The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 5 June 2025 at 10.00 – 12.45
Venue: Kao Park Boardroom, Kao Park, Harlow

	Item	Subject	Action	Lead	
01 Opening administration					
10.00	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	17
10.05		**Patient Story: Falls – reducing the risks**			
02 Chair and Chief Executive's reports					
10.30	2.1	Acting Chair's Report	Inform	Acting Chair	18
10.35	2.2	CEO's Report	Inform	Chief Executive	22
10.45		*Opportunity for members of the public to ask questions about the board discussions or have a question answered*			
03 Risk					
10.50	3.1	Corporate Risk Register	Approve	Medical Director	26
10.55	3.2	Board Assurance Framework 2025-26 *Diligent Resources: BAF 2025-26*	Review/ Approve	Director of Corporate Governance	31
04 Patients					
11.00	4.1	Reports from Quality and Safety Committee 30.05.25 • Part I • Part II	Assure/Approve	Committee Chairs	39 46
11.10	4.2	Maternity Reports: • Maternity Patient Safety Incidents (MPSIs)	Assure	Chief Nurse/ Director of Midwifery	49
11.20	4.3	Nursing, Midwifery and Care Staff Levels	Assure	Chief Nurse	54
11.25	4.4	Learning from Deaths (Mortality) Report	Assure	Medical Director	70
		BREAK 11.35 – 11.45			
05 People					
11.45	5.1	Report from People Committee 23.05.25 including Terms of Reference	Assure	Committee Chair	76

11.50	5.2	People Strategy	Approve	Chief People Officer	84
12.00	5.3	Fit and Proper Persons Annual Submission	Inform	Chief People Officer	Verbal
06 Performance/Pounds/Places					
12.10	6.1	Report from Performance and Finance Committee 29.05.25 including Terms of Reference	Assure	Chair of Committee	104
12.15	6.2	M1 Finance Update	Assure	Chief Finance & Infrastruture Officer	120
12.25	6.4	Integrated Performance Report (IPR)	Discuss	Chief Information Officer	128
07 Strategy/Governance					
	7.1	Report from Audit Committee Meeting held on 6 May 2025	Assure	Chair of Committee	142
	7.2	Report from West Essex Health and Care Partnership Board held on 15 May 2025 including Terms of Reference	Assure/Approve	Chair of Committee	145
	7.3	Report from Executive Board Meeting held on 20 May 2025	Assure	Chair of Committee	156
12.35		*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: 3 July 2025

The Princess Alexandra Hospital NHS Trust

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

Board Membership and Attendance 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 3 April 2025 from 09.30 to 12:45

Present:	
Darshana Bawa	**Acting Trust Chair (ATC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Liz Baker	Non-Executive Director (NED-LB)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO)
Fay Gilder	Medical Director (MD)
Phil Holland (non-voting)	Chief Information Officer (CIO)
Parag Jasani (non-voting)	Associate Non-Executive Director (ANED-PJ)
Bola Johnson (non-voting)	NExT Non-Executive Director (NNED-BJ)
Thom Lafferty	Chief Executive Officer (CEO)
Giovanna Leeks (non-voting)	Interim Chief People Officer (I-CPO)
Sharon McNally	Chief Nurse (CN)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Chief Clinical Transformation Officer (CTO)
Michael Meredith (non-voting)	Chief Strategy Officer (CSO)
Ben Molyneux (non-voting)	Associate Non-Executive Director (ANED-BM)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Camelia Melody	Deputy Chief Operating Officer (DCOO)
Hannah Winter (Staff Story)	Consultant Oncoplastic Breast Surgeon (HW)
Linda Machakaire (item 4.2)	Director of Midwifery (DoM)
Observing:	
Hannah Hobbs	Senior Communications Officer (SCO)
Ann Nutt	Chair of Patient Panel (CoPP)
Sam Gooden	Interim Deputy Chief People Officer (I-DCPO)
Beth Potton	Deputy Director of Finance (DDoF)
Freya Cannon	NHS Graduate Scheme (FC)
Members of the Public	
Ian Child	Procurement & Performance Director - Liaison
Matt Sweeting	Mid & South Essex NHS Foundation Trust
Russell Edwards	Commercial Director - The Surgical Consortium
Apologies:	
Stephanie Lawton	Chief Operating Officer (COO)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
Ralph Coulbeck (non-voting)	Associate Non-Executive Director (ANED-RC)
Secretariat:	
Heather Schultz	Director of Corporate Governance (DCG)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Acting Trust Chair (ATC) welcomed everyone 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 of 06.03.25 with no amendments.
1.4 Matters Arising and Action Log	
1.5	It was noted that most actions were proposed for closure.
1.6	At this point the CEO highlighted that at the People Committee earlier that week there had been a discussion on both the Gender Pay Gap and Ethnicity Pay Gap reports, both of which had associated actions on the Board action log. His view was that a broarder more holistic plan was needed in terms of tackling discrimination in and out of the organisation, and to link the data with the narrative. The plan therefore was to do a deep dive for a future People Committee to provide clear plans on both.
ACTION **TB1.03.04.25/01**	**People Committee to receive a deep dive into the action plans around the Gender Pay Gap and Ethnicity Pay Gap** **Lead: Interim Chief People Officer**
Staff Story: Sexual Safety	
1.7	The Board welcomed Hannah Winter (Consultant Oncoplastic Breast Surgeon) to the meeting (HW). HW would share her own personal experience in relation to the topic and the programme of work underway in the Trust.
1.8	HW informed members that early on in her career, she had experienced unsolicited attention from a senior colleague. Specific details of that experience were not shared for reasons of confidentiality. The aim of the story was to highlight the initiatives that were being put in place in the Trust, for example the Sexual Safety Steering Group, co-chaired by the Interim Deputy Chief People Officer (I-DCPO) and HW. The remit of this group included workstreams focusing on wellbeing, reporting and training to establish a PAHT framework to support all staff.
1.9	HW began her presentation with the following data from the 'Sexism in Medicine Report 2021' – a survey of nearly 2500 UK NHS doctors: • 91% female doctors described experiencing some form of sexism. • 56% unwanted verbal conduct. • 31% unwanted physical conduct. • 42% felt unable to report it.
1.10	HW then talked members through what PAHT was doing in terms of the sexual safety of its people. This included: • Reporting: Freedom to Speak Up Guardians, 'Tell Alexandra' (anonymous reporting), People Team and reporting via Datix. • Training: On-line eLearning, F2F training, external training for members of the working group. • Support and Wellbeing: 'Here for You' service, Medical Education pastoral team, Sexual Safety Ally and support packages. • Internal communications campaign launched in December 2024 – 'We say no to being made to feel uncomfortable'.
1.11	HW continued there were some barriers to success in terms of the above. The uptake of eLearning was not where it should be and consideration may need to be given to making training mandatory.
1.12	As a final point, HW informed members that through her own lived experience, the changes outlined above would lead to significant improvements in 1) Safety through reporting 2) Confidence in the process 3) Open and transparent dialogue 4) Victims being heard and signposted to support 5) A significant culture change and 6) Zero tolerance of sexual misconduct.
1.13	In response to the above the MD highlighted the need to support the workforce as a whole and reassure the organisation that cases would be taken very seriously and colleagues listened to.
1.14	Non-Executive Director George Wood (NED-GW) then commented that he would encourage sanctions for this type of behaviour to be stricter. He would very much welcome any training in this area becoming mandatory.

1.15	The CEO then thanked HW for her bravery and acknowledged sexual safety was a real issue for the NHS as a whole. He fully supported all the next steps talked about by HW, including making training mandatory. He agreed with NED-GW in that the organisation needed to take action and eliminate any potential differentiation based on seniority in terms of how cases were handled.
1.16	NED Liz Baker (NED-LB) thanked HW for sharing her story and commented that she too supported the notion of making training mandatory. Her view was that a big barrier was language, and people feeling able to talk about this in an open and transparent way. This also linked to the 'Incivility Costs Lives' initiative and that ultimately, sexual harassment could impact on performance and quality of care. HW responded that data was available in terms of how sexual safety impacted on patient safety.
1.17	In relation to how different levels of colleagues were treated, the MD commented that when managing individuals with concerning behaviours, the Equality Act was a very useful tool in terms of decision-making for the employer. As reassurance she confirmed that senior colleagues were treated no differently to junior colleagues at PAHT in terms of sanctions.
1.18	The CN then commended the leadership here of the Interim Deputy Chief People Officer (I-DCPO). As CN she was the Trust lead for safeguarding and as of 01.04.25. she had taken on executive stewardship for Freedom to Speak Up (FTSU). She reassured the Board that if safeguarding concerns were triggered, the ensuing process was really clear and robust in terms of both the investigation and possible outcome/s.
1.19	At this point the I-CPO thanked members for the conversation. She provided further assurance that in the previous 12 months colleagues had been monitoring the data and efforts to change the culture, at least at PAHT would continue alongside efforts to influence the national position via the ICB.
1.20	Associate NED Ben Molyneux (ANED-BM) then commended the work so far. In terms of training, his view was this was relevant to all staff, not just female staff but was a tool and not the solution.
1.21	NED Oge Austin-Chukwu (NED-OA) then commented that in her experience, the process could often be protracted, creating stress for oth the victim and alleged perpetrator. She asked how the Trust managed this element. HW acknowledged this was a challenging area given the confidentiality required but she was hoping, through the work-stream, to support communication with both parties whilst at the same maintaining confidentiality.
1.22	The final discussion was around bystander training and supporting colleagues to feel able to speak up when inappropriate behaviours were witnessed.
	The ATC summarised there was clearly more work that needed to be done. Some of this could be via the People Committee (actions and follow-ups). She requested consideration be given to making training on sexual safety mandatory.
ACTION **TB1.03.04.25/02**	**Consideration to be given to making 'Sexual Safety' training mandatory.** **Lead: People Committee**
02 Chair and Chief Executive's Reports	
2.1 Acting Chair's Report	
2.1	This item was presented by the Acting Trust Chair (ATC) and was a verbal update. The ATC informed members that one of her responsibilities as Chair was to shape the culture of the organisation. Culture was a theme that ran through several of the papers that day, including the Staff Story presented above. Shaping that culture had to begin with the organisation's leader and relationships was a key element of that. It was critical that relationships were developed, nurtured and maintained so that trust was built amongst colleagues.
2.2	This encompassed staff engagement and getting staff to engage so that the organisation's culture could be cascaded downwards. Relationships also included those with patients and those with partners and she would encourage colleagues to reflect on that as part of the transformation piece and in terms of the taking the organisation along that journey.
2.3	As a final comment the ATC acknowledged the work done by the previous Chair to drive the organisation's culture forward and re-affirmed the Board's responsibility in relation to leading improvements in culture.

2.2 CEO's Report	
2.4	The CEO presented his update. He welcomed the ATC to her first meeting as Chair and thanked the previous Chair for her huge contribution to the organisation. New Associate Non-Executive Directors Parag Jasani (ANED-PJ) and Ben Molyneux (ANED-BM) were also welcomed.
2.5	The CEO updated on the following key areas: **Government Announcement:** There had been an announcement on 13.03.25 that due to the need to rebalance national budgets from health to defence, there would be a need for the NHS to improve its financial position. As a result the following key changes had been announced: 1) NHS England (NHSE), would be formally incorporated into the Department of Health & Social Care (DHSC) and thereby cease to exist as a standalone authority 2) Integrated Care Boards (ICBs) would continue to exist but would need to reduce current resources by 50% 3) NHS provider organisations must seek to reduce growth in non-clinical costs by 50%, against pre-pandemic levels 4) Other system-wide infrastructure would also be reviewed in the context of the need to deliver efficiencies (e.g. Acute Provider Collaboratives, Clinical Networks). The CEO stated that it would be key to get on the front foot and embrace the changes to design the destiny of West Essex. He would encourage members to support this proactive approach.
2.6	NED George Wood (NED-GW) asked whether the proposed £20m investment for Harlow had been clarified in terms of associated health facilities. The CEO responded that the specifics were yet to be confirmed .
2.7	NED-LB then asked, given the reductions to be made, particularly in the ICB, would additional responsibilities then move towards acute providers and where would the accountability lie in the future. The CEO responded that more guidance was to come in terms of the mechanics but he had heard messages about the devolvement of functions (procurement, transformation, strategy) to place.
2.8	In response to the above the Chief Strategy Officer (CSO) commented this was the core of the delegation framework as set out in the host/lead provider framework where the Trust took on those commissioning responsibilities. As assurance those conversations were underway and he, along with Executive colleagues, were starting to look at all the functions in the acute, community and ICB and how to reshape those to best manage the business of Place.
2.9	NExT NED Bola Johnson (NNED-BJ) noted that communication would be key in terms of the changes to come - staff would be anxious and she enquired how the changes were being communicated.
2.10	The CEO responded that he agreed with the above and indeed over the last few days in addition to the comms' and videos, he had met face-to-face with staff to talk directly with colleagues and answer any questions. There would always be elements nationally and locally which had the potential to make staff anxious, but the culture he wanted to build going forward was one that embraced the changes.
2.11	NED Colin McCready (NED-CM) then asked if there was a risk with the national changes that local decisions may not be approved or be delayed. The CEO acknowledged this was a risk .
2.12	The ATC summarised that the Board supported the direction of travel but acknowledged the uncertainties for both staff and partners.
2.13	<u>Questions from the Public</u> Matt Sweeting commented that he agreed with everything that had been said above and emphasised the opportunities this change would bring.
03 Risk	
3.1 Corporate Risk Register (CRR)	

3.1	This update was presented by the Medical Director (MD). The paper presented a summary of the risks scoring 15 and above for all services. It was a snapshot taken from the Datix database on 26.02.25 and no further risks had been added to the CRR since then.
3.2	The MD informed members there were three risks currently scoring 20. Two may need to be re-evaluated/rescored. The first related to the emergency access standard and the second to the referral to treatment constitutional standard. Given performance in the first had recently improved, and there were no 52 week waiters, both these risks may need to be re-evaluated/rescored.
3.3	The new risk around the anaesthetic out-of-hours service was then highlighted. This related to insufficient capacity to cover emergencies so a business case was being developed and some bench-marking undertaken in relation to the rota.
3.4	At this point the MD informed members the Chief Finance & Infrastructure Officer (CFIO) had undertaken a piece of work on the Estates-related risks which he had presented at Risk Management Group (RMG). There had been some challenge here and those risks were now be re-evaluated.
3.5	NNED-BJ then commented there were some risks presented in the paper which were outside the organisation's risk appetite and she asked whether those were being reviewed at the RMG. The MD responded that they were and where appropriate, would be then be added to the CRR.
3.6	ANED-PJ then raised a concern around the cancer risks. The Deputy Chief Operating Officer (DCOO) responded that those were now on an improving trajectory following the recent implementation of Alex Health.
3.7	The ATC thanked the MD for her update, noting that the Estates risks were currently under review.
3.2 Board Assurance Framework 24/25	
3.8	This item was presented by the Director of Corporate Governance (DCG). She informed members that the risk scores had not changed that month. However the description of the EHR risk (1.4) had been amended as follows: '*There is a risk to the delivery of safe and high quality* ***caused by the stabilisation of Alex Health post go live'***. She highlighted the year end summary of the risks.
3.9	The Chief Nurse (CN) then added that in terms of triangulation with the above, herself and the MD were reviewing risk 1.1 (clinical outcomes) in terms of Alex Health stabilisation. The scores for both risks were closely aligned.
3.10	In reference to the above NNED-BJ asked how/when it would be clear that Alex Health had stabilised. The Chief Information Officer (CIO) responded there were a number of associated factors, one of which would be the steadiness of reporting; this was the biggest challenge currently. The second would be the establishment of the resource to support Alex Health sustainment going forward. His view was stabilisation would not be achieved for another few months or so. However, a robust governance structure was in place to manage any risks that arose.
3.11	The Chief Clinical Transformation Officer (CCTO) then added that the organisation had been slightly delayed in terms of coming out of stabilisation but work was ongoing in parallel in terms of the sustainment phase and on the benefits realisation. A team was also working in the background to ensure engagement with the system and there was some evidence this was now improving.
3.12	As a final point the interim Chief People Officer (I-CPO) drew members' attention to risk 2.3 (inability to recruit). She updated that the organisation had been successful in reducing its vacancy rate from 20% down to 6% in the last 18 months and a deep dive would now be undertaken into what else could be done to bring that down further. Once that work was concluded the risk score would be reviewed.
3.13	In line with the recommendation, the Board: • Approved the change to the wording of the EHR risk 1.4. • Noted the remaining BAF risk scores and the year-end summary.

Director of Midwifery invited to the table.	
04 Patients	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	Report from Quality & Safety Committee Part I – 28.03.25 The QSC Chair (NED Oge Austin-Chukwu (NED-OA) informed members that the Committee had discussed: • HSMR+, the new risk model being used by Telstra. • 40% of all open incidents (1411) had been open longer than 30 days but divisions had clear trajectories to reduce these. • The Organ Donation Annual Report 23/24 confirmed two consented donors, two actual solid organ donors which had resulted in eight patients receiving a transplant. • Work underway to address the high numbers of PALS, many related to elective activity.
4.2	Report from Quality & Safety Committee Part II - 28.03.25 In the absence of the QSCII Chair, the paper was taken as read. In response to a question from the ATC in relation to the closure of Maternity SIs/PSIIs, it was agreed this would be discussed under item 4.2 below. There were no other questions.
4.2 Maternity Reports	
4.3	Maternity Patient Safety Incidents Report This update was presented by the Director of Midwifery (DoM). She informed members there had been one new maternity PSII (indirect maternal death) declared since the last report in February 2025. One maternity SI had been closed and currently seven investigations were ongoing. Of the seven, two were SIs, four were PSIIs and one case was with MNSI. Incident themes remained the same and it had been confirmed the previous week by the Regional MNSI Lead, that the Trust was not an outlier in terms of its incident themes.
4.4	Maternity Quarterly Assurance Report This update was for the period October to December 2024 and its submission to the Board was a requirement of the Maternity Incentive Scheme (MIS) Year 6. Previous reporting on MIS to the Board had confirmed compliance with nine of the ten MIS safety actions. She was pleased to say that the organisation had just received confirmation that its mitigations in relation to the outstanding action had been considered, and two days previously a letter had been received confirming full compliance with the scheme. Thanks went to the Board for its support and in particular to the two Maternity Safety Champions (NED-OA and the CCTO). The scheme for Year 7 had been published the previous day.
4.5	The DoM continued that the following day the service would be meeting with the regional team in relation to its exit from the Maternity Safety & Support Programme (MSSP). QSCII would receive the request to exit the programme in April.
4.6	In response to the earlier question raised by the ATC in terms of the closure of incidents, the DoM confirmed that some incidents were still going through the Trust's own internal processes so were not yet closed.
4.7	ANED-BM then drew members' attention to table 8 in the paper and the 87 hours of consultant cover against the recommendation for 98. He asked whether this was by design or down to a shortage of workforce. The DoM responded this was on the service's sustainability plan. There was a recognition of the need to work to more resident hours and a target date of November 2025 had been set. The MD added that it was the number of hours associated with an anticipated increase in the number of births, which the Trust did not quite meet. It was not therefore down to understaffing, but was an aspiration for the future
4.8	The CEO then commended the service's achievements in terms of achieiving the MIS Year 6 requirements and the work to be in a position to exit the MSSP. This was huge testament to the team and the safety champions.
4.9	The CTO suggested the Board write to the Maternity Service to thank colleagues for all their hard work which was resulting in better care, under the leadership of the CN and others.
ACTION **TB1.03.04.25/03**	**A Board 'thank you' to be sent to Maternity Services.** **Lead: Board & Committee Secretary**

4.10	The CN then commented that the next critical step would be the exit from the MSSP. A recent '60 Steps to Safety' visit had gone well and a recommendation would be brought to the next Board meeting from QSCII following its review of the exit plan.
4.11	The ATC thanked the DoM for her update and commended the team for their achievements.
4.3 Nursing Midwifery and Care Staff Levels	
4.12	This update was presented by the CN. The key headlines were that there had been a sustained overall registered fill of > 95%. No wards had achieved < 75% overall fill rate in-month, and the increase in overall fill rates was due to enhanced care needs. The next interim establishment review (which underpinned the rota templates) commenced in March 2025.
4.13	The CN continued that the focus now for her was on the Staff Survey results where the theme was that staff were saying there were insufficient staff/resources to do their job properly. Whilst vacancy rates were now significantly lower, the skill-mix in nursing was fragile. As stated the next establishment review was underway and would come back to the Board in due course. The I-CPO added that whilst the workforce perception was that staffing levels weren't right, the paper told a different story.
4.14	NED-LB then commented that the title of the report 'Hard Truths' was hard hitting and whilst the information in the paper provided assurance that the position was positive, it was important that the Board did not become desensitised to the issue and continued to review and scrutinise the information. The CN responded that the Board could take assurance from the report that rota templates were being filled. For her it was about continuing to understand the position and to align that with any red flags and the overarching baseline. If there was a rising activity trend then colleagues would come back with recommendations on the baseline.
4.15	The ATC thanked the CN for her update, from which the Board could take assurance.
4.4 Learning from Deaths Update	
4.16	This update was presented by the MD. She informed members that Telstra had changed its risk model from HSMR to HSMR+. Critically important under the new methodology would be how frailty was accounted for and this had been shared with the coding team. This would be through an aggregation of indicators. The Trust had moved to SNOMED coding with its new Oracle Health solution and she had discussed this with Telstra who in turn had translated it across and confirmed there would be no impact, which was assuring.
4.17	The MD then drew members' attention to figure 3 in the paper and the Trust's very comfortable mortality position, compared to its peers.
4.18	As a final point the MD cautioned that the position in the paper was for November 23 to October 24. The Oracle Health solution had been implemented from November 2024 so there may be some instability over the next three months or so.
4.19	The ATC thanked the MD for her update, from which the Board could take assurance.
Break 11:08 to 11:20	
05 People	
5.1 Report from People Committee (PC) 31.03.25	
5.1	This update was presented by the ATC, as Chair of the PC. She praised the improvement in appraisal rates from 50% to 78% and the lowest staff turnover rates since 2013 at 9.49%.
5.2	The CEO then highlighted from the paper that the vast majority of People metrics were moving in the right direction. He referenced some of the discussions earlier in the meeting in that it was hard to engage with a workforce that was anxious so it was good to see that sickness was reducing and statutory/mandatory training compliance was as 88%. He also highlighted the great work around apprenticeships at PAHT which played into the Trust's role as an anchor institution but also had a positive effect on health inequalities.
5.3	The ATC summarised by noting the improvement in many KPIs, specifically in appraisal rates.

