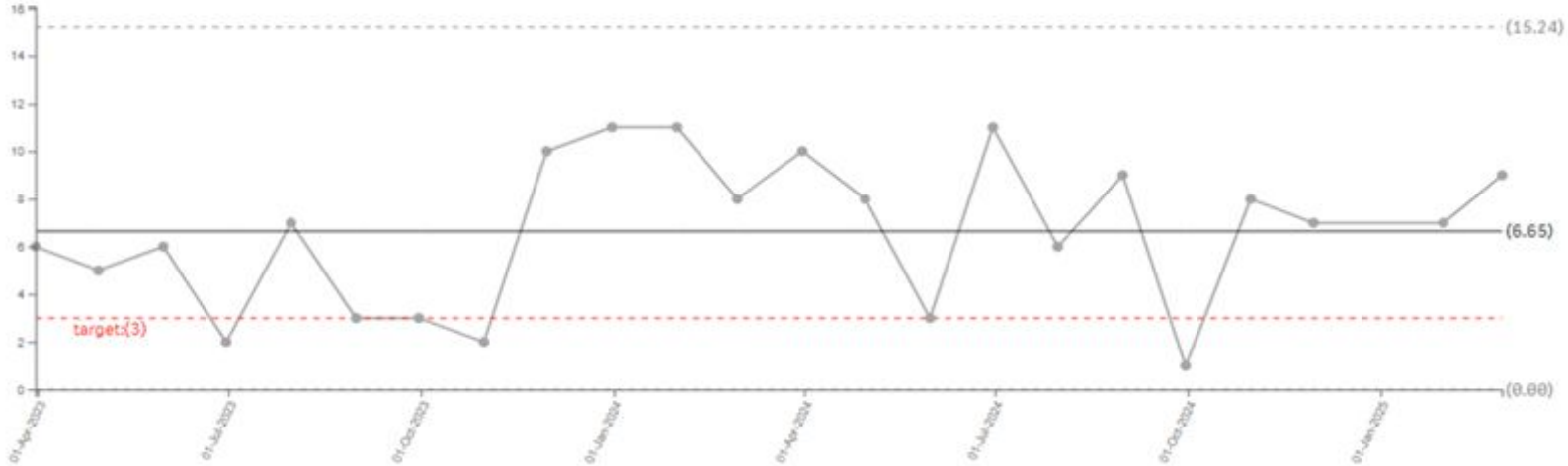
Previous month ...
January-2025

7

Month to date v...
February-2025

9

Target
February-2025
Target is at Trust-wide level



SPC for C.13 - Serious Incidents

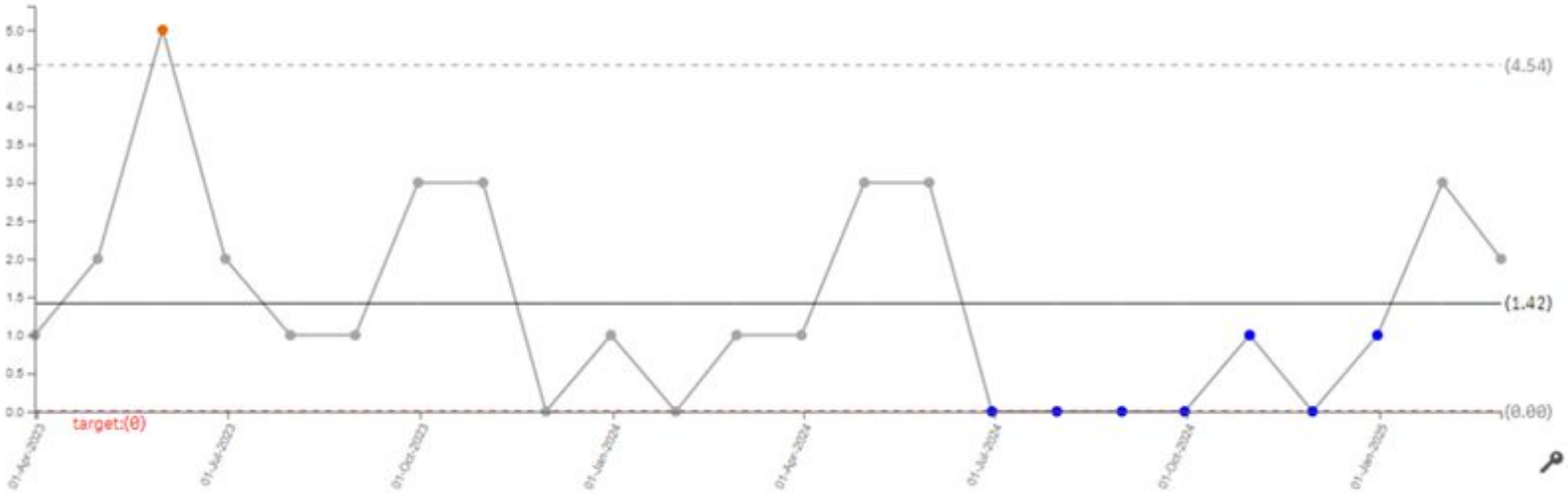
Previous month ...
January-2025

3

Month to date v...
February-2025

2

Target
February-2025
Target is at Trust-wide level



Patients section measures of interest

SPC for D.1 - Falls per 1000 bed days

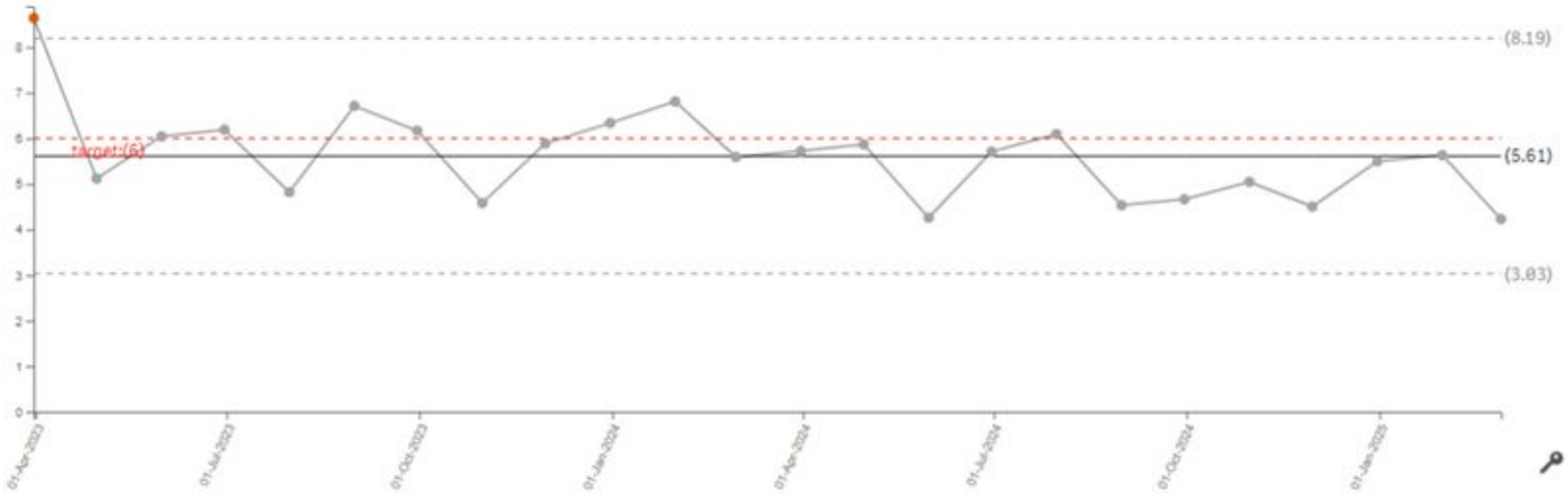
Previous month ...
February-2025

4.23

Month to date v...
March-2025

4.50

Target
February-2025
Target is at Trust-wide level



People section measures of interest

SPC for D.28 - Appraisals - non medical

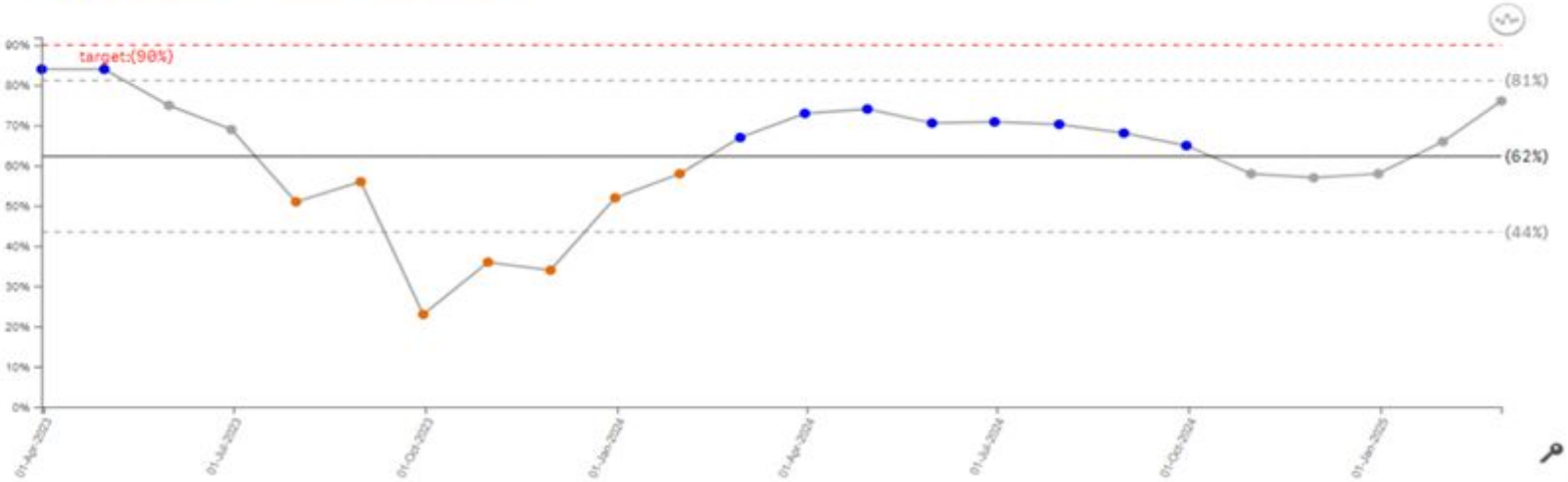
Previous month ...
January-2025

66.0%

Month to date v...
February-2025

76.1%

Target
February-2025
Target is at Trust-wide level



SPC for D.29 - Statutory & Mandatory training

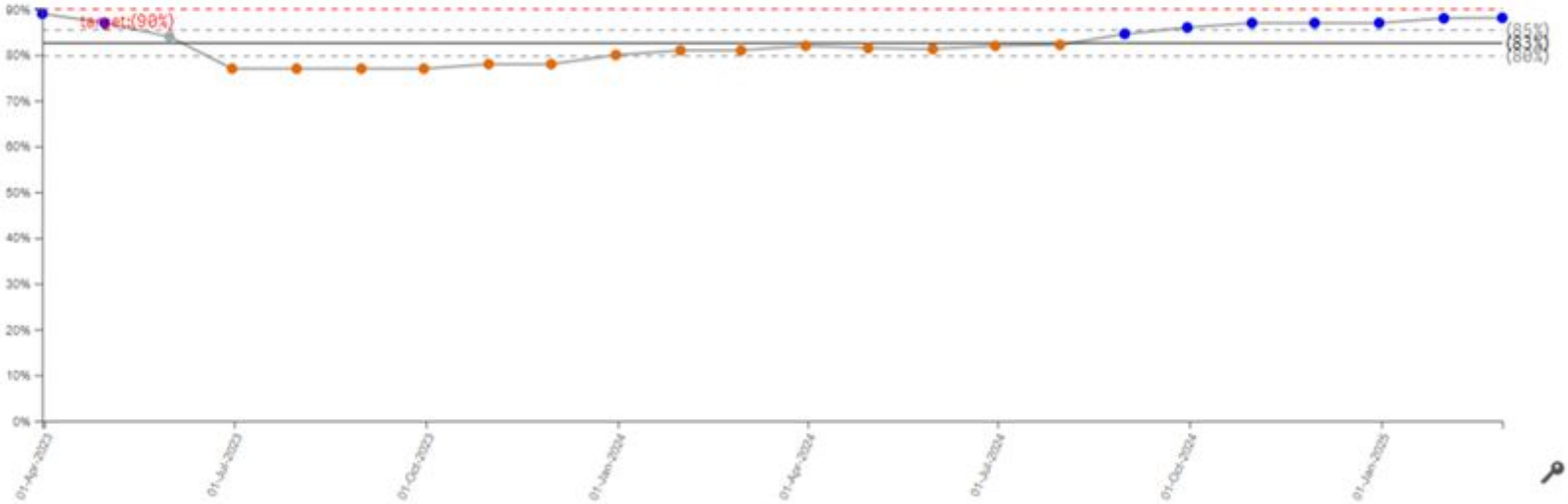
Previous month ...
January-2025

88.0%

Month to date v...
February-2025

88.1%

Target
February-2025
Target is at Trust-wide level



People section measures of interest

SPC for D.27 - Vacancy Rate

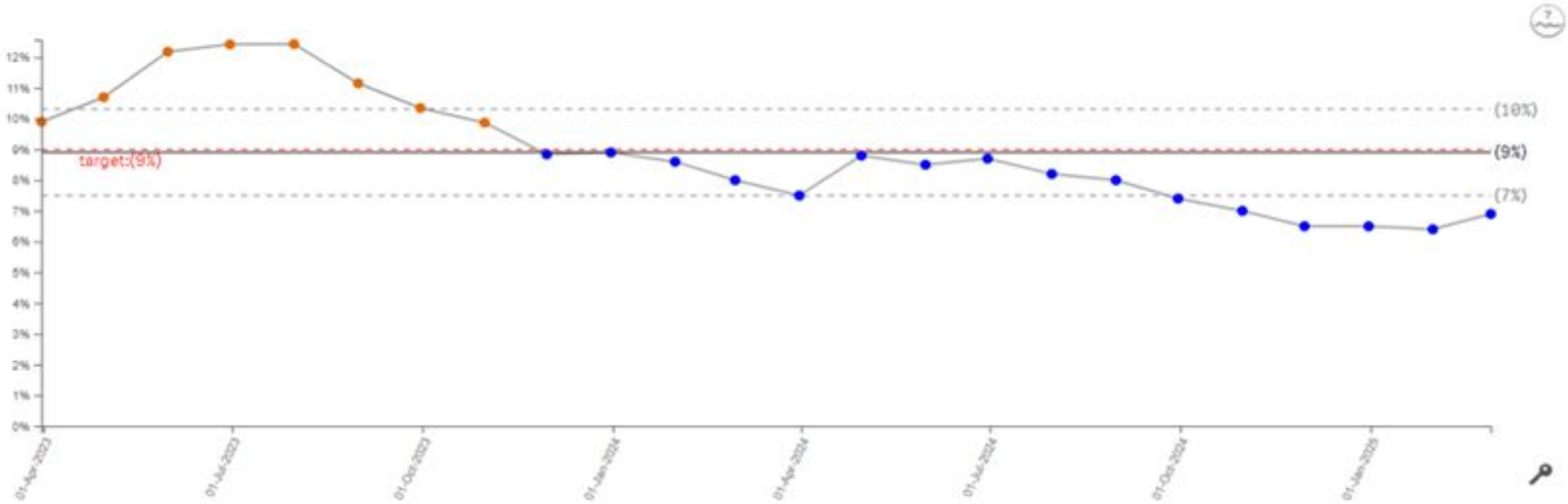
Previous month ...
January-2025

6.4%

Month to date v...
February-2025

6.9%

Target
February-2025
Target is at Trust-wide level



SPC for D.24 - Staff Turnover Voluntary

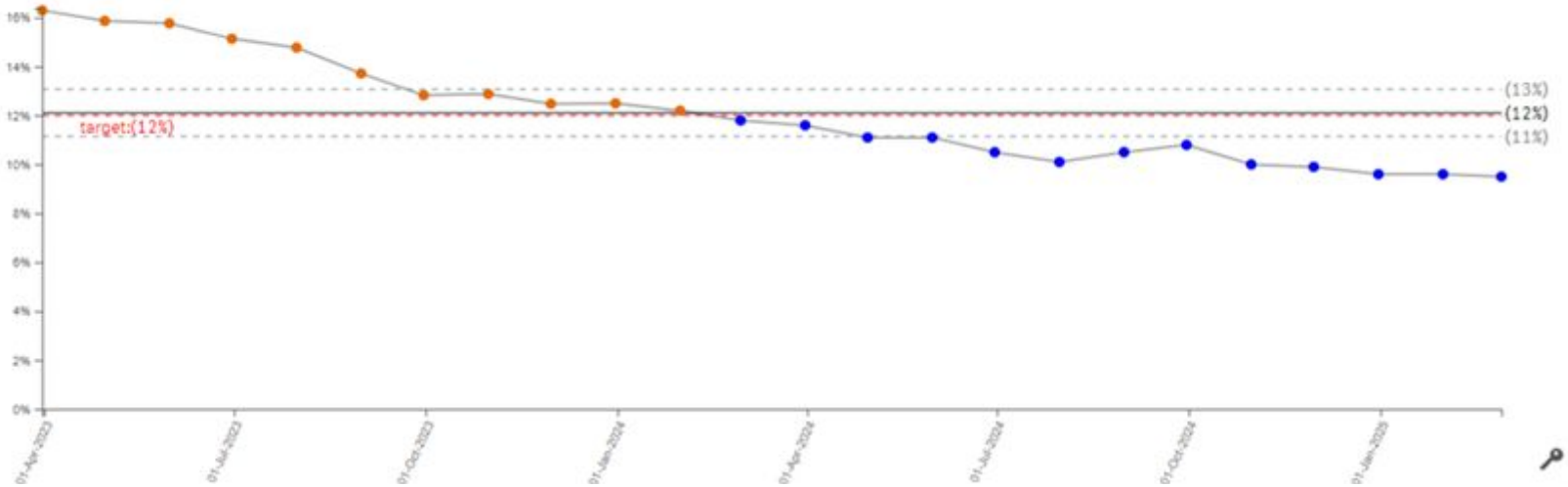
Previous month ...
January-2025

9.6%

Month to date v...
February-2025

9.5%

Target
February-2025
Target is at Trust-wide level



Performance section measures of interest

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

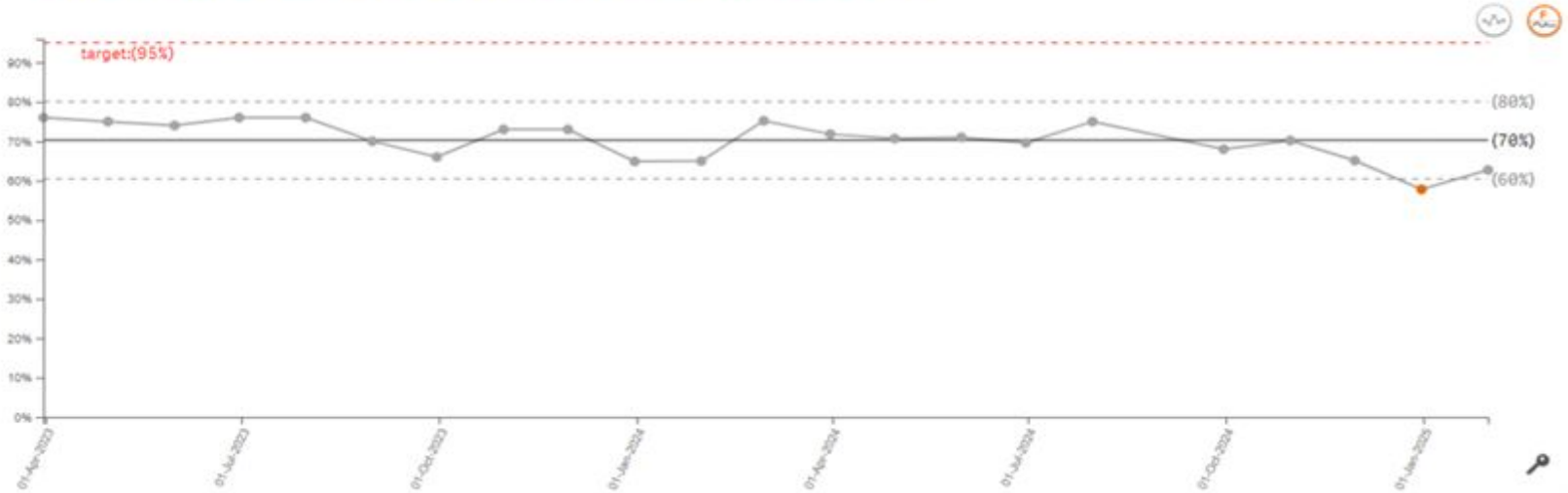
Previous month ...
December-2024

57.8%

Month to date v...
January-2025

62.7%

Target
January-2025
Target is at Trust-wide level



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

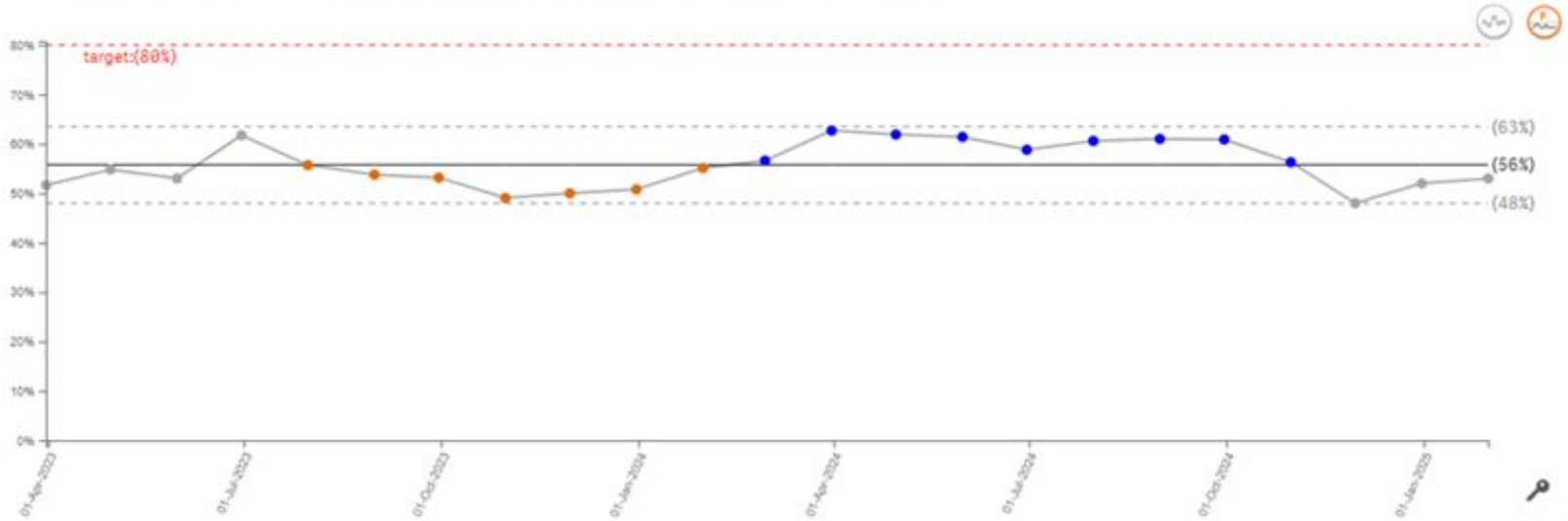
Previous month ...
December-2024

52.0%

Month to date v...
January-2025

53.0%

Target
January-2025
Target is at Trust-wide level



Performance section measures of interest

SPC for D.37 - RTT over 78 week waiters

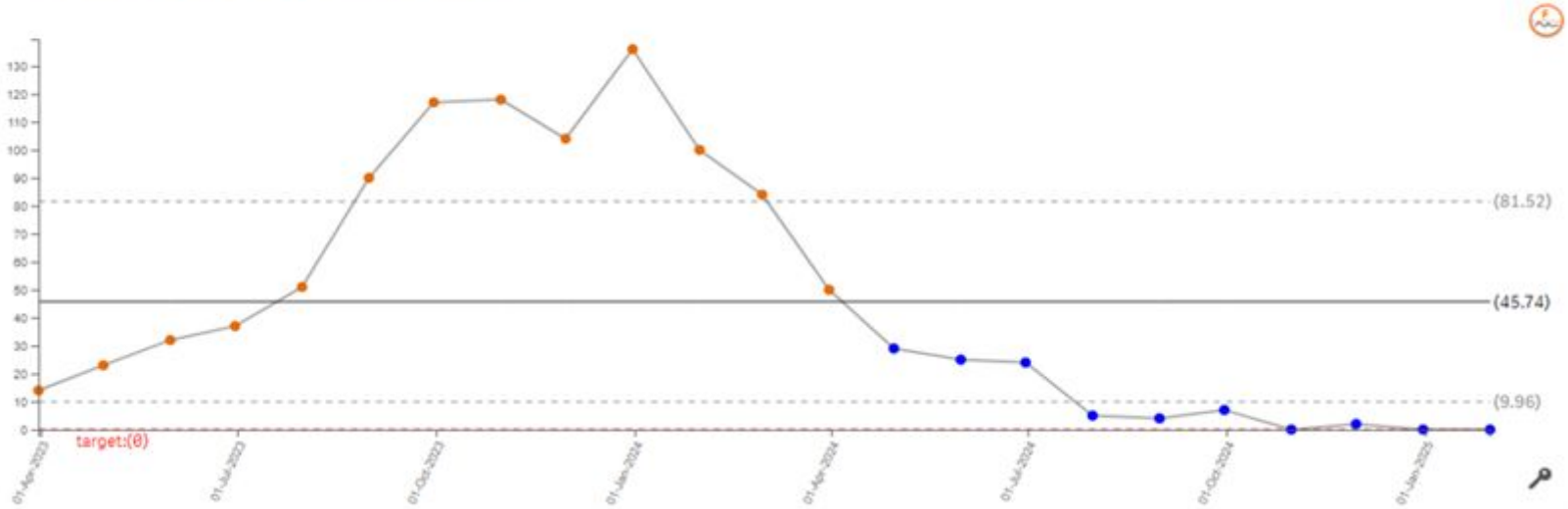
Previous month ...
December-2024

0

Month to date v...
January-2025

0

Target
January-2025
Target is at Trust-wide level



SPC for A.18 - Proportion of Ambulance Handovers Between 15 & 30 minutes

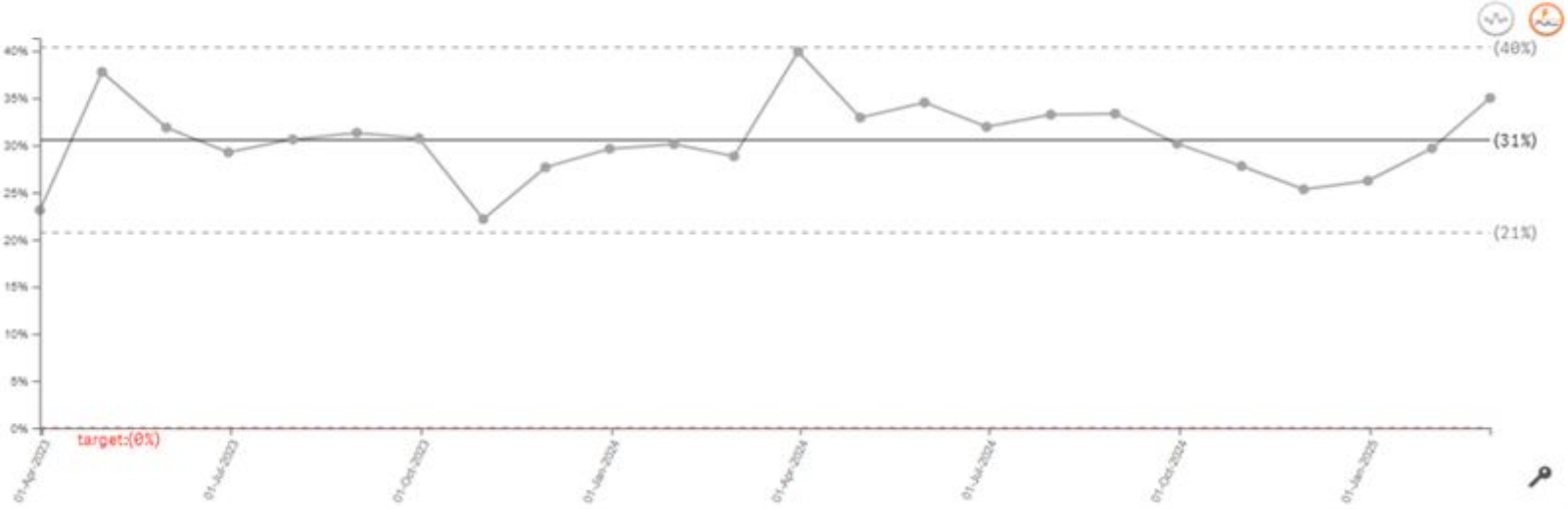
Previous month ...
February-2025

35.0%

Month to date v...
March-2025

42.8%

Target
February-2025
Target is at Trust-wide level



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) - 3rd April 2025

Agenda item:	7.1
Presented by:	Michael Meredith, Chief Strategy Officer
Prepared by:	Chloe Atkinson, Head of Strategy & Development, PAHT
Date prepared:	27th March 2025
Subject / title:	PAHT achieving Host and Lead Provider Status across West Essex

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