5.2 Staff Survey Update 2024	
5.4	This update was presented by the Interim Chief People Officer (I-CPO). The first point to highlight was the Trust's response rate which had been 49.33%. This was equal to the median response rate of the comparison group (49%) and less than 1% lower than the Trust's 2023 response rate (49.7%). Due to an increase in workforce in 2024 and the lower response rate, there had been an increase of 6.6% of staff engaging with the survey, equating to 275 people. There was now a whole package of engagement being developed to increase the future response rate and this would be presented to a future Board meeting.
5.5	The second point to highlight was around the benchmarking. Compared to the 2023 results, the 2024 results were marginally the same. In terms of the 'net promotor scores' the following were noted: • 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. The aim going forward would be to increase these score so that staff felt more able to recommend PAHT as a place to work or as a place of care. It should be noted here the Trust was not an outlier in terms of these scores and was within the national NHS benchmark.
5.6	In terms of next steps, and through engagement with the senior leadership at PAHT, the below priority areas had been identified: 1. People Promise: Compassionate and inclusive 2. People Promise: We are a team 3. People Promise: We are recognised and rewarded
5.7	NED-GW asked whether the above priorities were in line with the national picture. The I-CPO responded the Trust was completely aligned with the national picture from the Survey review that NHS Employers had undertaken.
5.8	NED-GW then commented it would be helpful to have some data as to why almost 50% of staff had not responded. The I-CPO responded that some colleagues had stated they had nothing to complain about so had not responded. Some had said they had no time. A good proportion of the non-responders were senior medics and delving further into this it had become apparent some had not even seen the Survey. Going forward there would need to be some consideration of protected time and additional face-to-face 'check-ins' as a reminder.
5.9	NED-CM then asked for an explanation of the various coloured arrows in the graph under section five. The ICPO confirmed that the graph showed that the Trust had declined in 5 areas. She confirmed that although there had been a slight Trust decline, it remained in line with its peers.
5.10	NED-CM then asked, in relation to the poor response rate from medics, whether there could be some form of tracking who was actually opening the Survey. The I-CPO responded that this was tracked at divisional and professional level. .
5.11	In response to the above ANED-PJ commented that allowing protected time for clinicians was always helpful. The I-CPO confirmed this had been offered along with assuarcne from the executive team around allowing this, but this had been more productive for nursing colleagues than medical.
5.12	NED-LB asked how the organisation could engage those working across teams, so that everyone felt responsible for the success of PAHT as a whole. The I-CPO responded that the work now would focus on a 'sense of purpose' to create a culture of togetherness.
5.13	The CN then highlighted the improvements in response rate from Estate & Facilities, UEC and also Medicine. What the different professional groups were saying would also be a focus going forward.
5.14	NNED-BJ then commented that in terms of engagement, what would be key would be the communication back to colleagues following their response to the Survey. As assurance the I-CPO confirmed that colleagues would be working with the divisions during May to create an action tracker which would be delivered back to the organisation.

5.15	The CEO then highlighted that to him it appeared there was some intra-hospital fragmentation from some of the responses he had seen; He said ,in addition to specific actions, there would be three or four key interventions that the majority of staff would feel made a difference. In addition, and in relation to staff not responding (not just medics), he hoped that under the new Director of Communications, the barriers to engagement would be removed.
5.16	The ATC summarised by stating that the improvements were noted, but there was still some work to be done. It would be key to listen to, and act, on those who had responded and also to understand the reasons for non-response.
5.3 EDI Annual Report 2023-24	
5.17	The I-CPO informed members this was a retrospective report. It was compliant with national requirements and provided assurance that the Trust was meeting its statutory duties under the Equality Act 2010. The report outlined the progress made towards delivering the Trust's annual equality objectives, provides a snapshot of staff diversity data as at 31.03.24 and highlighted the breadth of equality, diversity and inclusion activity taking place across the organisation.
5.18	In terms of the 11 actions noted in the paper, these had been matched to objectives and progress now in some areas was much more advanced. The actions were part of a bigger EDI plan which also incorporated actions from the Gender Pay Gap Report.
5.19	NED-CM flagged the low response rate for colleagues disclosing their sexuality, and asked whether this had now improved. The I-CPO confirmed a campaign had been started to encourage people to disclose this and providing assurance they would not be named. The CFIO had taken over as the Chair of the REACH Network and there was currently a lot of good work going on in this area. The CFIO added this was always a challenging area and from the first few meetings he had attended it was clear there was still stigma attached to declaring ones sexuality. He hoped the campaign would support improvements in this area.
5.20	The ATC thanked the I-CPO for her update and in line with the recommendation the Board: • Noted the contents of the report. • Approved the report for publication in line with national requirements.
06 Performance/Pounds/Places	
6.1 Report from Performance & Finance Committee (PAF) 27.03.25	
6.1	This update was presented by NED-CM as Chair of PAF. He informed members that PAF had endorsed the governance structure around the lead/host provider set-up. There had been a detailed discussion on the estates risks and a verbal update on Ophthalmology progress. Some additional detail was required here in terms of triangulating performance with the financials. The recent improvements in performance against the ED four hour standard were commended along with news that the full PQP target for the year would be achieved.
6.2	The CTO flagged that the delivery of the PQP target should be noted given the challenges faced that year. This had been supported by divisional leaders working together.
6.3	The ATC thanked the CTO for his update.
6.2 M11 Finance Update	
6.4	This update was presented by the CFIO. He confirmed the organisation would achieve its financial target for the2024/25 year, and this had mainly been driven by PQP performance, for which his thanks went to the divisional teams, the CCTO and his team and also the Finance team.
6.5	NED-CM acknowledged the huge achievement in terms of the finances.
6.6	The ATC summarised by commending the hard work of colleagues to achieve the financial outturn, noting also the hard work in relation to PQP delivery.
6.3 Operational Plan 25/26	

6.7	This item was presented by the CFIO. He informed members that PAF had seen a version of the paper under discussion that day because work had still been in flight. The system would be submitting a balanced plan for 25/26 and organisations had been encouraged to flag any delivery risks. Members would be aware the Trust required non-recurrent support every year but this had been recognised a lot earlier now in the process. Some of this had been translated into the first cut of the plan (£24m) but had still left a deficit (as a provider). As the organisation moved to lead/host provider there would be many more opportunities to deliver more efficiencies at Place, but plans would need to be developed for these.
6.8	The CEO then thanked the CFIO and previous CEO for their work in terms of the work they had undertaken to demonstrate the Trust's structural deficit and the settlements achived in the previous and current years. This had enabled the Trust to meet its financial target for 24/25 and to declare a forecast break-even for 25/26 – a significant improvement on the positions historically.
6.9	In response to the above NED-GW asked about repayment of the deficit. The CFIO responded this had not been clarified, and would be excluded from financial plans.
6.10	In response to a question from ANED-PJ, the CFIO responded it was positive the ERF cap had been lifted, but there was no additional funding for it.
6.11	The ATC thanked the CFIO for his update. She acknowledged the forecast break-even position and thanked colleagues for their work to achieve this. There were some risks however including the potential to repay the deficit.
6.4 M11 Integrated Performance Report (IPR)	
6.12	This update was presented by the CIO. He highlighted that access to data was currently a challenge following the recent Alex Health implementation. The Information/BI team were having to make some difficult decisions in terms of prioritising requests. There had been an Executive conversation around this the previous day in terms of the short-term mitigations but it was currently a real pressure in the organisation. The Information/BI team was being supported in terms of decision-making but they were under pressure.
6.13	The CIO reminded members that the full IPR went to the Board Sub-Committees each month. Highlights that month were that falls were in common cause variation following the impact of the Falls Strategy and there had been an improvement in appraisal compliance. The key point to note was in relation to the urgent care pathway where improvements in performance had been seen for the last four months and performance was now the best it had been since January 2022 (67%). This correlated with the performance on the non-admitted pathway, Paediatric ED performance, ambulance handover and 12 hour ED waits.
6.14	The DCOO added that ED performance should be taken in the context of the recent Alex Health go-live and a challenging winter.
6.15	The ATC thanked the CIO for his paper, on which the Board could take assurance.
07 STRATEGY/GOVERNANCE	
7.1 Host/Lead Provider Framework	
7.1	This item was presented by the Chief Strategy Officer (CSO) and the paper was taken as read. The CSO reflected that over the last three to four meetings, the importance of Place had really risen to the top of the agenda and the Executive team had talked about the importance of working collaboratively with the system to manage the significant demand there.
7.2	The CSO continued that everyone was in agreement that the way to manage that demand was by working together as a system to better deliver high quality, sustainable care both now, and into the future. A first step on that journey was 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. The focus that day would be on the host provider element. It was hoped this would come into play by May, with the lead provider role following by the end of Q1 or the beginning of Q2.
7.3	The CSO then highlighted that the recommendation that day, endorsed previously by PAF and QSC, was for the Board to 1) Approve taking the role of host provider for West Essex

	Place, pending approval by ICB Board, from May 2025 and 2) To agree the lead provider requirements based on the current position.
7.4	As previously discussed the recommendation was that the HCP Board would become a sub-committee of the PAHT Board which would be a significant change. In the first instance there would be 'shadow' running of the existing governance structures, with a recommendation to review the governance structures to eliminate duplication. Legal advice had been taken which supported this and the thinking to date was based heavily on work undertaken previously by West Herts Hospital.
7.5	The Medical Director (MD) then commented her view was this was the right thing to do and both PAF/QSC had reviewed the delegation framework. Her question however went back to something which had been alluded to by many previously i.e. the support the Trust would require in terms of commissioning expertise. She also drew members' attention to risk 7 in the paper '*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'*. She asked for more detail in the context of the ICB cost reductions.
7.6	The CSO responded that he had been in conversation with the ICB and, as the PAHT CEO had previously alluded to, there were some opportunities to bring core functions together to make savings and enable delivery. As assurance he confirmed colleagues were currently working very closely with the ICB on this.
7.7	Non-Executive Director Liz Baker (NED-LB) commented she recognised the huge amount of change that was happening very quickly and thanked colleagues for their engagement. She asked whether there were any stakeholder groups or individuals that had not yet been spoken with. The CSO responded he believed there had been wide engagement to date. The PAHT CEO had undertaken significant engagement over recent weeks including with the HCP Board. There was always a risk when change happened at pace and for him it would be key to ensure the organisation clearly understood the opportunities this presented for service transformation. This work had already begun in terms of the re-design of the clinical strategies and the next step would be to work with the system on this.
7.8	NED George Wood (NED-GW) then commended the work and asked what this meant in terms of patients being 'connected' and health records being shared. The Chief Information Officer (CIO) responded this was a significant opportunity in terms of the single patient record. Both EPUT and MSE would be procuring the same Oracle Health solution as PAHT and colleagues were starting to discuss the opportunities this would present not just in terms of sharing information but in terms of working as one single integrated team. The Patient Portal would go-live in June which would also bring opportunities in terms of that full holistic view.
7.9	The CEO then commented there were a myriad of technical complexities to work through but ultimately it would be amazing to have one single patient record for acute, community and mental health care provision in the majority of Essex. He acknowledged there were some challenges and further work would be required given the likely reconfiguration of ICS boundaries. Otherwise to date there had been good engagement in the work from primary care, mental health partners and EPUT. Once the HCP Board became a sub-committee of the PAHT Board it would only meet every other month. His view was more frequent conversations would be required so he had therefore invited EPUT and Primary Care to join the Trust's Executive Board to further shape the decision-making.
7.10	At this point Associate NED Ben Molyneux (ANED-BM) acknowledged he was new to the table but it would be helpful to come back on the 'so what' and the opportunities available and how colleagues/partners intended to achieve those opportunities over time. In addition, with the move to an ACO there was the risk of a postcode lottery so he would like to know more about how partners intended to maintain relationships with the wider population, not just the core.
7.11	The CSO responded that had been one of the key questions at the HCP Board, particularly amongst those who did not refer into PAHT. There had been some real challenge here including a focus on the wider Hertfordshire population and bringing in that cohort of patients

	too. There had been some engagement from the PCN and colleagues were very cognisant of those issues. There were currently no solutions but the concerns had been noted.
7.12	At this point the ATC thanked members for a good discussion and the Board: • Approve taking the role of host provider for West Essex Place, pending approval by ICB Board, from May 2025. • Agreed the lead provider requirements based on the current position.
7.2 Annual Report EPRR	
7.13	This update was presented by the Deputy Chief Operating Officer (DCOO). The paper aimed to provide the Board with assurance on compliance against core standards and the areas of further work. There were no significant areas of non-compliance.
7.14	In line with the recommendation, the Board: • Supported the EPRR submission of core standards which had been assessed as substantial compliance. • Was assured that the Business Continuity Management Programme was now a work in progress.
12:33 Matt Sweeting left the meeting.	
7.3 Report from Executive Board Meeting	
7.15	This item was presented by the CEO and members noted the items that had been discussed at the Executive Board on 11.03.25. Members had no comments.
7.4 Corporate Trustee: Report from Charitable Funds Committee	
7.16	This update was presented by the CFIO. He informed members the Charity team now had a full complement which it had not done in a long time. He was pleased to update the Committee had heard from the recipient of the charity funded CBT programme for menopause and breast cancer patients which had been very powerful.
7.17	At this point NED-GW referenced the earlier Staff Story related to sexual safety and asked whether there was anything the charity could do to support this work. The CFIO responded a charity engagement/strategy session was scheduled for 10.04.25 and he would be happy to bring that up there.
ACTION **TB1.03.04.25/04**	**Discussion to be held at Charity engagement/strategy session on 10.04.25 around the charity funding the work around sexual safety.** **Lead: Chief Finance & Infrastructure Officer**
7.5 Questions from the Public	
7.18	There were no questions from members of the public.
08 CLOSING ADMINISTRATION	
8.1 Any Unresolved Issues?	
8.1	There were no unresolved issues.
8.2 Review of Board Charter	
8.2	It was agreed that the Board had adhered to its charter.
8.3 Summary of Actions and Decisions	
8.3	These are noted in the shaded boxes above.
8.4 New Issues/Risks	
8.4	These were noted as: • BI capabilities during the Alex Health stabilisation phase. • ICB risk relating to the national changes outlined in the CEO's report above.
8.5	It was agreed that the CIO would update members on BI in private session.
ACTION **TB1.03.04.25/05**	**Update the Board on BI in private session.** **Lead: Chief Information Officer**
8.5 Any Other Business (AOB)	

8.6	In response to a question from NED-GW it was agreed lead/host provider plans would be shared with External Auditors noting they had been kept updated along the way.
8.6 Reflections on Meeting	
8.7	It was agreed there had been some good discussion. The Chief Nurse (CN) reflected that some of the work led by the previous CEO and then the current CEO since his appointment in November 2024, was now coming to fruition (appropriate funding) and she would leave the meeting feeling very positive in terms of the progress being made on a number of previously challenging metrics.
8.8	The meeting closed at 12:42.

Signed as a correct record of the meeting:	
Date:	01.05.25
Signature:	
Name:	Darshana Bawa
Title:	Acting Trust Chair

ACTION LOG: Trust Board (Public) 05.06.25

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
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
TB1.03.04.25/01	Gender Pay Gap/Ethnicity Pay Gap	People Committee to receive a deep dive into the action plans around the Gender Pay Gap and Ethnicity Pay Gap.	I-CPO	PC.28.07.25	To be undertaken at July PC.	Proposed for closure
TB1.03.04.25/02	Sexual Safety Training	Consideration to be given to making 'Sexual Safety' training mandatory.	People Committee	PC.23.05.25	Paper presented to People Committee on 23.05.25.	Proposed for closure
TB1.03.04/03	Board 'Thank you'	A Board 'thank you' to be sent to Maternity Services.	B&CS	TB1.05.06.25.	Actioned.	Closed
TB1.03.04.25/04	Charity Funding for Sexual Safety	Discussion to be held at Charity engagement/strategy session on 10.04.25 around the charity funding the work around sexual safety.	CFIO	TB1.05.06.25	Verbal update to be provided at TB1.05.06.25.	Open

The Princess Alexandra Hospital NHS Trust

2.1

Trust Board (Public) – 5 June 2025

Agenda item:	2.1
Presented by:	Darshana Bawa, Acting Trust chair
Prepared by:	Darshana Bawa
Date prepared:	29.05.25
Subject / title:	Acting Chair's Report

Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**		
Key issues:	To provide an update on my work and activities to date and evidence accountability for what I do.								
Recommendation:	The Board is asked to discuss and note the report.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				

Previously considered by:	Not applicable
Risk / links with the BAF:	No risks identified.
Legislation, regulatory, equality, diversity and dignity implications:	As the NED Staff & Well-being Champion this continues to guide my work in all areas, along with a broader focus on culture, hence - all aspects of the safety and well-being of our people.
Appendices:	Walkabout / ED Corridor Care Notes.

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

This report outlines what I have been doing in the first two months as Acting Chair.

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

2.0 NED Appraisals:

The NED appraisals have been mostly completed. We have until 30th September to submit these and will ensure that the official paperwork is sent well in good time.

The previous Chair's appraisal was also completed and is due for submission by the end of next month.

You may recall that Anne Wafula Strike has a special brief this year to develop the role of Ambassadors for us, supported by Phillipa Haslehurst our Voluntary Services Manager. This has finally got under way after an initial meeting was held earlier this month, where a role description for the community ambassadors was discussed and agreed. Two potential candidates for the role are under consideration; both are well-known and respected in the Harlow community. We will keep the Board updated as this initiative develops. It is important that this is in sync with other community initiatives so that they complement each other, so thought needs to be given to this.

3.0 System involvement:

I have had several introductory meetings with ICB colleagues as well as briefings from both Jane Halpin and Paul Burstow. I attended the East of England ICB and Provider CEOs and Chairs Event at the end of last month, which provided some insight the changing landscape as well as networking opportunities beyond the HWE ICB. I also attended my first HWE ICB CEO & Chairs meeting last week.

I have started to attend the Patient Panel (PP) meetings to ensure liaison between them and the board.

The PP has submitted an entry for the "Innovative Communication" category of the HSJ Awards, following the successful 'Meet your Hospital Leaders' event held in Harlow last month. They are looking to establish a programme of public meetings along similar lines.

4.0 Board visibility:

We are continuing to see high demand for our services and on behalf of all the Board I would like to note our thanks and appreciation for everything our amazing teams do to provide the best possible health care for our local population.

The NEDs continue to do regular visits to our services as well as a monthly visit to our urgent care pathway from each month. The rota for the next 6 months is confirmed and attached. The Chairs Walk round has re-started with a visit to the UTC and SDEC.

I would like to note our thanks to all the staff who take time out of their busy day to host our visits. It provides an invaluable opportunity for us to meet both staff and patients and receive direct feedback, which is reassuring.

I started the Aspiring Chairs Programme in April with the 1st module completed. The programme seems well run and suitably structured.

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

Author: **Darshana Bawa**
Acting Trust Chair

Date: 29.5.25

Title: Trust Board - Chair's and NEDS positive leadership walk rounds & action matrix

The Princess Alexandra Hospital NHS Trust

Team: PAHT Chair and non-executive directors | Updated: May 25

Non-Executive Directors initials:		Key for others
DB: Darshana Bawa (Chair) GW: George Wood (NED) CM: Colin McCready (NED) LB: Liz Baker (NED / SID) OA: Oge Austin-Chukwu (NED)	AWS: Anne Wafula-Strike MBE (Assoc.) RB: Ralph Coulbeck (Assoc.) BJ: Bolanle Johnson (NExT NED) BM: Dr Ben Molyneux (Assoc.) PJ: Dr Parag Jasani (Assoc.)	PP: Patient Panel FTSU: Freedom to Speak Up SHAW: Staff Health & Well-being

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
14/01/2025	DB, LB OA, BJ	Colposcopy	EHR transition focussed on patient safety. Passionate team with work ongoing to optimise productivity.	TBC	03/25	Follow up to explain Board role in safety, advocacy as clinical team wanted to be better informed of this.
10/02/2025	AWS, LB	Discharge lounge	No specific	NA	NA	NA
26/03/2025	DB, OA, HH	UTC/ SDEC	Informative and well supported	NA	NA	NED ED CC visits confirmed as per schedule below.
09/04/2025	OA, HH	ED	Calm , good flow, clear plans.	NA	NA	NA

ED Corridor Care Visits 2025	NED
May	BM (30.5.25)
June	AWS (9.6.25)
July	CM, PJ
August	BJ
September	OA
October	DB, BJ
November	LB
December	RC

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 5 June 2025

Agenda item:	2.2							
Presented by:	Thom Lafferty - CEO							
Prepared by:	Thom Lafferty - CEO							
Date prepared:	21 May 2025							
Subject / title:	Chief Executive Officer's report							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Executive Summary	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:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	N/A
Risk / links with the BAF:	CEO report links with all the BAF risks.
Legislation, regulatory, equality, diversity and dignity implications:	• Regulatory – Board requirement to assure itself of suitable practices and processes in place to minimise the risk to patient safety in relation to long waits for planned care and urgent care • Regulatory – recognition of our inability this year to meet our regulatory requirement to breakeven financially without support • EDI – impact of long waits for planned and urgent care on our different populations and the potential for a disproportionate impact • EDI – ongoing need to ensure that our recovery plans and our PQP plans are quality and equality impact assessed to prevent any unintended consequences or unequal impact on colleagues or patients • EDI – all the developments to our culture are underpinned by a proactive recognition of the need to ensure and to support EDI for all, for example, access to and ability to use digital enhancements (Alex Health)

Appendices:	None

Chief Executive's Report
Trust Board: Part I – 5 June 2025

1.0 Our Patients

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

We have been continuing to progress our work with system and NHS England colleagues to ensure we can maintain safe and effective facilities for our patients and staff. We need significant funding of around £120 million to maintain our estate ahead of the new hospital, with £70m of this above what we would expect to receive over the next 10 years. There is an urgent need for this funding to maintain key services that are deteriorating. Our absolute priority is patient safety and continuing to provide services effectively. You may have seen recent regional and local media coverage as part of our work to raise the profile of this issue.