Key issues:	To be prepared for significant increase in demand and restricted resources PAHT are working with system partners to integrate services on the front line with a potential end state of developing an integrated care organisation. A first step on this journey is for PAHT to take on a host provider role on behalf of WEHCP, and an additional lead provider role for Adult Community Services from May 2025. This paper outlines • the current position, • route to decision and • proposed governance structures The target date for implementation is 5th May 2025 for the host provider and Q1/2 for lead provider. The focus of this paper is the Host Provider model.
Recommendation:	Trust Board are asked to: • Agree the route to decision with the aim of launching the host provider arrangements from 5th May 2025. • Agree the lead provider requirements based on the current 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:	Executive Cabinet HCP Board (20th March 2025) ICB Board (28th March 2025) PAHT Trust Board (3rd April 2025)
Risk / links with the BAF:	Please see section 4 of this paper.
Legislation, regulatory, equality, diversity and dignity implications:	All regulatory and legal requirements are outlined in the paper.
Appendices:	n/a

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

This paper outlines the current position, route to decision and proposed governance structure to support PAHT to take on host provider status across West Essex from May 2025. Due to timeframes, this paper will predominantly focus on the Host Provider arrangement, although will include additional updates on the Lead Provider programme which we aim to commence during Q1/2 25/26.

2.0 Context

National guidance has created a permissive approach to establishing local governance arrangements that enable systems to develop and progress neighbourhood health care. In Hertfordshire & West Essex, this means a focus on prevention and population health need, recognising the need for distributed leadership, collaborative working, aligned financial incentives and funding models underpinned by clarity of oversight and accountability.

Hertfordshire and West Essex Integrated Care Board (ICB) has designed an operating model in response to these national drivers that enables the place-based partnerships to develop local models that reflect local geographies, health and care provider landscape and patient flows.

The ICB has expressed a preference for its constituent Health & Care Partnerships (HCPs) to develop host provider models.

3.0 Proposal

Host Provider

PAHT, WEHCP and HWEICB have been developing a Delegation Framework to support the host provider transfer. PAHT and HWEICB have both received independent legal advice and, upon review internally and with HCP Partners, are amending the draft Delegation Framework between HWEICB and PAHT

Key points to note from the proposed Delegation Framework:

- The operating model is a move towards a desired end state for Integrated Care Organisations.
- PAHT take on a host provider role on behalf of the WEHCP to act as a contractual integrator enabling effective partnership working between health and care organisations in west Essex and part of east Herts.
- The host provider through the HCP is responsible for their population for the operational delivery, performance improvement, outcomes, and financial recovery and sustainability. Accountability remains with the ICB who continues to hold the commissioning budget for the population and associated contracts.
- The host provider will discharge ICB commissioning responsibilities for the identified population through the WEHCP. WEHCP will function as a sub-committee of the PAHT Board. PAHT will require a change to its Scheme of Delegation to enable it to delegate the ICB responsibilities to the WEHCP Board.
- The ICB will be required to define the core terms of reference of the WEHCP sub- committee to ensure the host provider is discharging the ICBs

commissioning responsibilities in line with the ICBs statutory responsibilities relating to delegated functions. This will include membership and how the HCP will collaborate between partner organisations in a way that promotes shared responsibility and collective decision-making.

In order to discharge the functions laid out in the Delegation Framework, the current HCP Board will become a sub-committee of the PAHT Trust Board and, as such, the HCP Terms of Reference have been amended.

ICB contract values included within Host Provide framework

Please see table below for the scope of contracts which will continue to be held by the ICB, with responsibility then delegated onto PAHT as host provider and WEHCP.

West Essex Health & Care Partnership **NHS Budget 2024/25**		
Oct-24		
		Annual budget
		£'000
Acute NHS		315,012
Acute Passthrough		20,248
Hertford Urgent Care Centre		206
Acute winter resilience		373
Acute service developments		138
Other acute		35,926
Community Health		46,789
Urgent Treatment Centre		2,144
Children's services		6,151
Hospices		2,105
BCF/Discharge/Reablement		12,744
Continuing Care		32,189
Neuro-rehab, Carers, Palliative etc		2,348
Mental Health		55,799
Prescribing		51,268
Primary care		72,096
NHS 111		1,497
Transformation funding		11,627
Corporate/Management costs		8,424
		677,084

Route to Decision (Host Provider)

The draft Delegation Framework, HCP Terms of Reference and proposed Host Provider Governance Structure are due to be discussed at the following:

Board	Date
HCP Board	20th March 2025
ICB Board	28th March 2025

The Princess Alexandra Hospital NHS Trust

PAHT Trust Board	3rd April 2025

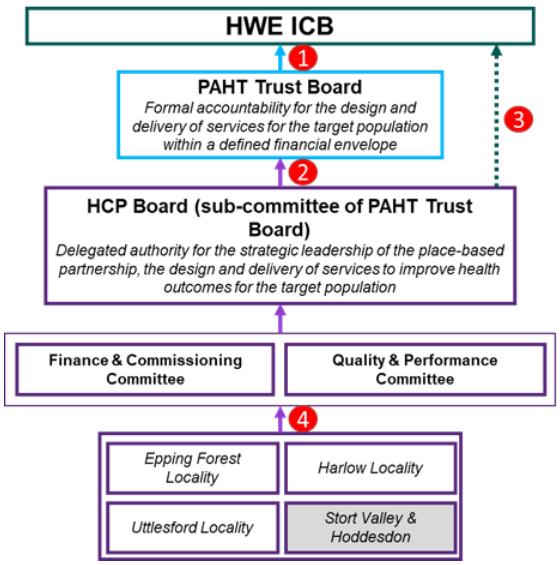
We had aimed to have the Delegation Framework and HCP Board ToR approved at each of the above Boards, but the ICB Board are not yet in a position to approve either the PAHT or West Herts proposals until their April Board on 25th April 2025. As a consequence, PAHT aim to present the final Delegation Framework and HCP Board ToR for approval to these Boards over April and May, and therefore be in a position to commence host provider status from 5th May 2025.

Outstanding requirements (Host Provider)

Outstanding requirements	Comments
Formal contract between ICB and PAHT outlining the responsibilities delegated to the host provider.	ICB are currently drafting this. It is expected to be consistent across WHHT and PAHT.
Financial due-diligence between ICB and PAHT.	Awaiting contract values from the ICB. The ICB will continue to be accountable for these contracts.
Scheme of delegation and SFI's for PAHT amended to support HCP Board to discharge responsibilities as a sub-committee of PAHT Trust Board.	Following legal advice, PAHT are proposing a change to SFI's to be discussed through PaF in April 2025 and PAHT Trust Board in May 2025.
Shadow governance period and PAHT requirements agreed	ICB to confirm the current governance structure in place which PAHT will begin to attend from May 2025.

Host Provider Governance

The following Host Provider governance framework has been proposed and will be presented at HCP Board, ICB Board and PAHT Trust Board between 20th March and 3rd April 2025, with the aim of launching this structure from May 2025.



1. Formal delegated responsibility for commissioning services delegated by the ICB to PAHT as host provider, along with corresponding share of ICB financial allocation. Enabling the host provider and HCP to take responsibility for designing, commissioning and delivering health and care services for the WE population.
2. PAHT discharges this function through the WEHCP Board, re-constituted as a committee of the PAHT Trust Board with co-opted members from across the health and care system, including Non-Executive representation from the ICB.
3. ICB Board non-executive membership of HCP Board ensures strategic 'join-up' and protects against any conflicts of interest with oversight of provider activity within the host provider.
4. Localities will become the delivery arm of the HCP and will embed the HCP's clinical and care operating model at a locality level whilst driving productivity and efficiency through transformational change.

It should be noted that the Finance & Commissioning Committee and Quality & Safety Committee governance structure will continue during the transition period. In order to remove any duplication, PAHT and HCP colleagues will review this structure regularly to understand where/if this structure can, or should be, merged with existing PAHT governance structures.

Lead provider Update

PAHT still aim to move to Lead Provider status for Adult Community Services across West Essex during Q1 25/26. The initial aim to achieve this status by 1st April 2025 has been delayed due to the requirement to novate the EPUT contract from the ICB to PAHT.

Points to note and on-going actions to move to Lead Provider status:

- Following discussions with the Procurement Hub, PAHT do have a route to market for the EPUT contract to be transferred to PAHT. It is likely this will be through a Direct Award arrangement.
- PAHT have received independent legal advice pertaining specifically to Lead Provider status. This includes any impact on our long term aim of becoming an Integrated Care Organisation which is very positive.
- Financial and contractual due-diligence is planned to start from 25th March 2025 through a PAHT/EPUT DoF to DoF session.
- Governance arrangements are still to be confirmed. A clinical governance workshop has taken place between ICB Clinical Quality Team and PAHT MD, CNO and Director of Clinical Quality. Further workshop to be arranged which will be supported by a draft Lead Provider governance structure and clear roles and responsibilities for the PAHT and ICB MD's and CNO's under the Lead Provider arrangements.
- A transitional governance agreement is currently being outlined and arranged will see PAHT MD and CNO shadowing current ICB Quality Assurance Meetings.
- Further EPUT/PAHT Executive to Executive session to be arranged to discuss principles and ways of working in more detail.

NHSE & ICB Support (both Lead & Host Provider)

Lead Provider

It must also be noted that due to the NHSE/ICB announcement on Thursday 13th March, the ICB support available to PAHT to develop the Lead Provider transition period is no longer clear. It does raise the risk profile for PAHT, although conversations are on-going to ensure PAHT are comfortable with the level of ICB support and access to this support prior to contract transfer.

Host Provider

Based on the current proposed Delegation Framework and the continued accountability of the ICB for all contracts within the Host Provider arrangement, this does not have a great impact on PAHT. This risk will need to be assessed in more detail if the Delegation Framework changes and HWEICB request further levels of delegation to PAHT over 2025/2026.

4.0 Risks

#	Risk	Host	Lead	Risk Type	Mitigation	Proposed timeframe
1	Limited visibility of the current financial schedules for the EPUT contract.		X	Financial	A full financial risk assessment of all delegated services will be undertaken prior to transfer of accountability and appropriate mitigations agreed in writing with HWE ICB	PAHT will require full EPUT financial schedules to undertake this risk assessment.
2	Limited visibility of the current financial schedules for ICB held contracts.	X		Financial	As the ICB will still be accountable for the commissioning of these contracts, the financial risk to PAHT is lower in this case.	We are in discussion with ICB representatives around the timeframe for all other contracts.
3	Existing Scheme of Delegation and Standing Financial Instructions for the host and lead provider do not support the delegated limits required to manage the delegated contracts	X	X	Financial	Following legal advice, the Scheme of Delegation and Standing Financial Instructions for PAHT will need to be amended to make suitable provisions for the move to host and lead provider status	Due for completion in April 2025, with formal approval being sought through April and May Boards/Committees
4	PAHT do not have the internal commissioning expertise or capability to successfully manage the commissioning function required within the lead provider arrangement.		X	Financial/ clinical/ contractual/ operational	PAHT will need to agree how to transfer across or access ICB contracting team who are currently responsible for commissioning all contracts included within the host and lead provider arrangement.	ICB and PAHT negotiations to be scheduled during WB 24th February 2025. Further discussion required in response to the national NHSE and ICB announcement.
5	Pending legal advice, PAHT may not be in a position to transfer accountability for the EPUT contract by 1st April 2025 if we are legally required to novate the contract and inform the market of this intent.		X	Financial/ contractual	PAHT will need to follow legal procurement advice which may delay the transfer date to May/June 2025. However, we may be able to include the EPUT services within the host provider arrangement from 1st April 2025, then move to lead provider status once contract is novated.	Legal advice has confirmed that the EPUT contract will need to be novated and a PSR process will be launched. Contract transfer now being scheduled for Q1/2 2025/26
6	Reputational risk if PAHT fail to deliver effectively and the ability to transform care in the system is compromised.	X	X	Reputational	Effective resource transfer from the ICB, development of PAHT staff, regular reporting against KPI's and strong oversight of performance through clear and concise governance structures.	