2.0 Our People

2.1 Celebrating 60 years of caring for our community

We were proud to mark our 60th anniversary on **27 April**, celebrating six decades of dedicated service to the communities of west Essex and east Hertfordshire. Since its official opening on **27 April 1965** by Her Royal Highness Princess Alexandra, The Honourable Lady Ogilvy, the hospital has remained at the heart of healthcare in the region.

We are incredibly proud of our history and, most importantly, our people. Our teams have worked with unwavering dedication, professionalism, and compassion, ensuring that we continue to provide high-quality care to our patients. This significant milestone was not only a chance to reflect on the past but also to look forward with excitement. Our investment in new facilities, digital technology, and the future new hospital means we are well placed to continue providing excellent healthcare services for the next 60 years and beyond.

3.0 Our Operational Performance

Following the national review of tiering, we were designated as a Tier 1 organisation for elective, cancer, and diagnostic recovery in April 2025. Our clinical and operational teams remain committed to meeting monthly improvement targets to support service recovery for our patients. We continue to see strong performance in outpatient care and referral-to-treatment (RTT) standards, with notable progress in reducing the number of patients waiting over 65 weeks—an achievement recognised by regional partners. We have set plans and trajectories to meet 60% of the 18-week RTT standard by the end of March 2026. The Trust successfully met the four-hour urgent care target by the end of March 2025. In addition, consistent performance in ambulance handovers is helping ensure timely care for patients arriving at our facilities. The operational board is now fully established and actively overseeing all delivery plans.

4.0 Places and Partnerships

4.1 Host provider/place update

As previously reported, PAHT has commenced as 'host provider' for the West Essex Health & Care Partnership (HCP) which is in line with the national direction of travel to develop integrated neighbourhood models of health and social care. I am pleased to confirm that the Health and Care Partnership (HCP) Board met this month for the first time as a sub-committee of the PAHT Trust Board. The HCP Board approved a 3 year integrated delivery plan for West Essex incorporating transformation aims and measurable outcomes.

First price increase for parking at local hospital since 2020 to help manage demand and cover costs

We have recently reviewed our car parking tariffs for patients and visitors at The Princess Alexandra Hospital.

The focus is on revising our charges to help manage demand in response to patient and visitor feedback on the availability of car parking spaces and ensure there is a contribution to the costs of maintaining the car parks.
Our existing free parking arrangements will remain in place for Blue Badge Holders, parents/guardians of children admitted overnight, frequent outpatient attendees, and a range of other patients with particular needs.

Full details are available on our website >

5.0 Our Pounds

The Trust has agreed a breakeven plan for the 2025/26 year. The ICS has also submitted a breakeven plan. To deliver the breakeven plan for the year the Trust is required to deliver a PQP target of £26.2m (5.8%).

In Month 1 (April 2025) the Trust achieved its planned financial position of £1.5m deficit and PQP target of £1.7m. Due to the phasing of PQP schemes the target will increase throughout the year and will require continued focus to ensure full delivery by the year end.

Thom Lafferty
Chief executive
June 2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 June 2025

3.1

Agenda item:	3.1							
Presented by:	Fay Gilder, Medical director							
Prepared by:	Lisa Flack – Compliance and clinical effectiveness manager							
Date prepared:	28 May 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 08.05.25 and updated following review by the risk management group. **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 31. **Table 2** details the numbers of risks by category that breach the Trust appetite tolerance. **Section 3** provides a summary of the one risk scoring 20. It is: • Risk id 85 relating to emergency access standard **Section 4** - There are three risks newly scoring 16, these are newly approved risks and one risk previously scored 20.							
Recommendation	• Review and discuss the contents of the corporate risk register • Note new risks scoring 16							
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	√	√	√	√	√			
Previously considered by:	Risk management group 13 March 2025							
	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. This paper reflects risks as they are recorded on the DATIX database on 08.05.25 and following review by the risk management group on 13.05.25.

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 29 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)	8 (6)	0 (0)	0 (0)	**8 (6)**
Corp - Estates & Facilities	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Corp - IM&T	0 (0)	0 (0)	1 (0)	0 (0)	**1 (0)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
CHAWs Child Health	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
CHAWs Women's Health	1 (1)	0 (1)	0 (0)	0 (0)	**1 (2)**
Medicine	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Surgery	2 (2)	2 (3)	0 (0)	0 (0)	**4(5)**
Urgent & Emergency Care	1 (2)	2 (1)	0 (0)	0 (0)	**3 (3)**
Trust wide	0 (0)	10 (8)	1 (3)	0 (0)	**11 (11)**
Totals	**4 (6)**	**26 (23)**	**1 (3)**	**(0)**	**30 (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 tolerance level	Risk Score					Totals
		10	12	15	16	20	
Quality – Safety	≥ 10	18 (20)	66 (59)	8 (8)	19 (20)	2 (3)	**113 (110)**
Quality – Patient Experience	≥ 12		10 (11)	0 (0)	4 (4)	0 (0)	**14 (15)**
Quality – Clinical Effectiveness	≥ 12		9 (11)	1 (1)	6 (5)	0 (0)	**16 (19)**
People	≥ 15			1 (1)	3 (4)	0 (0)	**4 (5)**
Statutory Compliance & Regulation	≥ 12		11 (12)	0 (2)	0 (0)	2 (2)	**13 (16)**
Finance	≥ 12		4 (5)	0 (0)	0 (0)	0 (0)	**4 (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 (2)	7 (6)	0 (0)	1 (1)	0 (1)	**10 (10)**
Systems and Partnerships	≥ 15			0 (0)	1 (1)	0 (0)	**1 (1)**

3.0 Summary of risks scoring 20

There is one risk with a score of 20 on the corporate risk register. A summary of this risk, mitigations and actions is below, information is taken from risk entry and lead:

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: Implementation of Trust wide improvement programme. Estate works taking place to support optimisation of ED clinical space. Implementation of full capacity process, which includes reverse boarding and utilisation of escalation capacity.

4.0 Risks scoring 16 added to the corporate risk register – five

4.1.1 Data quality – NEW risk

- There is a risk that services are unable to make informed decisions, measure compliance, audit, and accurately plan for the future. This is caused by a lack of business intelligence coming out of the new electronic patient record. This could result in poor decision making, financial loss, low morale, lack of knowledge.
  Risk id 717: is a Trust wide risk
  Actions / mitigations: Available data is being utilised. Business intelligence team working to scope limitations and identify actions required to mitigate.

4.1.2 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

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.
Previously scoring 20 this risk has Tier 1 monitoring in place and is on track with its recovery trajectory.

4.1.3 Chemotherapy preparation – NEW risk

- There is a risk that pharmacy will not be able to prepare the required chemotherapy each day to the Williams day unit. That is caused by an increase in demand on the Pharmacy Technical Services Unit (TSU) outweighing the capacity for the current staffing template to safely aseptically prepare compounded chemotherapy. This could result in delays to treatment, cancelled appointments, redirected treatment or omitted treatment, directly affecting patient care
  Risk id 708: Pharmacy clinical effectiveness risk
  Actions / mitigations: Utilisation of external companies to supply. Re-allocation of staff roles, streamlining the process. Vacancies to be recruited to. Training of existing staff.

4.1.4 Emergency Department – NEW risk

- There is a risk of poor patient and staff experience, potential harm to patients and a failure to ensure legal frameworks are complied with that is caused by the implementation of the Right Care Right Person framework, which enables police colleagues to delegate the care and detention responsibilities to PAH following the completion of a multi-agency risk assessment of the patient's presentation.
  Risk id 681: Emergency department safety risk
  Actions / mitigations: Trust guidance and staff training in place. Local collaboration meetings with Essex police. Trust security staff in place to support maintaining safety and security. Mental health liaison team in place.

5 New risks scoring 15 added to the corporate risk register - none

6.0 Recommendation

Trust board is asked to

- Review and discuss the contents of the corporate risk register
- Note new risks scoring 16

Author: Lisa Flack – Compliance and clinical effectiveness manager

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 June 2025

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Director of Corporate Governance
Prepared by:	Heather Schultz – Director of Corporate Governance
Subject / title:	Board Assurance Framework 2025/26

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

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during May 2025. There are two risks that require Board approval: - New BAF risk 1.3 as set out in the attached paper which replaces 3 existing risks, scoring 15 - BAF risk 5.1 (finance), revised for 2025/26, scoring 16 BAF risk 3.2 System Pressures was previously reviewed at STC and is attached for review now by the Board. There are no changes to the risk score. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Approve the new BAF risk 1.3 and the revised finance risk (Risk 5.1) - Review BAF risk 3.2 System Pressures - Note the reaming BAF risks

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

Previously considered by:	QSC, PC, and PAF in May 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 – Risk 1.3, Appendix B – Risk 5.1, Appendix C – Risk 3.2 Appendix D – BAF summary

Board Assurance Framework 2025-26

Purpose

This report provides an update on the BAF risks for June 2025 following a refresh of the risks for the year ahead.

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).

June 2025 review

The risks have been reviewed by executive leads and discussed at committees during May 2025. There are two changes to the risks that require Board approval:

New performance risk: Following a review of the performance BAF risks by the COO and DCG, it is proposed to close the existing risks as reflected on Appendix B and replace them with one overarching performance risk (Appendix A) covering all the elements within the individual risks:

BAF risk 1.3 Operating Plan:
Risk of poor outcomes and patient harm due to inability to deliver the national access standards.

The unmitigated risk score is 5x4=20 and with controls and mitigations applied, the score is 5x3 =15.

The risk will replace the following risks:
• Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment
• 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.
• ED: Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.

Finance risk 5.1: This risk has been updated to reflect the position at the start of the financial year and it is proposed that the risk is scored as a 16.

BAF risk 3.2 System Pressures: This risk was allocated to the Strategic Transformation Committee for review which has been dissolved and is now presented to Board for review. There are no changes to the risk score.

Recommendation:
The Board is asked to:

- Approve the new performance risk (Risk 1.3)
- Approve the revised finance risk (Risk 5.1)
- Review the System Pressures risk (Risk 3.2)
- Note the remaining risks

Author:
Heather Schultz – Director of Corporate Governance

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2024-25**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequities in our local population													
BAF 1.3		Operating Plan: Risk of poor outcomes and patient harm due to inability to deliver the national access standards.	Causes: i)due to increased demand in emergency care and poor flow through inpatient and community capacity ii) Due to infrastructure challenges e.g estates and capacity. iii) Workforce challenges in hard to recruit to specialities v) financial constraints	**5 X 4= 20**	Chief Operating Officer PAF	Controls: Daily reviews of staffing gaps across professional groups Annual planning process that forecasts capacity, workforce and financial impact. Demand & Capacity modelling of pathways including admitted, diagnostics and out patient activity Health & Wellbeing services in place to support staff, communication of services & encouragement to participate. Development of clinical strategies Linking of Quality Improvement and PQP programmes to the strategies, EHR Clinical review of patients on the waiting lists and harm reviews including regular review of the patient tracking list. Work underway to review patient waiting lists to identify patient cohorts suffering any detriment due to ethnicity and impact on health inequalities Host and lead provider opportunities and development of new pathways	3 x a day patient placement meetings Daily waiting list review meetings **Divisional** Review meetings Operational Board Executive Board PAF Fortnightly Tiering Meetings with NHSE ICB and regional meetings	IPR report to PAF Operating plan update to QSC and PAF (bi monthly) Annual operating plan Tiering report to NHSE	**5 x3 = 15**	None identified	None identified.	May-25	**NEW RISK**	**5 x 2 = 10** **March 2026**
			Effects: i) Increased numbers of patients and acuity levels ii) Reduced bed capacity and increased demand on critical services ii) Staff fatigue and reduced resilience iii) Potential for patient harm due to cancellation of elective surgery and protracted waiting times.											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2025-26**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
BAF 5.1		Finance - revenue : Risk that the Trust will fail to meet the financial plan due to the following factors: An annual plan has been set to deliver a breakeven plan inclusive of a CIP requirement of c. £26.2m in 2025/26 and ERF delivery at c. 128% of 2019/20. The plan was proposed at £15m deficit and has only been revised down by additional system support to be delivered through system efficiencies. The ERF funding has been agreed to be a block for 2025/26 linked to delivery of RTT performance by March 2026. Cash will be a challenge in year with non-delivery of the financial plan driving the Trust towards an adverse cash position.	Causes: The main causes of risk are : (i) The current financial regime operates under predominantly 'block contract' arrangements in the main (c. 70% of activity). There is limited capacity for Commissioner contracts to be varied and we do not feel the current allocation recognises the full cost of delivering services e.g. growth in urgent care, coupled with an increasingly challenged primary care offer. Much of our improved financial delivery requires us to maximise the variable elective aspect of our financial plans but we have less certainty in the new regime as to whether this will be guaranteed as has been the case in prior years. (ii) Productivity remains a challenge for the Trust having seen a decrease since Covid. We have agreed to an ambitious Elective work programme for 2025/26 which will deliver c. 128% of the activity delivered in 2019/20. While we are confident of achieving it, our reduced elective capacity compared to peers limits our ability to stretch delivery when non elective pressures remain high. (iii) Financial plans include a requirement to deliver CIPs which remain branded as Patient Quality and Productivity schemes (PQP). PQP programme is identified but delivery will be challenging with a significant element of risk within the current trajectory; there the plans have been modelled against GIRFT opportunity. There remains an unidentified PQP value required creating risk to deliver of the full amount. (iv) The delivery of our financial position requires the support of the ICB / Place to redesign pathways, maximise flow etc. This requires a full disclosure of our collective financial position which to date, there has been no appetite to explore. We are endeavouring to move this forward and believe we have identified our structural deficit but need recognition at system level to tackle these issues. v) We continue to be impaired in respect of overall delivery of activity by the age and condition of the estate. vi) The proposed deficit will lead to us having a cash shortfall in year which we will need to manage; it is not clear yet whether non recurrent support to achieve a breakeven plan is cash backed which will further mitigate some of this risk.	4 X 5= 20	**Exec leads:** DoF **Committee** : Performance and Finance Committee	Key Controls include : (i) Oversight of Directorates and their PQP programmes; the financial position is much better understood by all. We have undertaken a thorough budgeting approach this year and resolved a number of historic budgeting issues to ensure we can better manage the bottom line. (ii) Divisional / Corporate performance review meetings are in place and the emphasis on Performance Review as part of PQP Sessions is being further strengthened. (iii) Vacancy control groups are in place but will attract more scrutiny and oversight; linked to double and triple lock measures that are being mandated nationally. (iv) Oversight of the Trust's financial performance by the EMT, SMT, PAF, People and Audit Committee. (v) Monthly monitoring of financial performance by HWE and NHSE through the submission of financial returns; [potential to move to a more challenging environment e.g. SOF4. (vi) Strengthening of financial control and governance including an improved governance process for business case approval process. The Business Case Group is being refreshed. (vii) The Financial Recovery Programme Board has been instigated at a system level and recovery plans for 2025/26 are being developed that cross-cut at Place and System Level. (viii) Enhanced cash monitoring will be undertaken in year with more granularity on Capital Vs Revenue Cash. (ix) We are still pushing for a system level response to the underlying structural deficits and have set out our challenge via a formal letter to the system and national colleagues. (x) We have implemented a new financial ledger (Oracle SBS) which allows for better self service and oversight of individual positions.	(i) Performance review meetings - monitoring against plan and forecast, including reinvigorated Performance Review Meetings (PRM's). (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) PQP tracking including 'deep dives' by lead NED. (vi) Reductions in run rate evidenced alongside transformation initiatives.	Positive Assurances : (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial assurance rating on internal audit reports. iv) Monthly reports to PAF and IPR reporting v) A bottom up exercise is being undertaken to better understand the cost pressures driving the underlying position within the Trust. vi) The Trust is now more cognisant of the risks around financial delivery and actions are being taken to reduce run rates across all areas. vii) The position is being discussed with commissioners and regulators alike. viii) The system is now moving to a monthly cycle of meetings with NHSE chairing to oversee financial delivery within the Trust.	4x4=16	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning not fully triangulated with finances. (iii) PQP delivery plans established but being refined. (iv) Embedding management of temporary staffing costs and impact on the ground in light of clinical need. (v) We require the system to respond to our challenge to the underlying structural deficit across all healthcare provision within the system; we have not been able to progress this work to date.	**Gaps in Assurance :** (i) Proposed financial regime for oversight to be confirmed (both system level and regional) (ii) Fully triangulated business and operational planning including demand and capacity plans. (iii) Business case benefits development and realisation process. (iv) Focus and prioritisation of finance across the wider gamut of challenges across the Trust. (v) Pace of change of delivery given other cultural challenges.	24/05/2024	**Residual risk score not changed.**	**4 x 3 = 12 (Q4 2025/26)**
			Effects: **(I) Challenges to meet financial control targets, including delivery of our CIP** **(ii) Delivery of revenue position may impact on future capital availability.** **iii) May require additional external support in addition to prescribed system financed initiatives (above).**							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling to be regularised. (iii) Introduction of a PMO. (iv) Review of Governance Manual/SFI's (vi)				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2023-24**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership													
BAF 3.2		**System pressures:** Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	**Causes:** i) High levels of demand in Primary care and Mental health Services ii) Inability for all parts of system to meet demand impacting on PAHT services iii) Unmet demand post Covid iv) Resource constraints in primary care v) Long term sustainability of primary care and mental health services vi) Pressures on social care to meet needs of population vii) Community service and social care package and bed availability	**4 X4= 16**	DoS Strategic Transformation Committee	i) Acute collaboration developing to focus on hard pressed specialties and access to elective surgery ii) Capital investment across the system to support elective activity and CDCs iii) WE HCP Board and increasingly joined up and aligned projects across place ~~iv) HWE ICS oversight~~ ~~v) Local Delivery Board and ICS UEC meetings to support UEC actions and innovations and winter monies~~ iv) PAHT Host provider ararngemtns agreed v) HCP Board strenthened with Herts PCNs vi) Transformation priorities agreed and programmes in place vii) Care closer to home model agreed for community provision viii) System partners invited to Executive Board	Discussions at a range of meetings including: ~~i) STC meetings~~ ii) Trust Board meetings iii) Urgent care programme board iv) PRMs v) Divisional board meetings vi) QSC vii) PAF meetings viii) Local Delivery Board and ICS UEC meetings vii) HCP Board subcommittee of PAHT	i) Minutes and reports from system/partnership meetings/Boards ii) CEO/COO reports to Board (alternate months) and ICS updates	**4 X 4= 16**	i) Primary care under-resourced ii) Workforce plan to be developed to meet demand iii) Uncertainty around Capital allocation in the long term ~~iii) Development of HCP's and governance structure - potential Host Provider framework being discussed.~~ iii) lead provider model not agreed iv) Moving to Greater Essex ICB a potential risk (and opportunity)	~~Lack of clear and well developed place and system plans to fully address the causes and effects~~ i) ICB Boundary changes ii) New Governance framework not yet embedded iii) Place performance dashboard not in place	01/05/2025	**Risk score to remain at 16. Date for achieving target risk score extended to October 2025.**	**4x3=12** **~~December 2024~~** **October 2025**
			Effects: i) Increased demand for emergency services at PAHT with consequent increase in ambulance waits and concerns regarding patient safety in emergency department ii) Increased number of patients not meeting criteria to reside iii) Double running of capacity to meet Covid demand (red ED and IP ward capacity) iv) Patients receiving care in less than optimal settings as a result of lack of flow within and outside of the hospital v) Increased pressure on staff vi) Increased expenditure to meet demand for services											

Board Assurance Framework Summary 2025.26

Risk Ref. Committee	Risk description	Year- end score (Apr 25)	June 25	October 2025	December 2025	February 2026	April 2026		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						↔	12	CN MD
1.3 PAF	Operating Plan: Risk of poor outcomes and patient harm due to inability to deliver the national access standards.		15 New risk						**NEW RISK**	10	COO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15	**Closed (included in new BAF risk 1.3)**							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						↔	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						↔	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						↔	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						↔	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						↔	15	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	**Closed (included in new BAF risk 1.3)**							8	COO
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	20	**Closed (included in new BAF risk 1.3)**							12	COO

Board Assurance Framework Summary 2025.26

	Strategic Objective 5: Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way										
5.1 PAF	Finance - revenue : Risk that the Trust will fail to meet the financial plan due to the following factors: An annual plan has been set to deliver a breakeven plan inclusive of a CIP requirement of c. £26.2m in 2025/26 and ERF delivery at c. 128% of 2019/20. The plan was proposed at £15m deficit and has only been revised down by additional system support to be delivered through system efficiencies. The ERF funding has been agreed to be a block for 2025/26 linked to delivery of RTT performance by March 2026. Cash will be a challenge in year with non-delivery of the financial plan driving the Trust towards an adverse cash position.	12	16						**Revised score of 16 for 2025/26**	12	CFIO

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Reports from Feeder Groups	Y	Y	N	<u>Patient Safety Group (PSG)</u> PSG had received the Annual Legal Services and Annual Patient Safety Report. There had been quarterly performance updates from Surgery and CSS. PSG had noted the challenges in relation to VTE risks assessments since the implementation of Alex Health. An update on temporary escalation spaces (TES) was also provided and QSC requested some additional work to triangulate whether corridor care had contributed to patient harm (such as pressure sores). <u>Vulnerable People Group (VPG)</u> In terms of dementia and delirium PAHT had done well against the national average for length of stay. Learning Disability (Oliver McGowan) eLearning training compliance was slowly improving (32.5% against trajectory of 20%). Accurate compliance data for Safeguarding training now being provide by the divisions and compliance for L3 training now at 75%. Mental Health training provided in conjunction with EPUT now in place. <u>Patient Experience Group (PEG)</u> 197 complaints open, 87 in Surgery & Critical Care, 877 PALS cases open, 500 of those in Surgery & Critical Care.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				PEG had also received a Clinical Support Services deep dive and had discussed the Patient Experience Dashboard. Divisions were being held to account at their review meetings for numbers of open complaints <u>Strategic Learning from Deaths Group (SLfDG)</u> The meeting had not been quorate. The group had noted the April Medical Examiner's Report and Learning from Death Report along with the Femoral Fracture Update. <u>Clinical Effectiveness Group (CEG)</u> CEG had noted an improvement in the number of national quality account audit recommendations. Around 101 pieces of NICE guidance were currently with the divisions for review. In terms of PACE Ward Accreditation, Alex Health was transforming the ability to track and store patient data. The Research & Development Annual Report had been presented.
2.2 Learning from Deaths Update	Y	Y	N	The rolling 12 month HSMR+ position continued to be within 'as expected'. As expected, the Trust had been an outlier for SMR in November 2024 due to the go-live of its new

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				electronic health record and associated reduction in elective activity over that period.
2.3 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 with the expectation that it would reduce to 12 by October one the new electronic health record system was more stable.
2.4 Annual Patient Safety Report	Y	Y	y	The report provided a comprehensive review of patient safety, clinical effectiveness and compliance activities from 01.04.24 to 31.03.25. This included an annual update on the quality and patient safety priorities and an annual oversight of equality, diversity, inclusion, health inequalities and deprivation. QSC noted that the Trust had demonstrated strong performance and oversight in patient safety, clinical effectiveness and governance during 2024/25. Strategic priorities had been largely achieved, with robust systems in place for incident management and clinical audit oversight. There would be a continued focus on procedural compliance, digital integration and addressing health inequalities to support further improvements in 2025/26.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				QSC requested further assurance around progress with NatSSIPs and LocSSIPs (for November) and it was agreed to request People Committee to review data on 'staff on staff' abuse. QSC also requested the People Committee review current resourcing challenges in the People Team.
2.5 Nutrition Strategy 6 Monthly Update	Y	Y	N	Key headlines were: **Staff/Visitor Nutrition:** The tendering process was still underway to ensure the provision of hot food at any time. The restaurant had been awarded a 5 star rating (up from 4) from the Environmental Health Office in March 2025. **Patient Nutrition:** Work was underway to develop a policy for bringing in food from outside. A new inpatient menu was due to launch in September. **Specialist Patient Nutrition:** A divisional business case was being considered for a second Nutrition Nurse, given long length of stay was often related to nutrition. **Sustainable Procurement/Waste Reduction:** The focus remained on managing and reducing food waste including reducing carbon emissions and procurement of seasonal and locally source food. QSC requested a 'thank you' be sent to restaurant colleagues for the achievement of the 5 star rating.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.6 Update from Patient Panel	Y	Y	N	Key headlines were: • 50 responses so far to the survey requested by the Medical Director on Doctors' Communication. • Pharmacy Survey to be carried out at SMH/HEH in the coming weeks. • Patient Panel attendance at a recent public event in the Harlow Council Chambers with presentations from the PAHT CEO/staff on the new hospital, St. Albans elective care hub and Alex Health. • Work underway with the Panel/Pharmacy following recent press coverage on the alarming rates of types 1 and 2 diabetes.
3.1 M1 Integrated Performance Report	Y	Y	N	QSC requested colleagues attend a future meeting to present the new Patient Portal and a deep dive into complaints (including improvement trajectory) is to be included in the Patient Experience update in July.
3.2 Report Against Operating Plan	Y	Y	N	Key headlines included: **62 day standard -** performance for March was 52.2% with April's unvalidated position currently at 49.0% against a trajectory of 65%. Performance remained challenged in urology/lower and upper GI.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				65 week breaches - The Trust continued to successfully reduce the number of 65 week breaches, ending April 2025 on 5 x choice breaches (with 0 x 78+ since November 2024). **52 week breaches -** The Trust ended April on a total of 2403 breaches, equating to 4.7% of the total PTL size and ahead of target by 345 patients, a significant reduction from March. **% of patients over 12 hrs in ED** – In April, the Trust achieved 6% against a trajectory of 7.99%. In May, waits to be seen had risen and consequentially there had been a rise in those over 12 hours. May was currently 7%, which remained ahead of the 7.8% trajectory.
4.1 Draft Quality Account	Y	Y	N	QSC: • Reviewed the draft report and request for all amendments/improvements to be submitted to the paper author. • Endorsed the request for the Trust Board to give delegated authority for sign-off of the final document to the QSC Chair, Chief Nurse & Medical Director who would undertake a review when all of the outstanding information was available during the latter part of June.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.2 Horizon Scanning Update	Y	Y	N	The three key headlines were: **NHS England – Patient Safety Priorities in 2025/26:** NHS England had shared 3 patient safety ambitions for 2025/26 via a Webex in May (link in paper). **Health Services Safety Investigation Body (HSSIB)** had published its report on investigations into mental health inpatients with 2 safety recommendations: • The DHSC should continue to work to ensure recommendations made by national organisations specific to mental health inpatient settings are reviewed, considering the mechanisms that support or hinder implementation. • The Secretary of State for Health and Social Care should direct and oversee the development of a patient safety responsibilities and accountabilities strategy. **NHSE Introduction to patient safety healthcare inequalities framework:** The framework describes the national actions NHSE is taking and sets out future ambitions and opportunities to reduce patient safety healthcare inequalities.

BOARD OF DIRECTORS: **Trust Board 05.06.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 May 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Interim Dashboard Update	Y	Y	N	An update was received on the dashboard and data to January 2025; regional comparators were available for the full-year (2024). Areas of good performance included; bookings under 10 weeks, neonatal deaths and antenatal steroids. Areas for improvement were massive obstetric haemorrhage, obstetric anal sphincter injury rates and stillbirths (notably among Black and Brown women). Data cleansing is ongoing and corrected figures are expected in June. It was highlighted business intelligence support is required for real-time dashboard development. There is a plan to strengthen BI capacity across the Trust.
2.2 Maternity Annual Report	Y	N	N	The report detailed a summary of achievements and ongoing challenges for 2024/25. Key points were: • Service Recognition: Transition off of Maternity Safety Support Programme (MSSP) with regional endorsement. Achieved all 10 Safety Actions in NHS Resolution's Maternity & Perinatal Incentive Scheme. • Innovation & Improvement: Launch of Induction of Labour Clinic and sterile water injections. Expanded triage and postnatal care windows. Strong collaboration with Maternity and Neonatal Voices Partnership (MNVP). • Incidents & Risk: 1,723 incidents reported; 68% under investigation. 5 serious incidents (down from 7); 2 high-rated risks on register. • Challenges included; estates, AlexHealth and cross-border care • Staff survey and equity initiatives were progressing. • 23 expired procedural documents are being prioritised for review by end of Q2.

BOARD OF DIRECTORS: **Trust Board 05.06.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 May 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.3 Monthly Maternity Report	Y	Y	N	Highlights included; • Midwife vacancies at 10.06 WTE (6.06%); support worker vacancies at 9.63 WTE. Agency usage had slightly reduced; staffing remains under scrutiny. • Labour Ward: Compliance at 77.78%; red flags include induction delays. High-risk categories (III & IV) were most common. • Birth Centre: Compliance has improved to 53.89%; red flags include delays in critical activity and pain relief. • Inquest had concluded with a Regulation 28 Prevention of Further Deaths issued. Action plans were being implemented which included improved patient information, escalation training, and staff support. • Student midwife employment was discussed; the team are committed to exploring opportunities for recruitment. • Indirect Maternal Death: Case of pulmonary embolism at 12 weeks gestation; the pathway and referral processes are under review. • Challenges included; data collection, dashboard timeliness, staff and family support amid media scrutiny.
2.4 Maternity Patient Safety Incidents	Y	Y	N	There had been no new maternity incidents declared since the last report. Maternity services currently have 7 investigations ongoing; 2 SI's, 3 PSII's and 2 MNSI's. Two had been closed since the reports submission and would be reported to June's meeting. It was expected several of the open investigations would be closed by the end of June and reported to the Committee in due course. The committee noted the Trust's response to the MNSI escalation.
2.5 CQC Mock Inspection	Y	Y	N	An interim update was provided and it was noted that the likely rating from the mock inspection would be Requires Improvement. Key areas for improvement included the clinical strategy, the estate, IPC and triage. A more detailed report would be presented at the next meeting.

BOARD OF DIRECTORS: **Trust Board 05.06.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 May 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.6 Maternity Assurance Report	Y	Y	N	Highlights included: • Safety Action 8 (NLS training) remains a challenge; mitigation plans were in place. • Safety Action 2 (data) flagged as a potential risk due to system transition. • Guidelines: 24% of maternity procedural documents expired (up from 12%); specialist availability remains a challenge. • Three-Year Delivery Plan: 78% complete; all remaining actions on track for 2026 • Ockenden Compliance: 93% complete; remaining actions due by November 2025. • Saving Babies Lives v3: Fully compliant for 2025; Year 7 delivery in progress. • Maternity Self-Assessment Tool: All 185 actions completed; sustainability plan in place
2.6 Maternity Safety Champions Update	Y	N	N	Current visits were noted and the positive feedback from student midwives in regards to their experience at the Trust and the level of support/supervision received was noted. Concerns had been raised at LMNS meeting regarding community midwifery funding and MDT working. Regional alignment on strategic direction had been reaffirmed.

Other items noted:
- Horizon scanning

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 June 2025

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance
Date prepared:	02 May 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). This paper includes our response to an MNSI letter of concern (24 April 25) within appendix 1. There has been 0 new maternity PSII declared since the last report for March 2025. There has been 0 maternity SI closed since the last report (April 2025). Maternity services currently have 7 investigations ongoing. SI's - 2 PSII's - 3 MNSI – 2
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.30.05.25
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:	1. PAHT response to MNSI escalation regarding indirect maternal death

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

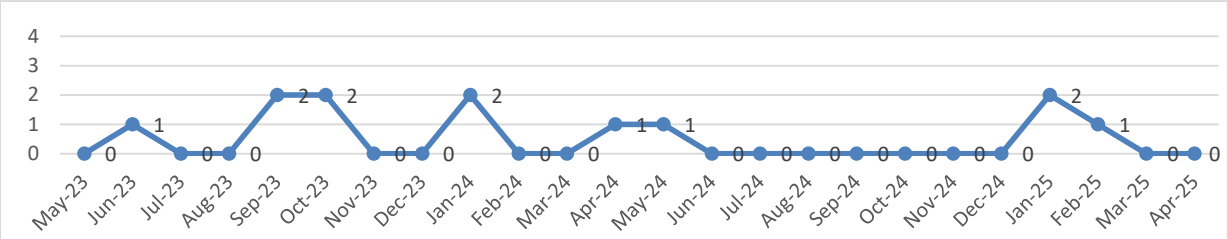
2.0 Background

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

3.0 Analysis

Maternity currently have 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 April 2025)



There was 0 new Maternity Patient Safety Incident Investigation (PSII) declared in April 2025.

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

Investigations			
Number Declared for April 2025			0
Number Submitted for April 2025			0
Number Past ICB Deadline as of April 2025 (Not including MNSI/Approved Extensions)			4
New Investigations declared in April 2025			
Ref	Ethnicity	Summary	Learning Points
Investigations closed in April 2025			

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to April 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 accepts the report with the information provided and the ongoing work with the investigation process.

Author: Erin Walters, Head of Maternity Governance and Assurance
Date: 02 May 2025

The Princess Alexandra Hospital NHS Trust

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

Sarah Cooper Investigation Team leader
Maternity & New Born Safety Investigation
Care Quality Commission
Second Floor
2 Redman Place
London
E20 1JQ

Via email: sarah.cooper@mnsi.org.uk

cc MNSIConcerns@mnsi.org.uk

1 May 2025

Dear Sarah,

Re escalation of concerns from MNSI investigation case number MI-039625

Thank you for your letter dated 24 April 2025 regarding escalation of concerns relating to case number MI-039625. Thank you for reviewing this case and for your comments.

In response to the panels concern and request for assurance on our urgent actions undertaken to improve patient safety for people presenting at any stage of pregnancy within the emergency department, we can confirm the following:

1. We have reviewed and strengthened our Maternal Medicine Organisational Policy with respect to:
    - the referral criteria for those pregnant people presenting unwell with a non-obstetric presentation (which includes, but is not exclusive, severe headaches, chest pain, shortness of breath and severe or unexplained abdominal pain). We have clarified the expectation that obstetric advice/ opinion from the most senior obstetrician available (registrar or consultant) is sought under the circumstances described above.
    - the care of pregnant people presenting to Emergency Department (ED) with acute symptoms (obstetric, gynaecological)

The Princess Alexandra Hospital NHS Trust

2. We have strengthened the referral pathway to the obstetric and gynaecological registrar for such patients from ED

3. In relation to the above, a communications plan is in place to increase the visibility and understanding of the pathways by all the relevant stakeholders.

4. In relation to the concerns relating to 'no senior clinical oversight', we confirm that we follow the Royal College of Emergency Medicine (RCEM) Clinical Standard 2016 which states that patients who are identified as higher risk (which includes patients who had an unscheduled return with the same condition within 72 hours of discharge) *'should be reviewed by a consultant in Emergency Medicine (EM) prior to discharge from the ED. If, due to insufficient numbers of consultant staff, an EM consultant is not immediately available on the 'shop floor' of the ED, then review may be carried out by a senior trainee in EM, or by a staff grade or similar substantive career grade doctor with sufficient ED experience to be designated to undertake this role by the EM consultant medical staff.*'

5. A working group consisting of our emergency care team, obstetrics and gynaecology team, led by the divisional directors, has been established to further refine the guidance/pathway and ensure all stakeholders are educated and informed. The pathway will be audited as well as the routine use of the national standardised maternity Early Warning System (mEWS) in such patients.

I would like to assure MNSI that this incident has been treated with the highest urgency and both our emergency and obstetric teams have been working in partnership to ensure the safety of our pregnant people that attend our Trust.

I can confirm that we have shared the letter of concern with our Board, discussed the MNSI concerns with our Quality and Safety Committee (sub-committee of the Trust Board) on 25 April and at our Trust Board (private) on 1st May.

Please do not hesitate to contact me if you have any further queries.

Kind regards

Dr Fay Gilder
Chief Medical Officer

Trust Board (Public) – 5 June 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:	17.04.2025
Subject / title:	Report on Nursing and Midwifery staff levels for February 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 continue to be driven by enhanced care needs. There is an area of focused work led by the deputy chief nurse to review enhanced care requirements and the governance framework. • The mid-year establishment review (which informs roster templates) has concluded and is currently under review.							
Recommendation:	The committee are asked to note the information within this report.							

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

Previously considered by:	PC.23.05.25
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 March 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 March 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 March 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% fill rate. The fill rate is based against the standard ward template

Greater than 100% fill rate for Registered Nurse (RN) and Healthcare support worker (HCSW) shifts continues to be mainly attributable to enhanced care requirements, the deputy chief nurse is facilitating a working group reviewing enhanced care requirements.

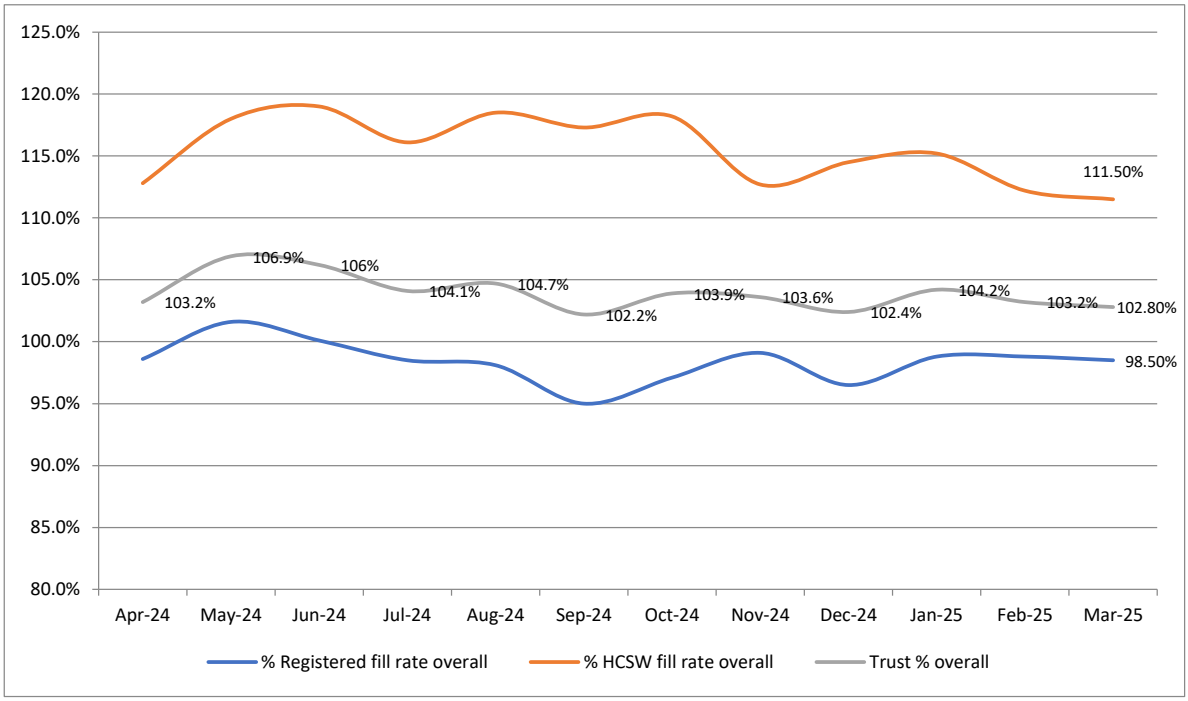
The Trust continues to utilise NHS Professionals and agency (for registered mental health nurses) to mitigate vacant shifts. Additional control measures continue to be in place regarding the creation of additional duties. Furthermore, our senior nurses and midwives are also supporting individual areas 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
95.8%	95.9%	102.0%	130.8%	98.5%	111.5%	102.8%

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.

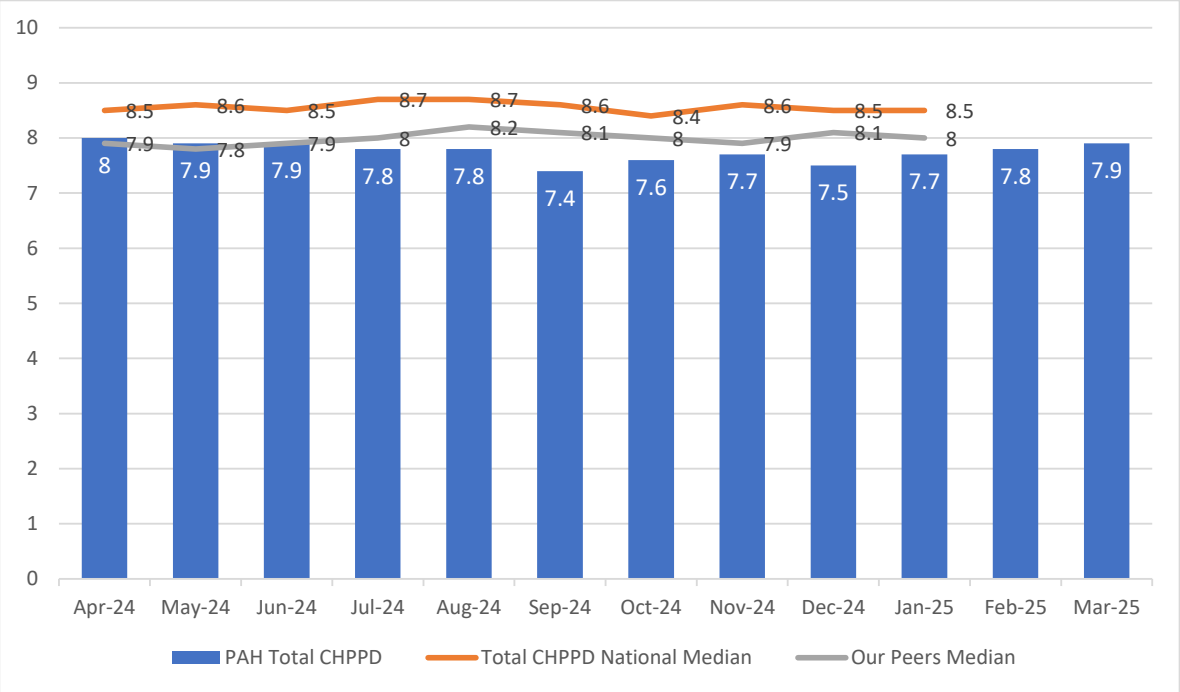
Table 3. Overall Care Hours Per Patient Day (CHPPD) March 2025

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.1	2.8	7.9

The Model Hospital data for January 2025 shows the Trust with a CHPPD of 7.7 against the national median of 8.5**.** 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 March 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 is due to enhanced care needs. There is an area of focused work led by the deputy chief nurse to review enhanced care requirements and the governance framework.