7	Insufficient access to appropriate expertise, data and capacity to successfully identify and manage risks related to delegated services may result in delayed or inappropriate responses to clinical quality issues within delegated services.		X	Clinical	PAHT will agree how to transfer across or access ICB contracting team who are currently responsible for commissioning all contracts included within the host and lead provider arrangement. Commissioning Workshop with ICB and PAHT Executives to outline principles of commissioning including assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes. Clinical Scenario Workshop with ICB System Quality Director to aid clarity and confidence over clinical governance and the PAHT clinical accountability	Dates TBC within March 2025
8	Inadequate clarity of how quality and safety issues will be managed during the transition period may result in lack of clarity on clinical responsibility and failure to effectively manage quality and safety issues in a timely manner		X	Clinical	Full clinical quality and safety governance structure and accountability to outlined and agreed with PAHT, EPUT and ICB prior to lead provider accountability transfer.	Clinical governance to be confirmed following Clinical Scenario Workshop and Commissioning Workshop over March 2025

5.0 Recommendation

Considering all risks identified, it is recommended that PAHT move to Host Provider status to commence from 5th May 2025.

Considering all risks identified, it is recommended that PAHT continue to move towards Lead Provider status to commence during Q1/2 2025/2026.

Author: Chloe Atkinson, Head of Strategy & Development, PAHT
Date: 27th March 2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 April 2025

Agenda item:	7.2							
Presented by:	Stephanie Lawton – Chief Operating Officer/Accountable Emergency Officer							
Prepared by:	Claire Aubrey Robson, Charlotte Mogford							
Date prepared:	14th February 2025							
Subject / title:	Emergency Preparedness Resilience Response (EPRR) and Business Continuity Annual Report							
Purpose:	**Approval**	**X**	**Decision**		**Information**		**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	To provide the Board with assurance on compliance against core standards and the areas of further work. To advise the committee there are no significant areas of non-compliance. To outline the process of developing robust Business Continuity Plans and the new Business Continuity Management System To set out the approach for Major Incident preparedness & Training and Exercise							
Recommendation:	To support the EPRR submission of core standards which has been assessed as substantial compliance. Be assured that the Business continuity management programme is now a work in progress							

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:	Operational Cell 19.02.25 and PAF.27.02.25.
Risk / links with the BAF:	BAF Risk 3.1 (Estate and Infrastructure) and 4.1 (Seasonal Pressures)
Legislation, regulatory, equality, diversity and dignity implications:	Civil Contingency Act 2004 Health and Social Care Act 2022 NHS England EPRR Core standards NHS England EPRR Framework 2021 NSH Core Standard Contract
Appendices:	Appendix 1: Core Standards Report 2024

1.0 Purpose/issue

This paper reports on the Trust's emergency preparedness in line with the Civil Contingencies Act (CCA) 2004, the NHS England Emergency Preparedness Framework 2013 and the NHS England annual core standards assurance return.

The paper will cover:

- The trust's emergency preparedness, measured through the 2024 Core standards report
- The business continuity management system (BCMS) cycle and programme
- Testing and exercising
- Major incident preparation of staff, equipment and preparedness

2.0 Background

The CCA 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, whilst continuing with its responsibilities as an acute hospital.

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

3.0 Emergency preparedness and Core Standards report

As an organisation the Trust scored substantially compliant against the 2024 NHS England Core Standards Assurance. The 2024 core standards differed in the level of scrutiny from previous years by requiring evidence and documentation of the self-assessment.

The 2024 'deep dive' focussed on Cyber Security and the response to IT related incidents. The Trust achieved fully compliant, adding to its preparedness for cyber security and IT incidents. A Cyber test and exercise is scheduled for second quarter of 2025.

The core standards report highlighted several areas of improvement with business continuity being the main area of concern. The need for additional staff within the EPRR team was also highlighted during the core standards assurance process.

Appendix 1 shows the breakdown of the substantially compliant areas across the 10 domains which include governance, business continuity (BC) and Cooperation. Overall 57 out of the 62 areas were fully compliant and 5 partially compliant, giving an overall rating of substantially compliant at 91.9%

The scoring for the core standards 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

Following planned changes within the small EPRR team, discussions across the ICS are underway to explore the opportunity of joint roles to support core functions of EPRR and business continuity.

4.0 Business Continuity

The business continuity management process has begun with the development of a 'trust wide' business impact analysis. This is being done through engaging business continuity champions from each department in a series of meetings focuses on a particular aspect of business continuity such as loss of people. The initial meeting took place on Thursday 13th February and saw positive engagement from a range of departments. Once the BIA for the trust has been completed work will begin on writing trust wide business continuity plans for the 5 triggers of business continuity; denial of access to building of part of a building; loss of staff; loss of supplies/services; loss of IT and telephony; and loss of utilities such as water gas electricity.

The divisions are currently working through development of business continuity policies (BCP) and business impact analyses (BIA). Each division will have an up to date BCP and BIA in place in a trust standardised format. Business continuity training is taking place for those departmental business continuity champions, this is being delivered by the ICB. This training will ensure that staff in charge of their departments business continuity plans are fully conversant with the completion, review and testing procedures required.

During 2024, there were a number of business continuity incidents at the Trust such as the Incident in theatres 1 and 2 in August 2024 and the switchboard faults in September 2024. All BC incident had an after-action review with learning and good practices shared and implemented.

5.0 Testing and Exercise

Since the last board report work has been carried out on the testing and exercise programme, however this has been limited due to operational pressures and staffing challenges.

In October 2024, two live tests of the tent erection procedure for CBRNe incidents took place, a full test was not able to take place due to the volume of ambulances and demands on ED services on the particular days. However, the process was recording by the communications team with the aim for this to be used within CBRNe training to demonstrate the procedure. A further live test will be scheduled for summer of 2025.

Over the course of 2024/25 PAHT took part in eight test and exercises both internally and externally with ICB and regional partners, these included a fire and evacuation major incident and a Multi-Agency MTA exercise.

Looking forward, the testing and exercise plan for 2025/26 has been developed and includes a cyber security exercises and mass casualty. The first exercise took place on the 6th February 2025, covering Alex Health downtime procedures.