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 March 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	83.3%	121.5%	101.2%	157.1%	90.6%	138.5%	107.9%
Henry Moore	132.8%	130.5%	180.4%	148.1%	151.8%	138.9%	146.2%
ITU & HDU	91.4%	29.0%	95.6%	97.1%	93.5%	63.0%	90.7%
John Snow	104.3%	41.9%	100.0%	64.5%	102.2%	49.0%	79.3%
Penn	100.3%	108.0%	104.0%	177.9%	101.8%	134.5%	113.5%
Saunders	93.2%	107.0%	123.1%	169.8%	104.4%	130.8%	114.4%
Surgery Total	97.4%	97.3%	109.0%	146.5%	102.5%	117.7%	107.1%
Fleming	88.4%	97.4%	99.9%	127.3%	93.3%	111.7%	98.9%
Harold	92.1%	91.9%	100.5%	118.0%	95.8%	104.4%	98.5%
Kingsmoor	89.8%	124.9%	107.6%	148.7%	96.6%	136.3%	111.4%
Lister	96.2%	97.2%	102.0%	128.7%	98.6%	112.3%	104.1%
Locke	94.6%	112.1%	99.0%	156.1%	96.5%	133.1%	111.1%
Nightingale	102.3%	86.7%	101.5%	206.2%	101.9%	124.2%	111.5%
Opal	101.2%	97.5%	84.9%	112.9%	93.4%	104.9%	98.0%
Ray	103.3%	95.7%	114.3%	174.5%	108.0%	125.6%	114.3%
Tye Green	97.3%	86.8%	101.0%	150.5%	98.9%	112.7%	104.3%
Winter	97.7%	95.6%	100.8%	121.3%	99.0%	107.9%	102.5%
Medicine Total	95.4%	98.7%	101.5%	140.2%	98.0%	117.4%	105.2%
AAU	97.2%	112.5%	106.4%	138.0%	101.3%	124.7%	106.2%
Charnley	91.9%	143.8%	99.9%	164.3%	95.7%	153.6%	112.3%
UEC Total	95.1%	128.2%	103.7%	151.2%	99.1%	139.2%	108.8%
Birthing	84.9%	86.8%	74.7%	77.4%	80.0%	82.3%	80.8%
Chamberlen	95.3%	61.4%	87.9%	57.8%	91.8%	59.6%	83.8%
Dolphin	102.5%	61.6%	120.8%	103.9%	110.6%	75.7%	101.9%
Labour	91.1%	83.9%	87.6%	95.0%	89.4%	89.2%	89.4%
Neo-Natal Unit	93.0%	88.1%	97.1%	80.6%	95.1%	84.4%	93.3%
Samson	100.3%	74.7%	91.3%	81.4%	96.0%	77.9%	85.6%
CHAWS Total	94.8%	75.2%	94.8%	83.6%	94.8%	79.0%	90.1%
Total	95.8%	95.9%	102.0%	130.8%	98.5%	111.5%	102.8%

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.

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. A recruitment campaign for support workers took place in February, for surgery and critical care where 2.0 WTE were offered critical care.

Nightingale Ward - fillrate is currently affected due to the wards standard template and the use of optional shifts, these hours are counted but are not part of the standard template leading to a high fillrate, when used. Discussions have been held with the ADoN and the optional night HCA shift has been removed and converted to a standard shift from the 12th May Roster aligning the template with the SNCT results. This should start to have an impact on the fillrate for ward in the May paper.

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.

The Trust continues as 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.

The interim establishment review (which underpins the rota templates) commenced in March 2025 and finished 1st April 2025 This is for adult and paediatric inpatient wards and assessment units along with main and paediatric emergency departments.

Emergency Departments - National reporting is currently for inpatient areas and therefore does not include areas including the emergency department (ED). To ensure the Board is sighted to staffing in these areas, the data for ED and Paediatric ED is included below (Appendix 1a and 1b) using the same methodology as the full UNIFY report.

Appendix 1a: ED data and narrative: fill rates March 2025 *(Standard Planned Demand)*

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
99.5%	77.5%	116.3%	95.1%	107.0%	85.3%	100.1%

Appendix 1b: Paediatric ED data and narrative: fill rates March 2025 *(Standard Planned Demand)*

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
133.7%	69.2%	145.1%	96.8%	138.8%	83.0%	121.6%

Appendix 2: Ward level data: CHPPD March 2025

Care Hours Per Patient Day (CHPPD)			
Ward	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total	**5.1**	**2.8**	**7.9**
Harvey Ward	3.8	3.3	7.2
Henry Moore Ward	4.1	2.9	7.0
ITU & HDU	18.0	1.2	19.2
John Snow Ward	5.2	1.9	7.1
Penn Ward	3.9	2.9	6.8
Saunders Unit	3.7	2.8	6.6
Surgery Total	**5.4**	**2.7**	**8.1**
Fleming Ward	3.9	2.0	5.9
Harold Ward	4.5	2.3	6.8
Kingsmoor General	3.6	3.0	6.6
Lister Ward	4.0	3.0	7.0
Locke Ward	3.6	3.3	6.9
Nightingale Ward	2.9	2.7	5.6
Opal Unit	5.8	4.4	10.2
Ray Ward	4.7	3.0	7.7
Tye Green Ward	4.6	3.3	7.9
Winter Ward	3.7	2.7	6.4
Medicine Total	**4.1**	**2.9**	**7.0**
AAU	6.9	2.3	9.2
Charnley Ward	4.5	2.9	7.4
UEC Total	**5.7**	**2.6**	**8.3**
Birthing Unit	16.3	8.4	24.7
Chamberlen Ward	5.8	1.3	7.1
Dolphin Ward	9.3	2.1	11.4
Labour Ward	24.0	6.8	30.8
Neo-Natal Unit	9.2	1.6	10.8
Samson Ward	2.5	2.7	5.3
CHAWS Total	**7.7**	**2.8**	**10.5**

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 increased by 13 occasions in March 2025 to 84. The majority of these shortfalls continue to be in Maternity, which had 57. 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 February 2025

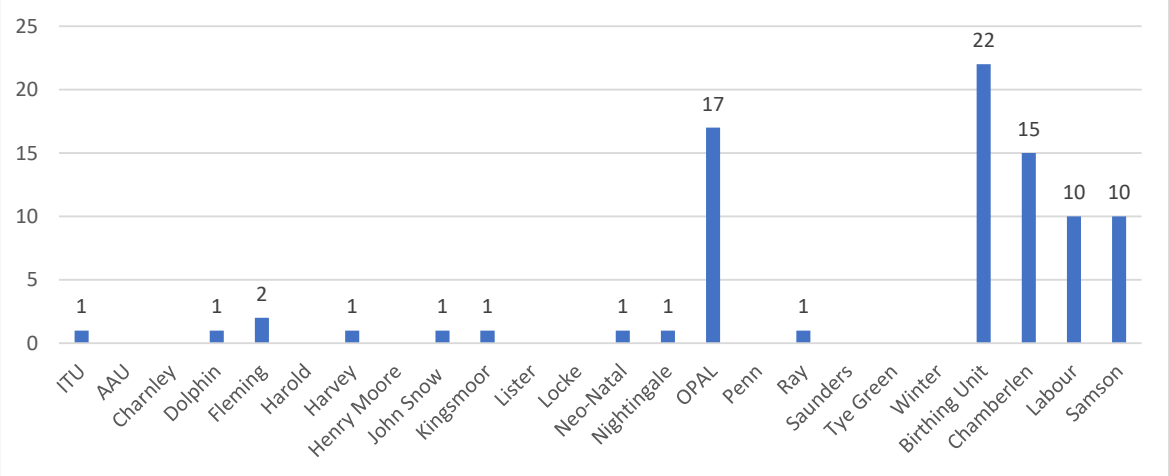
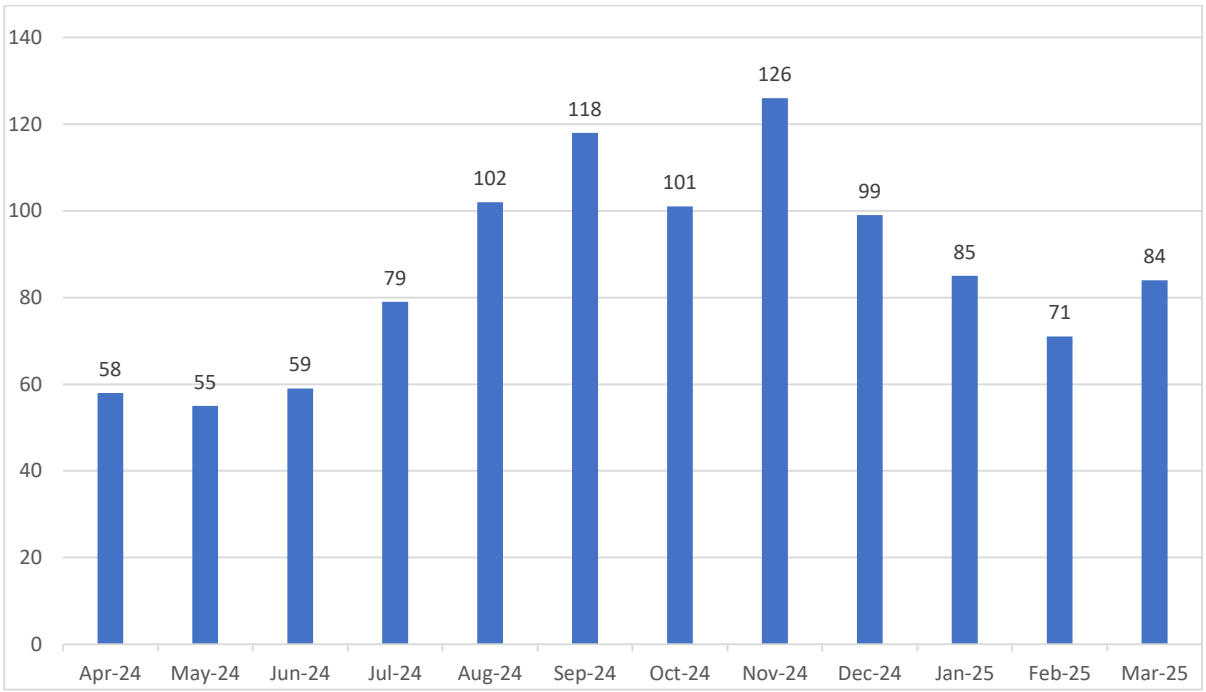


Table 2. Occasions when registered staffing fell below 75% of standard template Trend Data April 2024 – March 2025



All adult inpatient areas should be capturing staffing shortfalls on SafeCare by raising a Red Flag on the system, refresher training by the Safe Staffing and Enhanced Care Leads has been undertaken. Table 3a shows the Red Flags raised through SafeCare in March 2025. Table 3b shows the number of Red Flags raised for adult inpatient wards has increased with 77 raised in March against 51 for February.

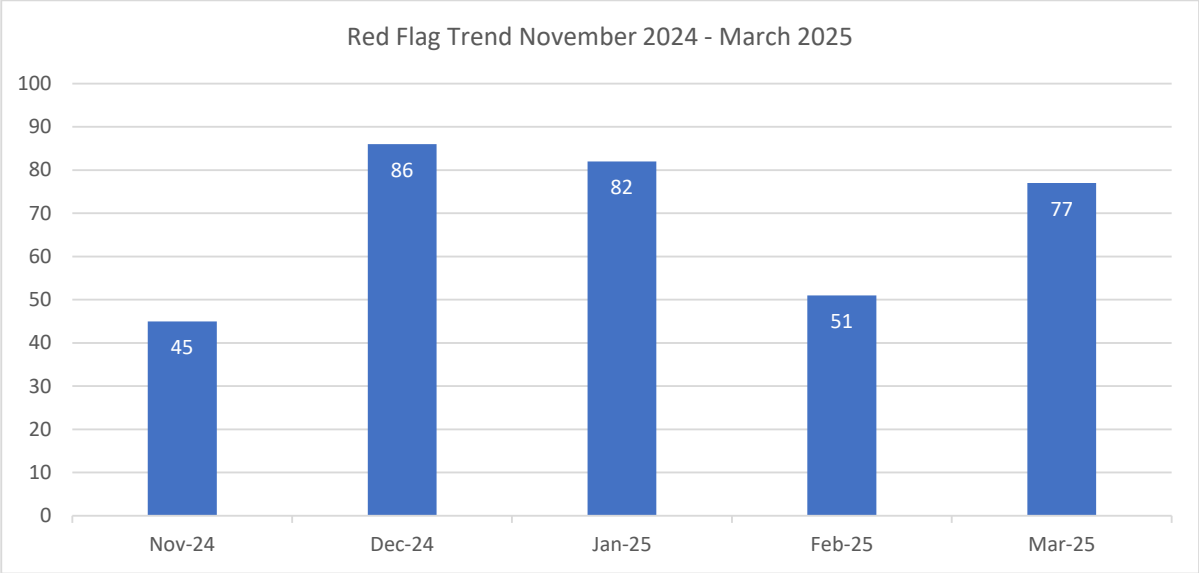
To improve oversight into how many incidents relating to when Enhanced Care could not be provided, the Trust has also added a local Red Flag highlighting when this occurs in SafeCare. This and the addition of Enhanced Care Level 3 Patient task will also enable the Trust to provide data to the Enhanced 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 currently demonstrated in Table 3a below. This will be a focused aspect of work with the divisions.

Table 3a. Red Flags raised via SafeCare March 2025

	Delay in providing pain relief	Less than 2 RNs on shift	Missed 'intentional rounding'	Shortfall in RN time	Unable to provide Enhanced Care	Unplanned omission in providing medications	Vital signs not assessed or recorded	Grand Total
Nov-24	1		3	22	12		7	45
Dec-24	4	3	7	37	33	1	1	86
Jan-25			6	24	52			82
Feb-25		2	11	10	27		1	51
Mar-25			4	14	59			77

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 March 2025 with Tye Green redeploying the highest number of substantive staff with AAU and Lister Ward being the next highest. Although Tye Green deployed the highest amount of staff, Safe Care was used to inform this decision making which include a review of patient activity and acuity. The highest net receiver of staff was Henry Moore followed by Locke and Fleming Ward. Table 5 demonstrates the number of substantive staff redeployments per month trend

Table 4. Hours of substantive staff redeployed March 2025

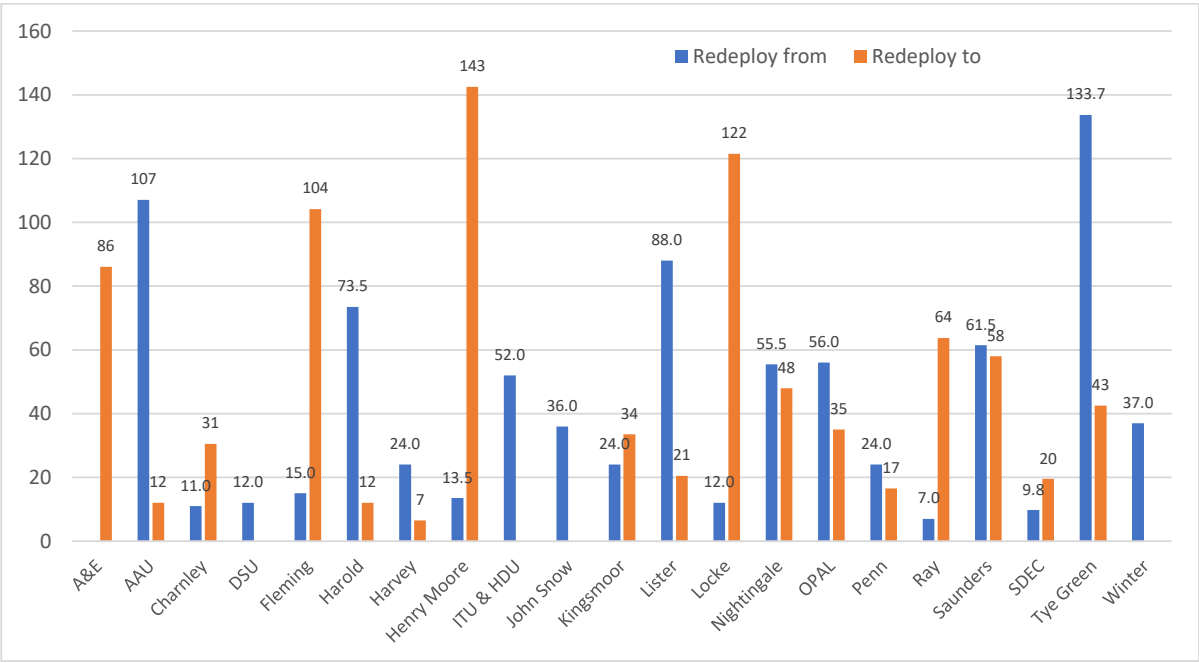


Table 5. Substantive staff redeployment trend

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.

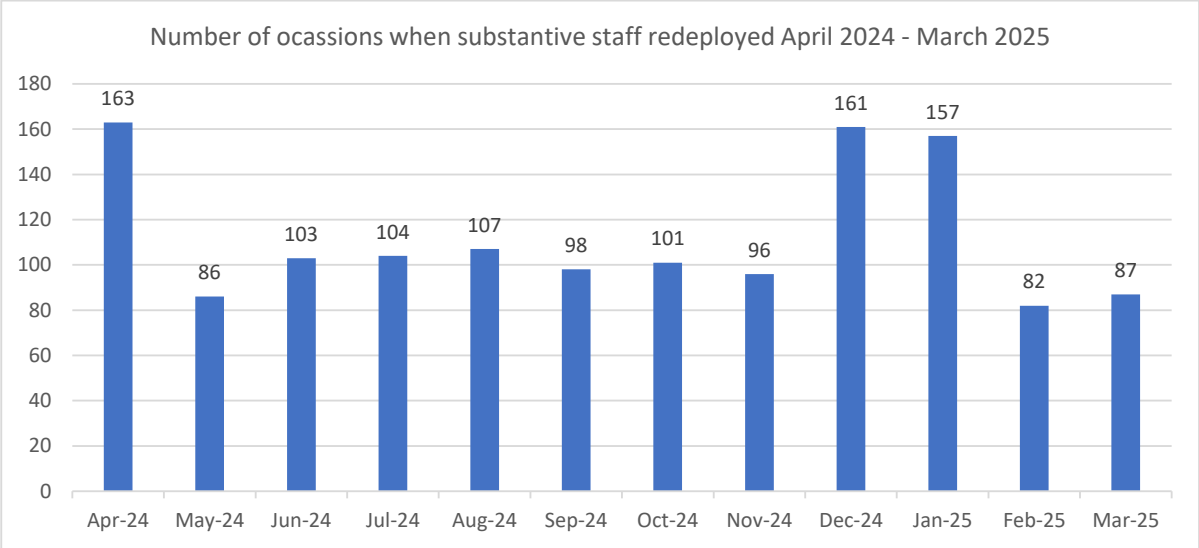


Table 6 shows the hours of substantive staff moved as a percentage of total hours worked.

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
852	140605	0.61%

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)
1987	140605	1.41%

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

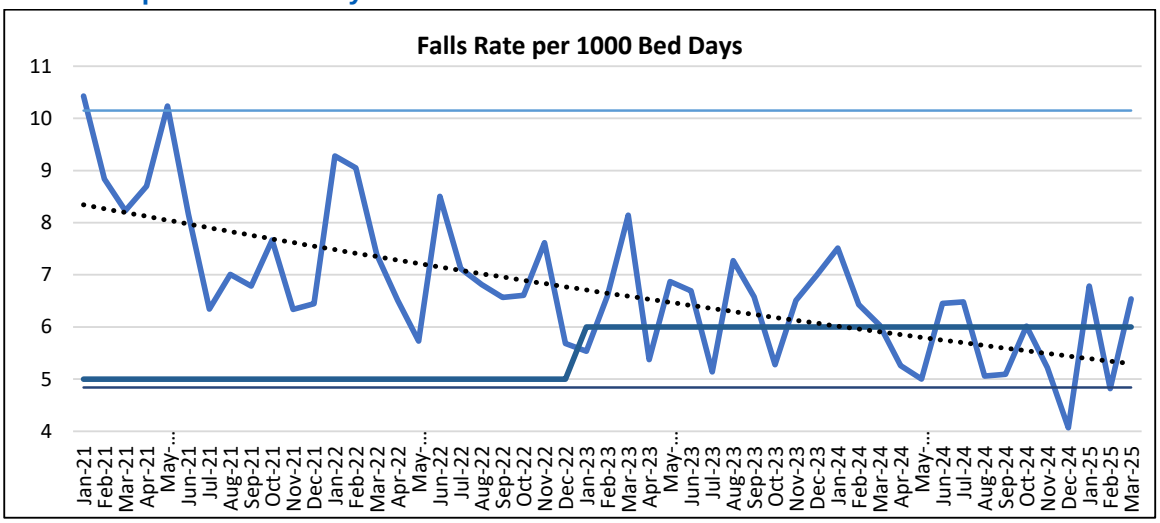
Table 1. Number of falls, unwitnessed falls and falls with harm in March 2025, with the top 3 wards being highlighted

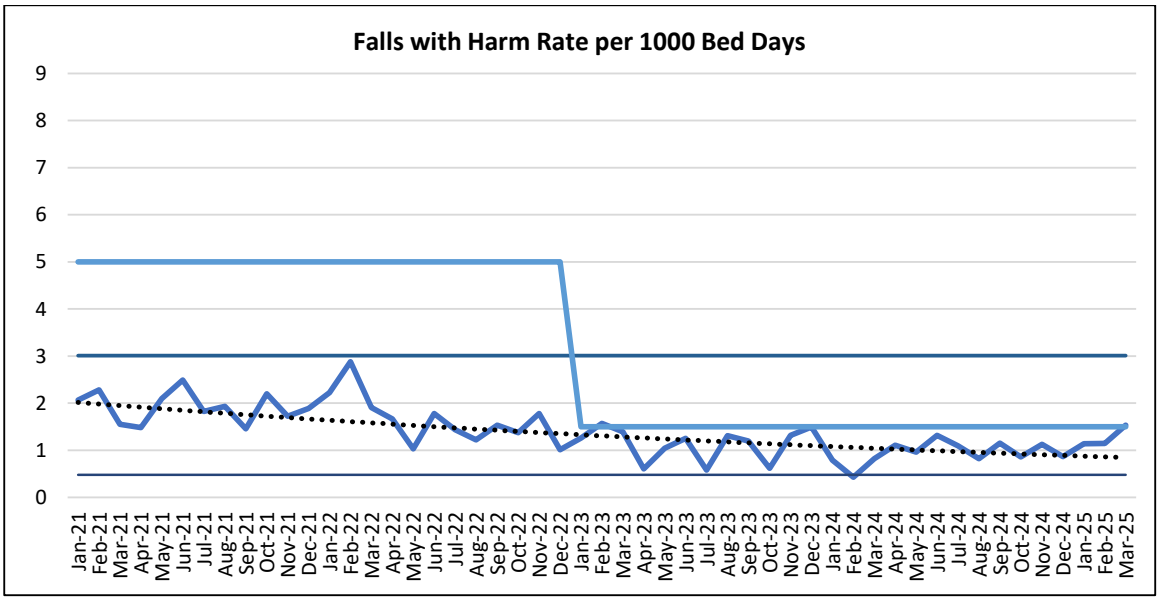
	Total falls in month	Top 3 wards		
Total falls	97	Locke 12	Kingsmoor 11	Tye Green 11
Unwitnessed falls	89	Locke 12	Tye Green 11	Kingsmoor 10
Falls with harm *	18	Tye Green 3	Nightingale 3	Ray 3

**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%.

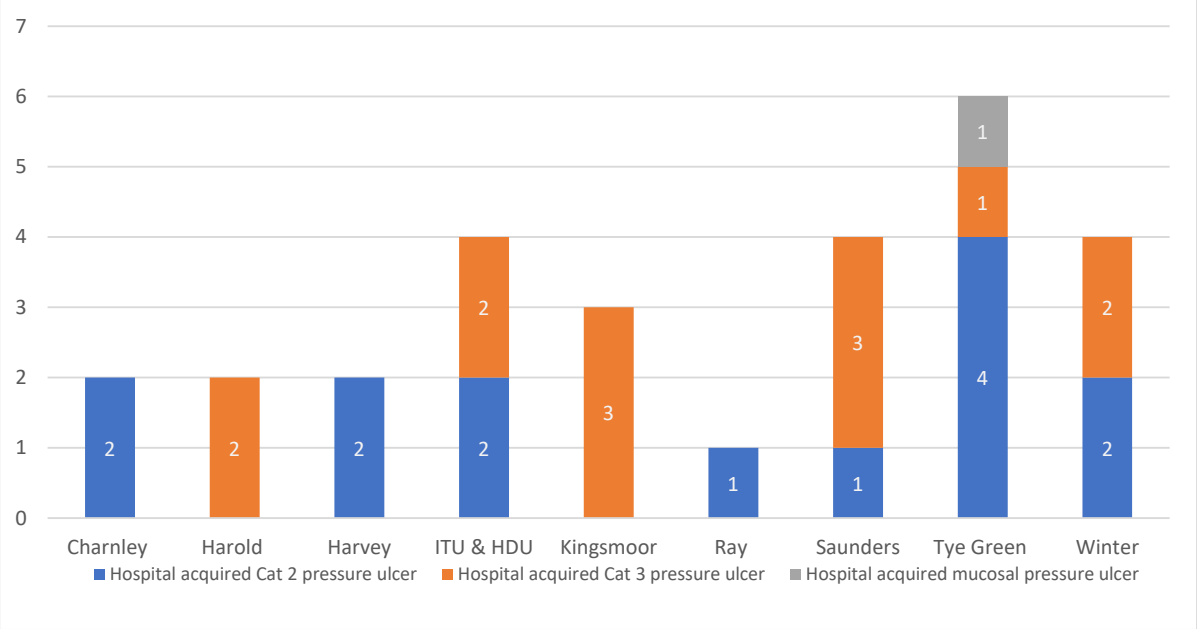
Falls Rate per 1000 bed days





Pressure Ulcers

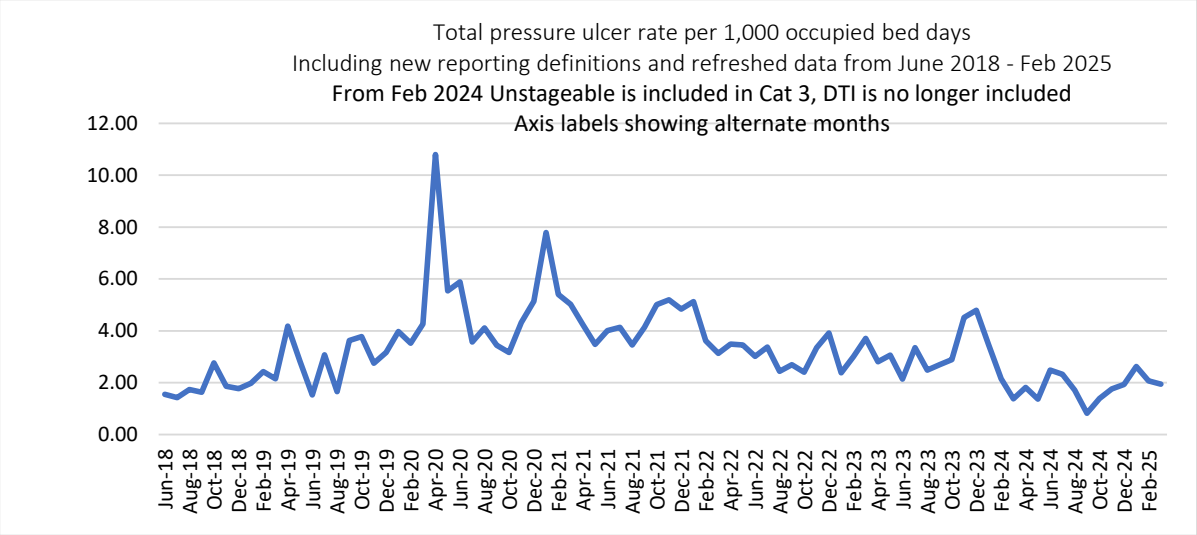
Table 2. Number of Hospital Acquired Pressure Ulcers (HAPU) Cat 2 and Cat 3 Pressure Ulcers (including unstageable)

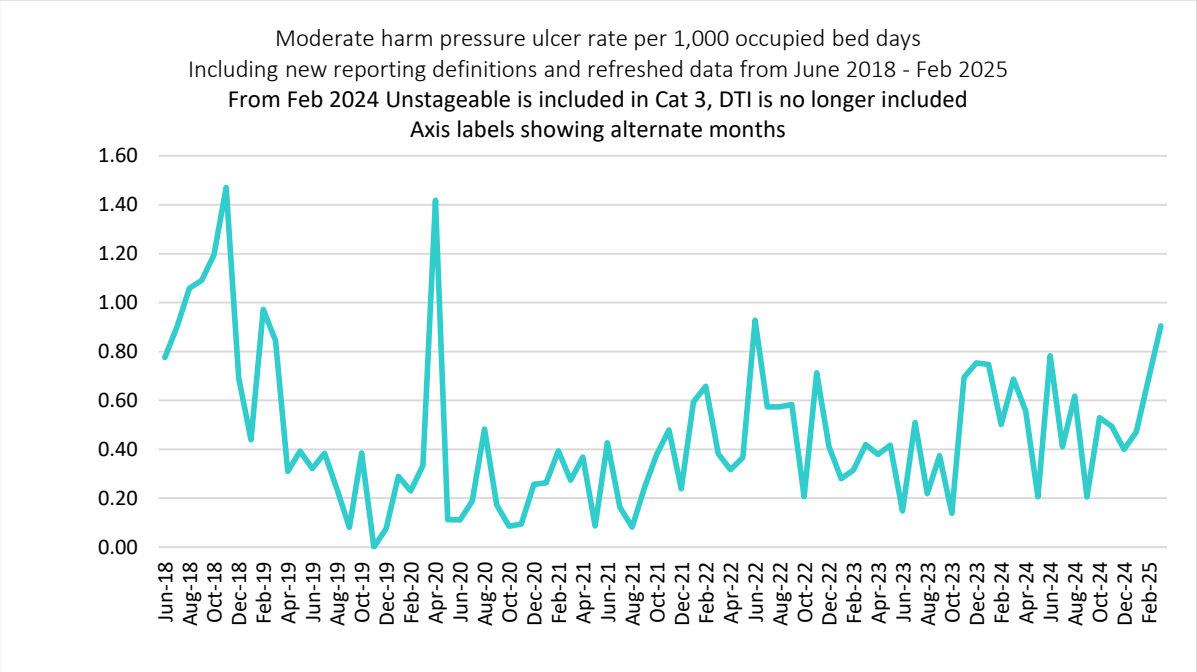


In March 2025 there was an increase in HAPU, with 28 HAPU's in month compared to 27 in February.

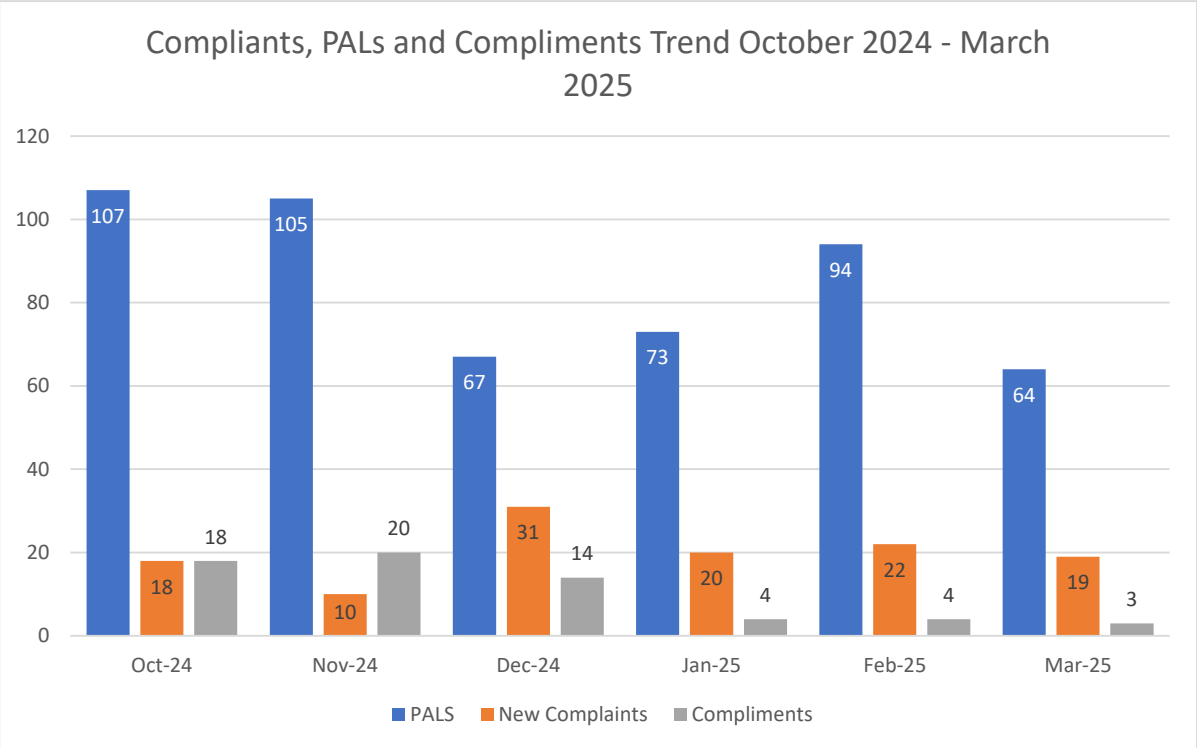
Total in month	Top 3 wards	
28	Tye Green - 6	Winter, Saunders and ITU & HDU - 4

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 Septemebr 2024 – February 2025



Complaints, PALS and Compliments

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

	Total in month	Top 3 wards		
New complaints	19	A&E 4	Penn 3	Labour and Ray 2
PALs	64	A&E 21	Kingsmoor 6	Henry Moore and Penn 4
Compliments	3	A&E 2	Harvey 1	

Not all compliments received in March have been logged in this month's data.

The 3 main PALS themes for February were:

- Delay – 37.6%, Communication – 27.75%, Cancellations – 11.33%

Complaints themes for February were as follows
Medical care – 23.29%, Appointments 19.18% and Delays – 13.7%

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 June 2025

4.4

Agenda item:	4.4							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Fay Gilder | Medical Director							
Date prepared:	21st May 2025							
Subject / title:	Learning from Deaths and Mortality							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This paper provides assurance on the learning from deaths process. It 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 deaths 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 Deaths Group Quality and Safety Committee
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:	n/a

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patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.4

1.0 PURPOSE

The purpose of this paper is to provide monthly assurance on the learning from death process gathered from the Telstra monthly report.

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.

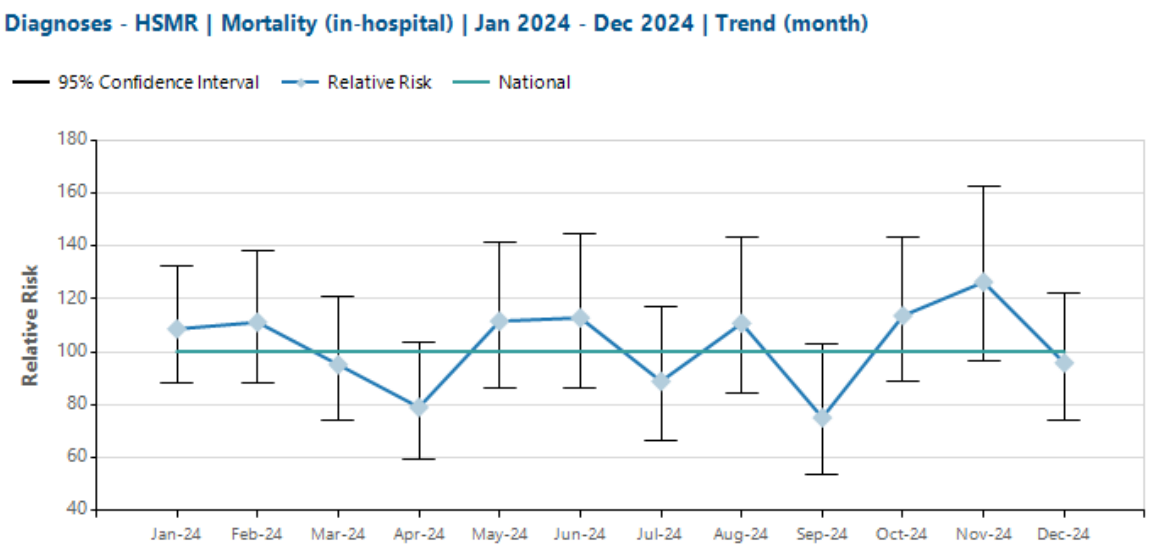
3.0 CURRENT TELSTRA UPDATE ON MORTALITY INDICES FOR PAHT

3.1 Background

Telstra provides an in-hospital mortality report for all inpatient admissions. This report covers the 12-month time period Jan 2024 – Dec 2024.

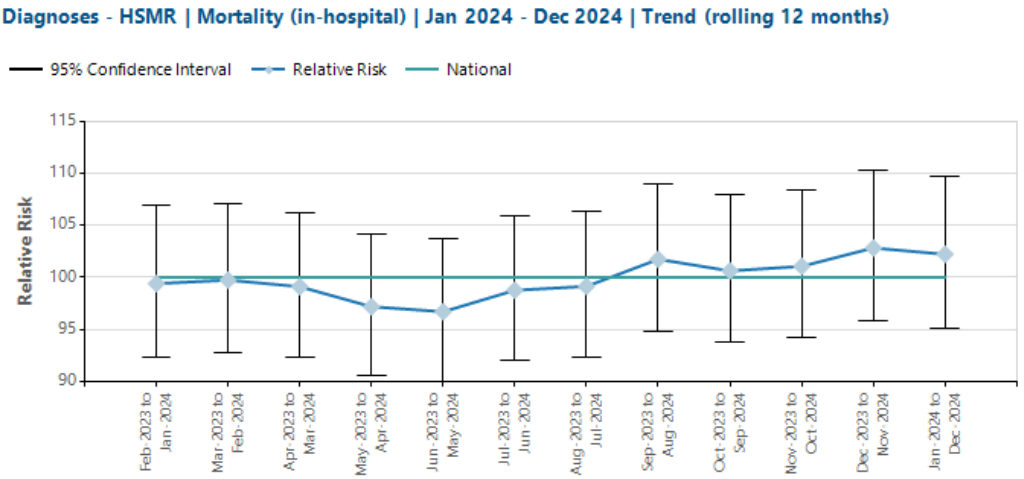
3.2 Analysis

Hospital standardised mortality ratio (HSMR) overview
Figure 1 – HSMR Monthly Trend Jan - Dec 24 HSMR for Dec 24 is 'within expected'



HSMR+ for Dec-24 is 95.8 and "within expected".

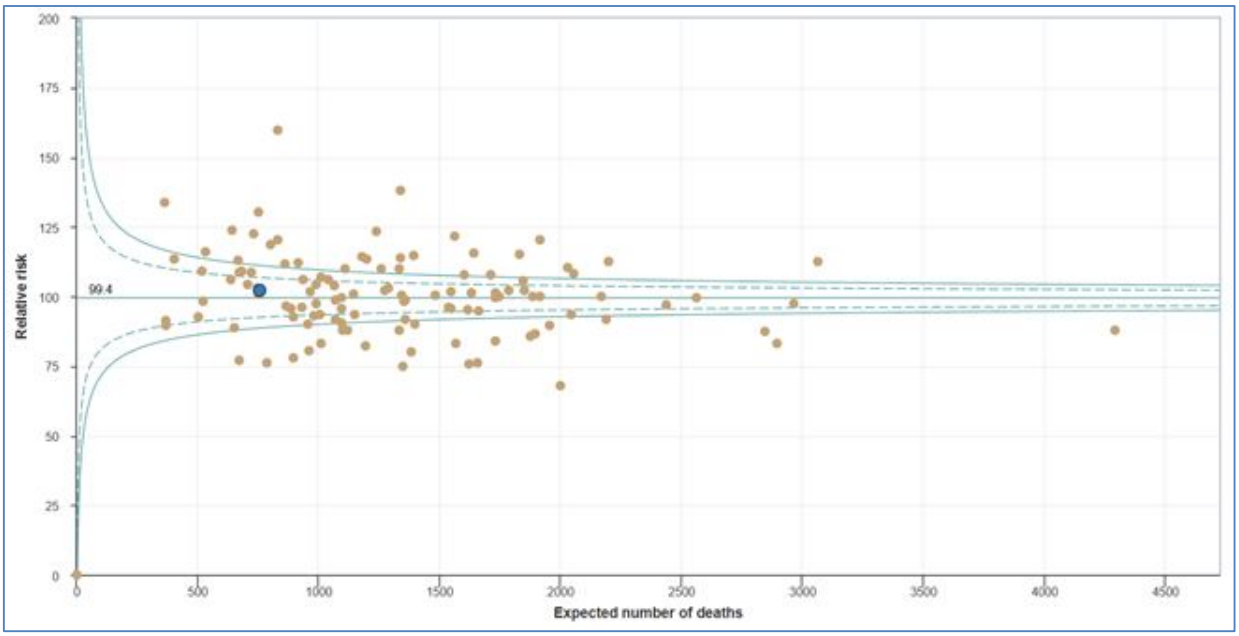
Figure 2 – HSMR+ 12 month rolling trend



The rolling 12 month HSMR (figure 2) for the period Jan – Dec 2024 is 102.21 and is **'within expected'**.

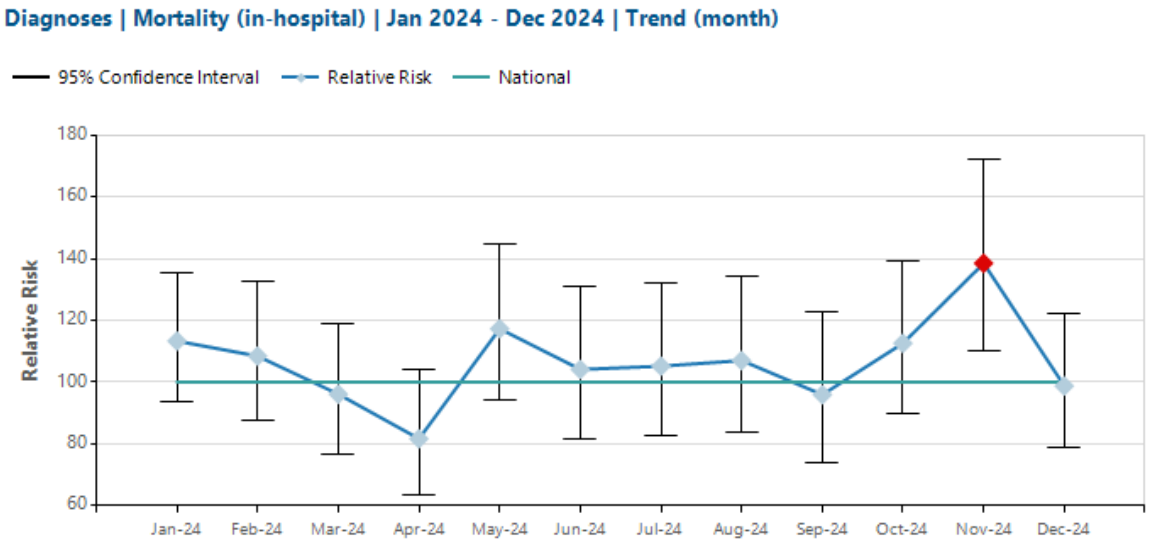
Figure 3 – HSMR+ National Peer Comparison (Last 12 Months)

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



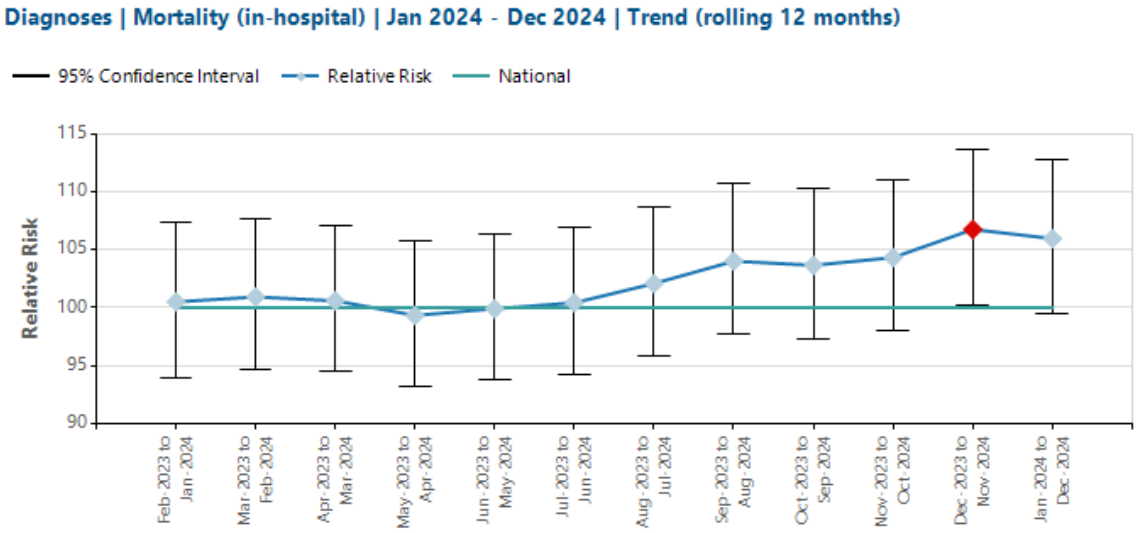
Standardised Mortality Ratio (SMR) overview

Figure 4 – SMR+ for Dec 24 – which is 'within expected'



SMR+ for Dec-24 is 98.7 and "within expected"
From the analysis, the monthly SMR+ for November is likely to be caused by unfamiliarity with data entry post go-live of AlexHealth.