6.0 Major Incident preparation of staff equipment and preparedness

The trust's major incident policy was due for review in 2024, however due to the size of the review and update required to bring it in line with current legislation and procedures, this will now be completed by April 2025.

There were no major incidents to report, however there was two critical incidents, one being the ITU Pendant incident in March and the other being the burst pipe in the CSS plant room in May.

Throughout 2024, PAHT collaborated with the Hertfordshire Local Health Resilience Partnership (LHRP) to ensure system wide health resilience and planning, providing strategic direction for Health EPRR in Hertfordshire. The ICB have represented PAHT at the Essex LHRP.

In relation to major incident equipment, 2024 saw the completion of the new major incident equipment building. All equipment has been transferred over, however, the building requires power supply to enable an ambient temperature complying with the manufacturer's recommendation for all the major/critical incident and CBRNE equipment, and prevent condensation and mould within the store. Currently the completion date for the supply of power to the major incident store is being finalised. m

7.0 Training

This year has been a successful year for EPRR training with a range of training courses being attended by the EPRR team as well as wider PAHT staff.

Following the commencement of the Trust's CBRNe training in February 2023, 125 members of staff have now been trained in the erection and use of the Hazmat decontamination tent, donning and doffing a Hazmat PRPS suit and the processes in the management of a CBRNe incident.

95% of Gold and Silver on-call staff have attended ICB and NHS England strategic and tactical commander training, to develop their knowledge and skills in effectively managing major, critical or business continuity incidents.

There has been a significant increase in the number of PAHT staff who have undertaken ICB loggist training, as of 2024 we now have 11 trained staff who should an incident occur can undertake loggist duties.

In order to develop the training provided at PAHT, the EPRR team are exploring the possibility of facilitating HMIMMS training. This training is the leading course for hospital staff responsible for planning, training and managing aspects of incidents. The provision of this course is subject to funding.

8.0 Recommendation

The board considers the 2024 Core standards return prior to 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 & Charlotte Mogford
Date: 14th February 2025

The Princess Alexandra Hospital NHS Trust

APPENDIX 1 – core standards report PAHTT 2024 - Substantially Compliant

Core Standards Report PAHTT 2024

See separate appendix A documentation.

PAH Core standards

Domain:	Fully Compliant	Partially Compliant	Non Compliant
Governance	6		
Duty to risk assess	2		
Duty to maintain plans	10	1	
Command and Control	2		
Decision Making (Training and exercing)	4		
Response	7		
Warning and Informing	4		
Cooperation	4		
Business Continuity	7	3	
CBRN	11	1	
	57	5	0

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board – 3 April 2025**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Executive Board (EB)**			
REPORT FROM:	**Committee Chair –Thom Lafferty**			
DATE OF COMMITTEE MEETING:	**11 March 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 CEO Strategic update	Y	Y	N	Progress towards the Trust becoming a host provider of adult community services continues. As part of the host provider arrangements PAHT will also take on an additional role as a lead provider for Adult Community Services for west Essex with further delegation through a lead provider arrangement. A discussion took place on mental health services at the front door; further work is underway to explore this.
2.2 Quality Account	Y	N	N	The Executive Board approved the Quality Account priorities for 2025/26.
3.1 Staff Survey	Y	Y	Y (divisions)	EB agreed that the divisional directors would review the free text data and to discuss the results with their divisions. An update will be provided to next month's Executive Board
3.2 Fit & Proper Persons – Annual Review & Submission	Y			An update was noted by Executive Board. The review process is underway and an update will be presented to People Committee in March 2025.
3.3 Appraisals	Y	N	N	A new e-form appraisal form is being developed for 2025/26 to reduce the number of pages following feedback received from last year. From 2025/26 appraisals will be on a rolling 12 month process and the cascade format will be abolished

3.4 EDI Report	Y			Report noted by Executive Board. EB requested an evaluation be included in the report on how the trust is performing in terms of EDI.
3.5 Senior Leaders Forum	Y	N	N	The first Senior Leaders Forum will be held on the 1st April, The Executive Board approved the objectives of the Senior Leaders Forum.
4.1 Performance	Y			As at 11th March the ED standard YTD was 64%. The trust continues to push towards achieving the 70% nationally agreed 4hr target by the 31st March 2025. Other areas of performance were discussed and further monitoring will take place at the newly established Operational Board.
4.3 Data Security Protection & Toolkit	Y	N	N	Executive Board approved the four Data Security Protection Toolkit (DSPT) 24/25 outcomes. Information Governance report submitted for information and noted by Executive Board.
4.2 Corporate Risk Register	Y	N	N	Risks submitted to Executive Board reviewed and agreed for inclusion in the CRR report to Trust Board.
6.2 Finance Update	Y	N	N	Delivery of the agreed financial position for 2024/25 was noted. PQP delivery was discussed and the latest position in relation to the Trust's operating plan was noted.
7.1 Feeder Reports	Y	N	N	All feeder reports noted and no escalations to Executive Board.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board 3 April 2025**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Committee Chair- Helen Howe**			
DATE OF COMMITTEE MEETING:	**18 March 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Recipient Stories	-	-	-	The Committee heard from the facilitator and recipient of the charity funded CBT programme for menopause and breast cancer patients. The recipient stated: *"The programme had helped to improve her symptoms of the menopause and she found the programme positive and looked forward to attending sessions."* CFC commended the programme noting the positive feedback.
2.1 Stroke Legacy Fund Request	-	-	Yes (CFIO/CC)	The request for funds was to purchase equipment to support early rehabilitation of patients with neurological, frailty, dementia, motor sensory and long term conditions. The requested funds totalled £63,423.50. Delegated authority was granted to the Committee Chair and the CFIO for approval of the request subject to answering further questions from members.
2.2 Dementia Garden Request for Funding	-	-	Yes (Capital Working Group)	A request for additional funding was considered following the requirement to relocate the sensory garden; the development of the Garden of Reflection had been temporarily paused. The Committee did not approve the additional request for funds, the works would proceed with the two gardens already in progress (sensory and staff). It was agreed the request for additional funding would be considered at Capital Working Group as part of the 2025/26 capital plan.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board 3 April 2025**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Committee Chair- Helen Howe**			
DATE OF COMMITTEE MEETING:	**18 March 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Charity Update including Charitable Funds Strategy Update	Y	Y	N	An update was received on charitable activities to date including; corporate partner activities, community supporters, legacy donations and the planned approach to measure return on investment. Feedback was received in regards to the Volunteers Christmas Lunch noting the volunteers had enjoyed their time and appreciated the support from the charity. In regards to the strategy; progress to date was noted. Next steps were discussed and updates and changes would be discussed at the upcoming strategy meeting in April.
2.4 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; Spice and Sparkle 16th May 2025 and the Christmas Party 6 December 2025. Risk assessments are now being completed for proposed events.
3.1 Charitable Funds Finance Report	Y	N	N	The total fund balance at M09 was £819k. The total income received at M09 was £614k against an expenditure of £538k.