Figure 5 – 12 month rolling SMR Jan – Dec 24 which is 'within expected'



12 month rolling SMR+ is 106.0 (within expected). Explanation for the November 2024 figure is the same as for the monthly SMR.

SMR Significant Diagnosis Group Alerts

There are three SMR diagnostic group outlier alerts this month.

Glaucoma
Further detail implies that this patient was very elderly and frail. The record will be looked at from a coding, documentation and care perspective.

Acute and Unspecified Renal Failure
Further details imply that a number of these patients were very frail and elderly. The records will be looked at from a coding, documentation and care perspective.

Senility and Organic Mental Disorders
Further details imply that a number of these patients were very frail and elderly. The records will be looked at from a coding, documentation and care perspective.

3.3 Summary

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

The SMR outliers detailed above will be reviewed with the results presented at strategic learning from deaths group in July.

4.0 MORTALITY PROGRAMME UPDATES

The Strategic Learning from Deaths Group (SLfDG) was held on 20th May 2025.

5.0 LEARNING FROM DEATHS PROCESS UPDATE

5.1 Mortality Narrative

- There were 70 deaths in April 2025.
- 6 cases referred for SJRs.

5.2 Deaths Investigated Under the Patient Safety Incident Response Framework

Figure 5 – Possible avoidable Deaths (June 2024)

2 Deaths are currently under investigation

5.3 Cases awaiting the second review panel

- Nil

5.4 Themes and Issues Identified from Reviews and Investigation

- Improved communication between clinical teams.
- Improved communication and documentation of end of life decisions, including family and patient involvement .
- Thorough and good clinical assessments.
- Timely specialist input, including palliative care.
- Good nursing care.

5.5 Actions Taken in Response to Avoidable Deaths

- Nil required until investigations referred to above are complete

6.0 MEDICAL EXAMINER (ME) HEADLINES

6.1 Scrutiny Update

- 100% were scrutinised by 7 Medical Examiners.

- 9 cases were referred to the Coroner.

National MCCDs issued within 72 hours: (National Target)

- 86.9% of MCCDs were issued within 72 hours in April 2025.

6.2 Ongoing Developments

- A project has started with support from the Quality First Team 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 Board to provide feedback on the contents of the paper to ensure a dynamic development of the information provided so that assurance can be provided.

BOARD OF DIRECTORS: Trust Board - Public 5 June 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 23 May 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
1.6 Committee Effectiveness Review 24/25 and Terms of Reference 2025/26	Yes	Yes	No	The Committee discussed the effectiveness review and noted the following key points: • Quality of papers – improvement was acknowledged but there are still some papers that requires improvement in structure, consistency and oversight of metrics. • Follow up of actions – some actions are not addressed within the timescales and target dates are deferred. Clarity on actions and timescales during the meeting would be helpful. • Arrangements for meetings – it was agreed that every other meeting would be held face to face at Kao Park, starting from July The Terms of Reference are recommended to Board for approval and are attached as **Appendix 1**.
2.1 People Report	Yes	No	No	The Committee noted the good progress on the people metrics with the majority rated as green. The vacancy rate was 8.03% and the sickness level was below target (4.5%) at 4.14% and rolling sickness at 4.2%. Bank and agency expenditure remained a key focus. Voluntary turnover is at the lowest it has been since 2013 at 9.41%. Stability rate is reported at 85% which is just below Trust target of 90%.
2.2 Staff Survey	Yes	No	No	The report was noted and the following was highlighted:

BOARD OF DIRECTORS: Trust Board - Public 5 June 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 23 May 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Divisional directors are progressing locally identified themes and actions and are reporting these through the Executive Board • Activities are underway for the 3 over-arching themes • A new monthly staff awards programme is starting in July 2025 • The NSS24 comparison reports have not been received from NHS England survey centre so will be reported at the next People Committee meeting
2.3 People Strategy	Yes	Yes	No	The Committee reviewed the strategy and noted that it would be a dynamic document and updated as and when required, and so recommended it to Board for approval. The report is on the Board agenda.
2.4 Freedom to Speak Up Report	Yes	No	No	The Committee noted the report. There has been a slow but positive increase in referrals and the reasons for approaching the FTSU service remain constant, with the highest reported concerns related to behaviours experienced by our staff. Opportunities to strengthen our speaking up service will be progressed over the coming year.
2.5 Guardian of Safer Working Hours Report	Yes	No	No	In the 3 month period January to March 2025, 55 exception reports were received, the majority due to working over hours. 2 immediate patient safety concerns were reported with associated actions taken to address the concerns. The quarter did not highlight an exceptionally high number of

BOARD OF DIRECTORS: Trust Board - Public 5 June 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 23 May 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				exception reports in any area but rather single figure reports in a wide number of specialties. It was noted that all locally employed doctors have now been added to the Allocate system.
2.6 Sexual Safety Training	Yes	No	No	The Committee supported the proposal to add the Sexual Safety e-learning module to the essential suite of training.
2.7 Learning and OD Update	Yes	No	No	The following was highlighted: • Statutory and mandatory training compliance is at 88% and appraisals at 77%. • Average course attendance for Ready to Manage continues to be above 80% (63% last year) • New monthly staff award being developed for teams, non-clinical and clinical categories • £4k apprenticeship levy has been gifted to a care home in Essex
2.8 Fit and Proper Persons Report	Yes	Yes	No	The Committee noted the current position; minor checks were in progress and the final position would be reported to Trust Board. The report is on the Board agenda.
2.9 Safer Nurse Staffing Report	Yes	No	No	There has been a sustained Registered Nurse fill rate of > 95%. No wards in month that achieved < 75% overall fill rate. The increase in overall fill rates is multifaced with a combination of enhanced care needs and supernumerary time driving this. The mid-year establishment review (which

BOARD OF DIRECTORS: Trust Board - Public 5 June 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 23 May 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				informs roster templates) has concluded and is currently under review.
2.10 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 is underway to review the data underpinning the recruitment, retention and engagement elements of the risk.
2.11 Horizon Scanning	Yes	No	No	The following items were discussed: • VSM pay framework has been received • A review of the nursing job profiles is expected • Resident doctors will receive ballot papers on the 27th May in relation to the trade dispute in respect of the lack of an acceptable and timely pay agreement for resident doctors in England for the 2025/26 pay round. More information to follow.
3.1 Communications Update	Yes	Yes	No	The Committee noted the report. It highlighted that current internal communications are not reaching a sufficient number / breadth of staff. A review of communication channels will be undertaken, including engaging staff, and a plan will be brought back.

The Princess Alexandra Hospital NHS Trust

5.1

PEOPLE COMMITTEE

TERMS OF REFERENCE 2025-26

PURPOSE:

The purpose of the People Committee:

- Maintain oversight of the development and design of the Trust's workforce and ensure it is aligned with the strategic context within which the Trust is required to operate.
- Assure the Board on all aspects of People, Staff health and well-being and Organisational Development and provide leadership and oversight for the Trust on people issues that support delivery of the Trust's annual objectives.
- Assure the Board that the Trust has adequate staff with the necessary skills, training and competencies to meet both the current and future needs of the Trust and ensure delivery of efficient services to patients and service users.
- Assure the Board that statutory and regulatory requirements relating to workforce are met.
- ~~Maintain oversight of the implementation of the communications strategy and delivery of communications to patients, staff, the media and stakeholders~~.
- Maintain oversight of staff engagement and internal communications, supporting staff wellbeing, morale and efficient working

DUTIES:

The following comprise the People Committee's main duties as delegated by the Board of Directors:

1. To promote the Trust's values and behaviours
2. Provide assurance on the development and delivery of a People and OD strategy that supports the Trust plans and ensure an appropriate workforce culture is in place and monitor their implementation.
3. Keep under review the Trust's plans in relation to its people including recruitment and retention of staff, Organisational Development, learning, and employee engagement and staff health and wellbeing.
4. Review people performance metrics and oversee the development of a balanced scorecard for all people indicators.
5. Maintain oversight of staffing levels ensuring the Trust has adequate staff with the necessary skills, training and competencies to meet both the current and future needs of the Trust and ensure delivery of high quality care to patients through safe and effective staffing (*Developing Workforce Safeguards, October 2018*).
6. Review the outcomes of national and local staff surveys and monitor the progress of action plans.
7. Monitor staff engagement initiatives and outcomes
8. Ensure the Trust meets its statutory obligations regarding Diversity and Inclusion.
9. Oversee the Trust's relationship with educational partners to maximise the benefits of these relationships to the Trust.
10. Review and monitor people, organisational development and education and training risks including those reflected on the Board Assurance Framework and seek assurance that plans/actions are in place to mitigate identified risks.
11. The Committee shall request and review reports from other sub groups as deemed necessary
12. Other People/OD/Training activity as requested by the Board.

13. Keep under review the development of a Communications Strategy and monitor its implementation.
14. Review and monitor the portfolio of volunteer activities and services.
15. Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in policy and national guidance including receiving regular reports from the Freedom to Speak up Guardians.

WORKPLAN: **Annual Work Plan and Committee Effectiveness**
Every year, set an Annual Work Plan and conduct an effectiveness review (which will include the achievement of the Annual Work Plan and a review of the terms of reference) and report this to the Board.

ACCOUNTABLE TO: Trust Board.

REPORTING A Committee report shall be provided to the next meeting of the Board of Directors. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the People Committee and advise of progress against the Annual Work Plan.

CHAIRMAN: Non-Executive Director.

COMPOSITION OF MEMBERSHIP: The People Committee is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed membership is:

- Chair – Non-Executive Director
- Non-Executive Directors/Associate Non-Executive Directors
- Chief People Officer
- Chief Operating Officer
- Chief Nurse

The Chair of the People Committee shall be appointed by the Chair of the Trust Board; s/he shall have recent and relevant finance or business or workforce experience.

If not already a member of the People Committee, the Audit Committee Chair may attend any meeting.

~~The Chair and Chief Executive of the Board reserve the right to attend meetings and will attend alternate meetings of the Committee.~~

All members will have one vote. In the event of votes being equal, the Chair will have the casting vote. Deputies attending the meeting on behalf of a member of the Committee are not entitled to exercise a vote.

ATTENDANCE: Members are expected to attend all meetings of the Committee. An attendance register shall be taken at each meeting and an annual register of attendance included in the Trust's annual report.
In addition to the members of the Board, the following shall be expected to attend each meeting:

- Deputy Chief People Officer
- Associate Director of Learning and OD
- ~~Associate~~ Director of Communications

The following shall attend meetings as required:

- Medical Education Manager
- Director of Medical Education

To ensure appropriate accountability, others will be invited to attend where areas of risk or operation are being discussed within their areas of responsibility.

Where considered appropriate and necessary, the Internal Auditors may be invited to attend meetings to present reports of any audits conducted by them in respect of issues within the scope of the Committee.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chair, another Non-Executive Director member of the People Committee will chair the meeting.
Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance. In the absence of an Executive member his/her designated deputy may attend with the permission of the Chief Executive Officer.

QUORUM:

The quorum for any meeting shall be the attendance of a minimum of one Non-Executive member, and one other Executive member.

DECLARATION OF INTERESTS:

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

LEAD EXECUTIVES:

Chief People Officer

MEETING FREQUENCY:
MEETING ORGANISATION:

Meetings of the People Committee shall be bi-monthly.

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting will be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- All final Committee reports must be submitted six clear days* before the meeting.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting.

*'clear day' is a day which is not a Saturday or Sunday or a public or bank holiday.

AUTHORITY

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

The People Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the People Committee.

The People Committee is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary.

TERMS OF REFERENCE:

The terms of reference of the People Committee shall be reviewed at least annually and presented to the Trust Board.

The Princess Alexandra Hospital NHS Trust

DATE By People Committee:
APPROVED: By Trust Board:

5.1

MEMBERSHIP

Membership and Those in Attendance	
Members	
Chair: Non-Executive Director	Darshana Bawa
Non-Executive Director	Oge Austin-Chukwu
NExT Non-Executive Director	Bola Johnson
Associate Non-Executive Director	Anne Wafula-Strike
Chief People Officer	Giovanna Leeks
Chief Operating Officer	Stephanie Lawton
Chief Nurse	Sharon McNally
In Attendance	
Chief Executive	Thom Lafferty
Associate Director of Learning and OD	Denise Amoss
Medical Education Manager	Judith Butcher
Deputy Chief People Officer	Samantha Gooden
Director of Communications	Marcel Berenblut
Director of Medical Education	Preethi Gopinath
Secretariat	
Director of Corporate Governance	Heather Schultz
Corporate Governance Officer	Becky Warwick

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 June 2025

5.2

Agenda item:	5.2							
Presented by:	Giovanna Leeks, Chief People Officer							
Prepared by:	Giovanna Leeks, Chief People Officer							
Date prepared:	29 May 2025							
Subject / title:	People Strategy							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	x
Key issues:	The purpose of this paper is to highlight the People Team's vision, mission and strategy for 2025-2027 and to seek board approval for implementation. The strategy was reviewed at People Committee and recommended to Board.							
Recommendation:	This paper is presented for approval							

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

Previously considered by:	People committee - supported 23/05/25 Staff side Peer reviews workshops
Risk / links with the BAF:	NHS People Plan 2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	People process impact ED&I Best practice applied to people processes People Strategy including NHSE People Plan
Appendices:	n/a

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The Princess Alexandra Hospital NHS Trust

Executive Summary

The purpose of this paper is to highlight the People Team's vision, mission and strategy for 2025-2027 and to seek board approval for implementation.

1. Highlight achievements from 2019-2025

Our People Strategy 2019/2024 set out a number of ambitions around five pillars: Health and Wellbeing, Resourcing, Leadership, New Services, and Technology. The strategy has been developed with reference and alighnment to the trust's key strategies.

5.2

The metrics highlighted in fig. 1, illustrate that the result have improved year and year with stellar results making PAH one of the best in the East of England and one of the best performing trust's in the country in term of our agency spend reduction.

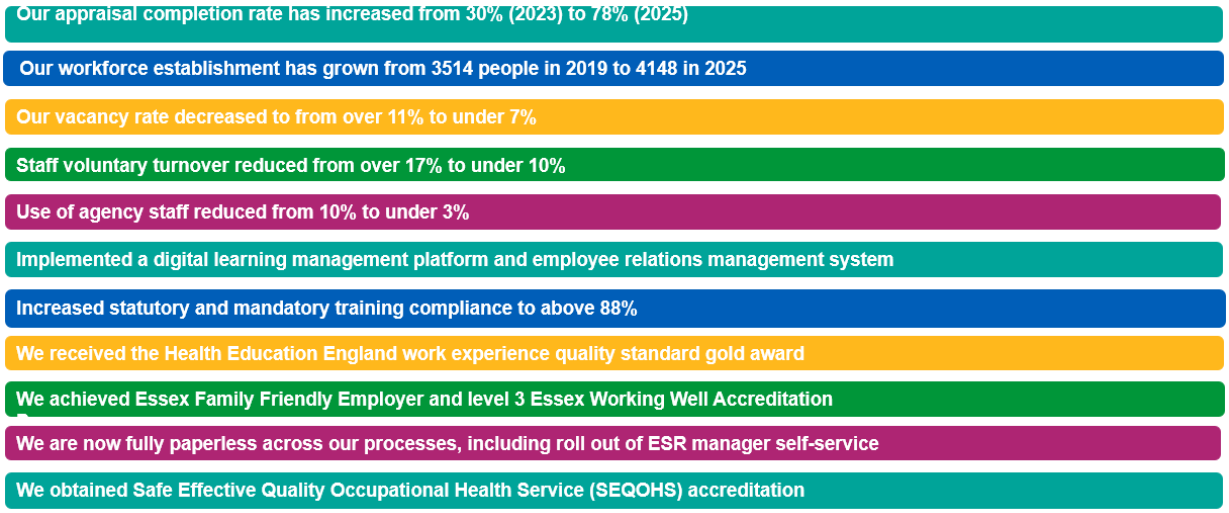


Figure 1

We have undertaken a benchmarking exercise, peer review, tabled at People Committee, consultation with the Chair, Chief Executive Officer, Executive and Non-Excutive colleagues, workshops and engagement with the wider trust, to enable us to identify our drivers for change and consequently draw on paper our strategy.

In addition it is worth noting that the current NHS landscape and its challenges and constraints have also added a further dimension to this work, therefore it is intended that this strategy is to be aligned and future proofed, Consequently, it will need to be fluid and reviewed periodically to enable us to deliver the best care for our patients and the community we serve while at the same time looking after our people.

2. Drivers for change

Significantly, over 70% of our people live within our close community, with 60% living in Harlow which provide opportunity to leverage PAH's as an anchor institution. The strategy therefore is predicated on us focusing on improving the lives of our people, which will intrinsically lead to investing in our community and all the patients we serve.

The recently issued Caring Communities Commission shows Harlow as an outlier across Essex with regard to health outcomes and inequalities. Consequently, this presents a great opportunity for us to address the health inequalities for our People and enhance patient care within the community we serve, whilst also supporting our community to live better and healthier lives.

The strategy aims to deliver across 5 key drivers:

People Planning – to be future-ready workforce through strategic recruitment, retention, and career development

Equality, Diversity, Inclusion and Belonging – to embed fairness, representation, and inclusivity at every level

Staff Wellbeing – to prioritising our people's mental health, resilience, and a positive workplace culture

Sustainability – to strengthen our workforce resilience, long-term workforce planning, and cost-effectiveness

Digital – to leverage technology in order to enhance recruitment, learning, and staff engagement

Figure 2

These drivers have enabled us to create a framework as identified on fig. 3

Figure 3

3. Strategic priorities

Through benchmarking and wider engagement it became clear that our strategic priorities had to be described in simple translatable common language, to ensure buy-in and commitment from board to ward. An emphasis on going back to basics and creating a sure foundation to deliver our strategy with a focus on patients, our people and community creating a centre of excellence while doing so.

3.1 Attract & Recruit

We are committed to positioning PAHT as an employer of choice by strengthening talent pipelines, expanding career opportunities, and ensuring inclusive recruitment. We have articulated the key elements, namely: *'enhancing our brand', 'expanding talent pipeline', 'leveraging technology for recruitment', implement a values-based recruitment'* and how we will deliver this through our 5 drivers for change.

Below on fig. 4 we have our timelines for delivery of our key projects.

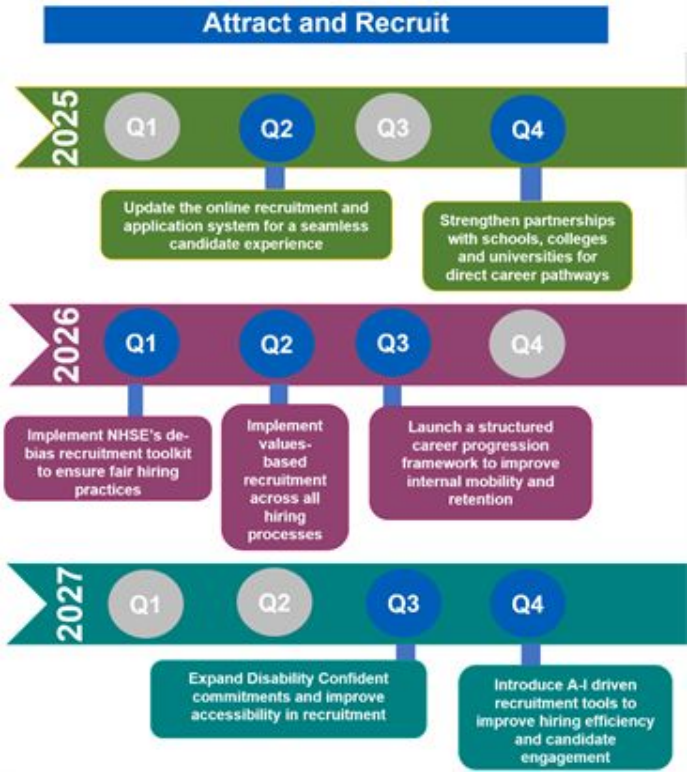


Figure 4

3.2 Develop & Retain

Our ambition is to create a culture of growth, leadership, and progression, where every individual is supported to thrive.

Similarly, we have concentrated on some key elements in order to deliver this strategic objective: *'develop competence and capability', 'create learning opportunities', 'transform our culture', 'personal growth and career development'.*

Figure 5 identify the timelines for this priority.

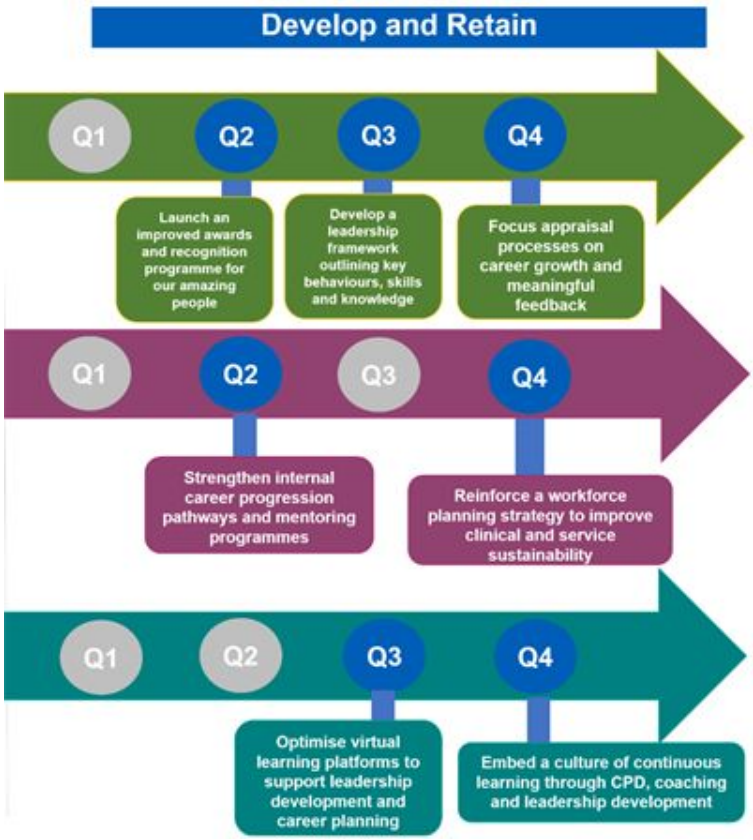


Figure 5

4. Measuring Success

In order for this Strategy to be successful we will require monitoring of the key measures aligned to the milestones. The monitoring will be done via People Committee and Trust Board updates as and when required.

Attract & Recruit				
Metric	Source	Current*	Target 25/26	Target 26/27
Staff recommending PAHT as a place to work	NHS Staff Survey	50%	55%	61%
Time to hire (working days)	Workforce information	51	45	42
Vacancy rate (%)	Workforce information	6.90%	To remain below 9%	To remain below 9%
Leavers in first 12 months (%)	Workforce information	30.37%	25%	19%
Diversity of new hires (WRES & WDES improvements)	Workforce information	61.24%	To remain stable	To remain stable
Use of temporary staffing (% of workforce cost)	Workforce information	13.33%	12%	10%
Apprenticeships intake (placements per year)	Workforce information	103	150	200
Early careers intake (work experience placements per year)	Workforce information	184	210	250
Develop & Retain				
Metric	Source	Current*	Target 25/26	Target 26/27
NHS Staff survey completion rate	NHS Staff Survey	49%	60%	65%
Turnover rate (%)	Workforce information	9.49%	To remain below 12%	To remain below 12%
Internal promotions and career progression (%)	Workforce information	10.21%	15%	20%
Appraisal completion rate (%)	Workforce information	78%	90%	90%
Staff participation in leadership development	Workforce information	308	340	380
Staff participation in CPD	Workforce information	948	1000	1050

Figure 6

The Princess Alexandra Hospital NHS Trust

5. Recommendation

The Trust Board is asked to

- note the progress made through engagement in order to present this People Strategy
- approve this strategy to be published and socialised across the Trust.

People Strategy

Our Amazing People

Attract, recruit, develop and retain people for the future

2025-2027

First published 00/00/25

Welcome from Giovanna Leeks, Chief People Officer

PAHT is a fantastic organisation to work for where colleagues are friendly and caring, with a real passion for the work they do. We have so much talent and potential that our **Amazing People Strategy** is here to support our people to care for the thousands of patients that we serve.

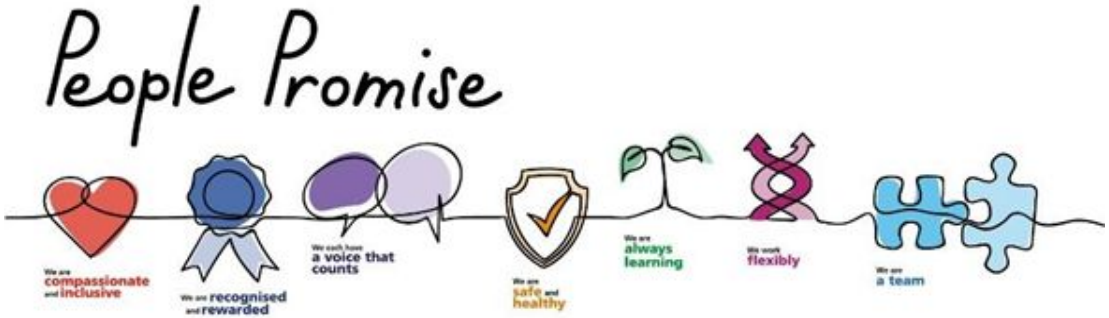
Our mission is to deliver outstanding, compassionate care to every patient, every time. We are committed to improving lives through innovation, collaboration, and excellence, fostering a culture of respect, inclusivity and continuous learning. Together, we strive to be a trusted partner in health and wellbeing for our community, ensuring dignity and kindness are at the heat of everything we do.

Our people are our greatest asset and as we move forward their physical and mental wellbeing and a sense of belonging have never been more important. The new world of healthcare places collaboration at its core. The drive to develop an NHS that is fit for purpose continues, and collaboration with partners across health and social care in the system is essential and will shape and determine our future workforce planning and success.

We will also have a new blueprint for how the human resources (HR) and organisational development (OD) profession will operate over the next 10 years, with the national 10-year plan that should be launched soon.

In this context, we have developed a strategy to take us on a journey of transformation and improvement that will lead us successfully into the future, enabling us to deliver **modern**, **integrated** and **outstanding** care that keeps our growing and ageing population healthier. Guided by the principles of our values: **patient at heart**, **everyday excellence** and **creative collaboration**, one of its pillars is **our culture**. Our **Amazing People Strategy** is our journey for the next three years towards a culture of fostering and nurturing an environment where our people are engaged, listened to, supported and helped to grow.

A strategy for our almost 4,500 people is a big challenge. We face national and international shortages of talented people, the environment which our people work in is not always ideal, and people have lacked time and space to develop and grow. Our **Amazing People Strategy** is designed to show the way, and provide a roadmap to achieving our **modern, integrated** and **outstanding** ambition, through amazing people.



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Our population and commitment

Wider Catchment area (2025)

As an anchor institution, PAHT plays a crucial role in shaping the health, wellbeing, and economic prosperity of the communities we serve. We are more than a healthcare provider – we are a key employer, a skills developer, and a driver of local economic and social value. Our position within our neighbourhoods allows us to work collaboratively across health and care services, ensuring that we are delivering care that is not only clinically excellent but also rooted in place-based/neighbourhood needs.

73% of our People have homes within our close community, with 60% of our People living in Harlow. By investing in our People we are playing a strong role in enhancing our community lives and supporting the health inequalities disparities.

In terms of patients, PAHT currently (2025) serves a local population of around 350,000 in west Essex and east Hertfordshire, including Harlow, Bishop's Stortford, Epping, and surrounding areas. Our current wider catchment area extends up to 500,000 residents across Hoddesdon, Cheshunt, and Broxbourne, and we are part of a broader systems footprint covering 1.6 million people.

As a place-based leader, we are committed to:

- Strengthening health and care partnerships to improve integrated services, enhancing our community leaving standards while addressing local health inequalities.
- Continue to delop a workforce that reflects our community, ensuring inclusive recruitment and career development opportunities for local people.
- Supporting economic growth by being a major local employer and investing in skills, apprenticeships, and training for residents, with a particular focus on young people with disabilities and long term unemployed.

Our commitment as an anchor institution

As we move forward, PAHT will continue to embed place-based leadership and workforce development at the heart of our People Strategy, ensuring that our role as an anchor organisation:

- Supports local workforce sustainability and economic growth.
- Drives long-term career opportunities for our local people.
- Creates a stronger, healthier, and more resilient community.

Highlight achievements from 2019-2025

Our People Strategy 2019/2024 set out a number of ambitions around five pillars: Health and Wellbeing, Resourcing, Leadership, New Services, and Technology.

- Our appraisal completion rate has increased from 30% (2023) to 78% (2025)
- Our workforce establishment has grown from 3514 people in 2019 to 4148 in 2025
- Our vacancy rate decreased to from over 11% to under 7%
- Staff voluntary turnover reduced from over 17% to under 10%
- Use of agency staff reduced from 10% to under 3%
- Implemented a digital learning management platform and employee relations management system
- Increased statutory and mandatory training compliance to above 88%
- We received the Health Education England work experience quality standard gold award
- We achieved Essex Family Friendly Employer and level 3 Essex Working Well Accreditation
- We are now fully paperless across our processes, including roll out of ESR manager self-service

We obtained Safe Effective Quality Occupational Health Service (SEQOHS) accreditation

Where we are

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Drivers for change

People planning	• Workforce shortages remain a significant challenge across the NHS, requiring proactive recruitment and retention strategies. • Retention is critical, as high turnover impacts patient care, increases costs, and reduces team stability. • We must anticipate future demand, ensuring the right skills are in place for long-term sustainability. • Effective workforce planning prevents skill shortages and over-reliance on temporary staffing. • Requirements for collaboration across services, demanding new workforce models and partnerships.
Equality, Diversity, Inclusion & Belonging	• A diverse and inclusive workforce leads to better decision-making, innovation, and patient care. • Addressing workplace inequalities ensures fair access to opportunities and supports retention. • Our people must feel psychologically safe to speak up and report concerns without fear. • Diverse leadership ensures better representation and stronger decision-making across all workforce levels. • Recognising and celebrating our people's achievements enhances engagement and retention.
Staff Wellbeing	• A compassionate, values-driven culture improves staff engagement and patient outcomes. • Misaligned cultures are known to be a cause of people to leave organisations, impacting service delivery. • A healthy and supported workforce delivers better patient care and performs at a higher level. • Mental health and psychological safety are key to creating an engaged and productive workforce
Sustainability	• Future-proofing the workforce ensures that skills and resources align with long-term NHS priorities. • The NHS must adapt to technological advancements, requiring continuous training and upskilling. • Workforce resilience is essential to maintaining service delivery in an evolving healthcare landscape. • Strong leadership and career development pathways attract and retains top talent. • Transparent career progression supports motivation and reduces workforce attrition.
Digital	• Digital tools and AI can improve recruitment, training, and workforce efficiency. • Staff must be equipped with digital skills to adapt to new healthcare technologies. • Optimised virtual learning environments will improve training accessibility and career development.

SWOT Analysis

Strengths

- A workforce committed to delivering high-quality patient care despite pressures.
- Partnership working
- Stability on our turnover – experienced and knowledgeable teams
- Quality improvement methodology
- Progress in Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
- Increased mental health and wellbeing support initiatives.
- PAHT is an anchor institution, with strong collaborations across health and social care partners.
- Largest local employer, providing stability and career opportunities within the region.
- Board commitment to leadership and engagement
- Implementation of a digital learning management platform to support workforce development.

Weaknesses

- Workforce shortages remain a challenge, particularly in specialist clinical roles.
- High workloads and staff burnout persist, impacting overall wellbeing and retention.
- Non-medical staff appraisal completion sits at 78%, below the 90% target.
- Lack of consistent career development discussions, which may impact progression and motivation.
- Workload intensity and staffing pressures may contribute to staff fatigue and stress-related absence.
- Short-term sickness (2.92%) is higher than the target (1.85%)
- Some processes remain manual, slowing efficiency in recruitment and learning.
- Senior leadership is not yet fully reflective of workforce diversity.
- Staff from underrepresented groups may lack clear progression pathways into leadership.

Opportunities

- Flexible working expansion can improve work-life balance.
- Joint workforce planning within the system can help fill vacancies and share resources.
- Potential for rotational roles and cross-organisational career development.
- AI-driven workforce tools can help streamline recruitment, onboarding, and training.
- E-learning expansion can support digital learning and upskilling.
- NHS-wide commitments to Workforce Race Equality (WRES) and Disability Confident Employer initiatives can help improve representation.
- Targeted leadership development for underrepresented groups.
- Strengthening partnerships with schools, colleges, and universities to bring new talent into PAHT.
- Apprenticeship and internship growth to help fill entry-level roles.

Threats

- National NHS landscape and drive to reduce corporate costs, leading to restructure processes that can impact morale and performance
- National and local shortages in key NHS roles in addition to competition from private healthcare and other NHS Trusts for small pool of candidates.
- A national drive for increase performance regulation, which may inhibit our ability to deliver the People Strategy.
- Budget constraints could limit investments in new workforce initiatives.
- Rising costs of living and wage pressures could impact workforce satisfaction.
- Potential for policy changes to affect recruitment and workforce planning.
- Additional compliance and regulatory requirements could increase administrative burden.
- Continued stress and burnout risks leading to increased turnover.
- Without stronger career development opportunities, staff may seek external progression.
- Some staff may struggle with new digital tools, slowing adoption of AI and

Our Amazing People Strategy framework

In developing this overarching strategy, we have reviewed **best practice, national NHS aspirations, and the evolving world of work.** We recognise the importance of **partnerships, digital transformation, and workforce sustainability** in delivering outstanding patient care.

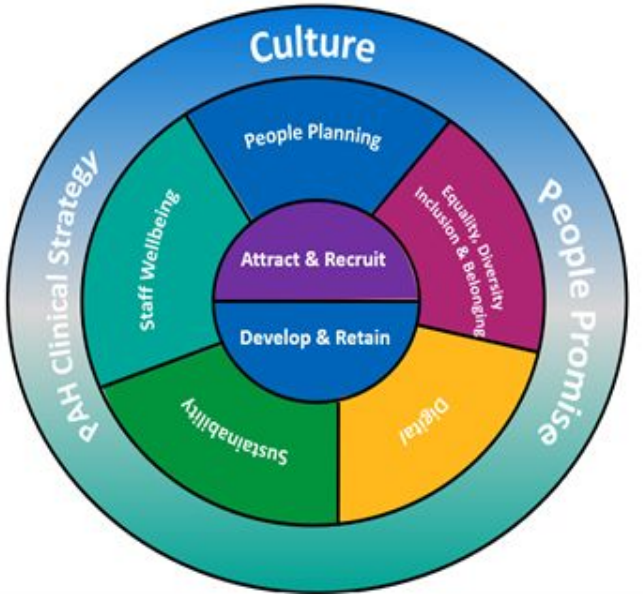
Our **Amazing People Strategy** is intrinsically linked to **PAH Clinical Strategy, NHS People Promise** and the **NHS Long Term Workforce Plan**, ensuring that we build a workplace where our people **thrive, feel valued and deliver outstanding care.** It is underpinned by our **five key platforms,** each of which will be supported by dedicated strategies to drive targeted improvements:

- **People planning** – ensuring a future-ready workforce through strategic recruitment, retention, and career development.
- **Equality, Diversity, Inclusion & Belonging** – embedding fairness, representation, and inclusivity at every level.
- **Staff wellbeing** – prioritising mental health, resilience, and a positive workplace culture.
- **Sustainability** – strengthening workforce resilience, long-term workforce planning, and cost-effectiveness.
- **Digital** – leveraging technology to enhance recruitment, learning, and staff engagement.

Our strategy is built around two strategic key pillars:

Attract & Recruit – Positioning PAH as an employer of choice by strengthening talent pipelines, expanding career opportunities, and ensuring inclusive recruitment.
Develop & Retain – Creating a culture of growth, leadership, and progression, where every individual is supported to thrive.

At the heart of this strategy is our **culture**—one that fosters **collaboration, inclusivity, and continuous learning.** We are committed to building a **modern, integrated, and outstanding organisation** where our people feel a strong sense of **belonging, purpose, and pride** in the work they do.



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Strategic priority – Attract & Recruit

Enhance our brand

We are committed to fostering a **compassionate**, **diverse**, and **inclusive** workplace that reflects the NHS People Promise. Through **celebrating success**, sharing patient and staff stories, and showcasing innovation in care, we inspire and **attract talent** from all backgrounds. We actively engage in recruitment efforts, career events, and outreach programmes to highlight **opportunities for growth** and the benefits of joining our team. By continuously reviewing our compensation packages and providing a welcoming environment through open days and hospital events, we aim for every individual to feel **valued**, **respected**, and **empowered**.

Expand talent pipelines

We are committed to building a **diverse** and **inclusive workforce** by creating accessible career pathways into healthcare. Through partnerships with schools, colleges, and universities, we will **inspire** future professionals while offering flexible recruitment and career progression opportunities. By engaging with prospective candidates and supporting young adults through work experience, apprenticeships, and internships, we will **nurture future talent**. We will also widen participation, helping unemployed and disabled individuals into meaningful NHS careers, reinforcing our commitment to being a Disability Confident employer.

Leverage technology for recruitment

By 2030, our recruitment approach at PAH will be streamlined, inclusive, and technology-driven to attract and retain top talent. We will implement a **user-friendly online application system** that simplifies the process and meets the diverse needs of applicants. **Optimised recruitment workflows** will reduce hiring time, ensuring continuous engagement with candidates. Leveraging **AI-driven applicant tracking**, we will identify and connect with outstanding individuals efficiently.

Implement values-based recruitment

Our recruitment approach will be **values-driven**, **inclusive**, and focused on building an **outstanding workforce**. We will recruit for **attitude and behaviours**, using values-based recruitment to ensure candidates align with our culture. Our interview and assessment processes will integrate tools that evaluate alignment with the NHS People Promise and PAH values, setting the stage for continuous growth. We are committed to **attracting a diverse workforce** with inclusive practices that reflect the communities we serve.

Attract & Recruit

Actions that underpin	
People planning	• Actively promote career opportunities to attract a diverse range of candidates and help individuals realise their potential within the NHS • Strengthen partnerships with schools, colleges, and universities to develop direct pathways into healthcare careers, including nursing, medicine, and allied health professions • Expand opportunities for work experience, apprenticeships, and internships to inspire young people and career changers to join the NHS • Design flexible roles and career pathways that empower employees to grow, develop, and progress within the organisation • Implement structured development programs that support long-term career growth and retention • Adopt a values-based recruitment approach, ensuring candidates align with our culture and commitment to patient care • Enhance the selection process by incorporating tools that assess alignment with the NHS People Promise and PAH values, setting the foundation for growth and success
Equality, Diversity, Inclusion & Belonging	• Champion the NHS People Promise, reinforcing our commitment to a compassionate, diverse, and inclusive workplace where everyone belongs • Embed inclusive recruitment practices that reflect the diversity of the community we serve, ensuring fair access to opportunities for all • Implement NHSE's de-bias recruitment toolkit to remove barriers and create fair and equitable hiring processes • Support initiatives that increase employment opportunities for underrepresented groups, particularly disabled individuals, as part of our commitment to the Disability Confident scheme • Foster a culture where every employee feels safe and empowered to bring their whole selves to work, knowing they are valued, respected, and included
Staff Wellbeing	• Celebrate our workforce by sharing success stories, patient testimonials, and innovations in patient care to highlight the impact of our people • Develop a comprehensive onboarding programme that provides new starters with orientation, training, and mentorship, ensuring they feel welcomed, valued, and supported from day one • Regularly review benefits, and incentive structures to remain competitive and attract a high-caliber, diverse workforce • Create a workplace culture that prioritizes wellbeing, engagement, and professional development, helping employees to thrive
Sustainability	• Develop strong educational partnerships with local schools, colleges, and universities to ensure a sustainable pipeline of future NHS professionals • Support underemployed and economically inactive individuals in accessing NHS careers, creating long-term employment pathways for the local community • Design career development initiatives that retain and upskill existing staff, reducing turnover and ensuring workforce stability
Digital	• Digital tools and AI can improve recruitment, training, and workforce efficiency. • Staff must be equipped with digital skills to adapt to new healthcare technologies. • Optimised virtual learning environments will improve training accessibility and career development.

Strategic priority – Develop & Retain

Develop competence and capability

We are committed to fostering **outstanding leadership** by defining key behaviours, skills, and knowledge while challenging everyone to role model our values daily. Leadership development will align with NHS expectations, ensuring managers support their teams effectively. Senior leaders will embrace the **NHS Leadership Way** while clearly communicating our mission and achievements. By reinforcing our core behavioural framework, we will ensure a **consistent, respectful workplace culture**. We will enhance appraisals to improve development conversations and explore AI, machine learning, and emerging technologies to equip us for the future.

Create learning opportunities

We aim to enhance education and learning throughout PAH by developing a **governance framework** for mandatory, statutory, role-specific training and professional development. Career support will be strengthened through **buddying, advocacy, coaching, mentoring, secondments,** and **experiential opportunities**. Additionally, we will **optimise our virtual learning environment**, integrating functionality to support appraisals, one-to-one conversations, development, and career planning.

Transform our culture

We will foster a **just and learning culture**, promoting civility where people feel confident to speak up, learn from errors, and improve services. Through **appreciative inquiry**, we will identify and replicate success. We will take **positive action** to ensure **diverse leadership** at all levels and drive **equality, diversity, and inclusion** by tackling workforce inequality, bullying, harassment, and discrimination, including sexual safety. Our **Thrive at Work** approach will create conditions where everyone feels they belong, differences are celebrated, and inclusion is embedded.

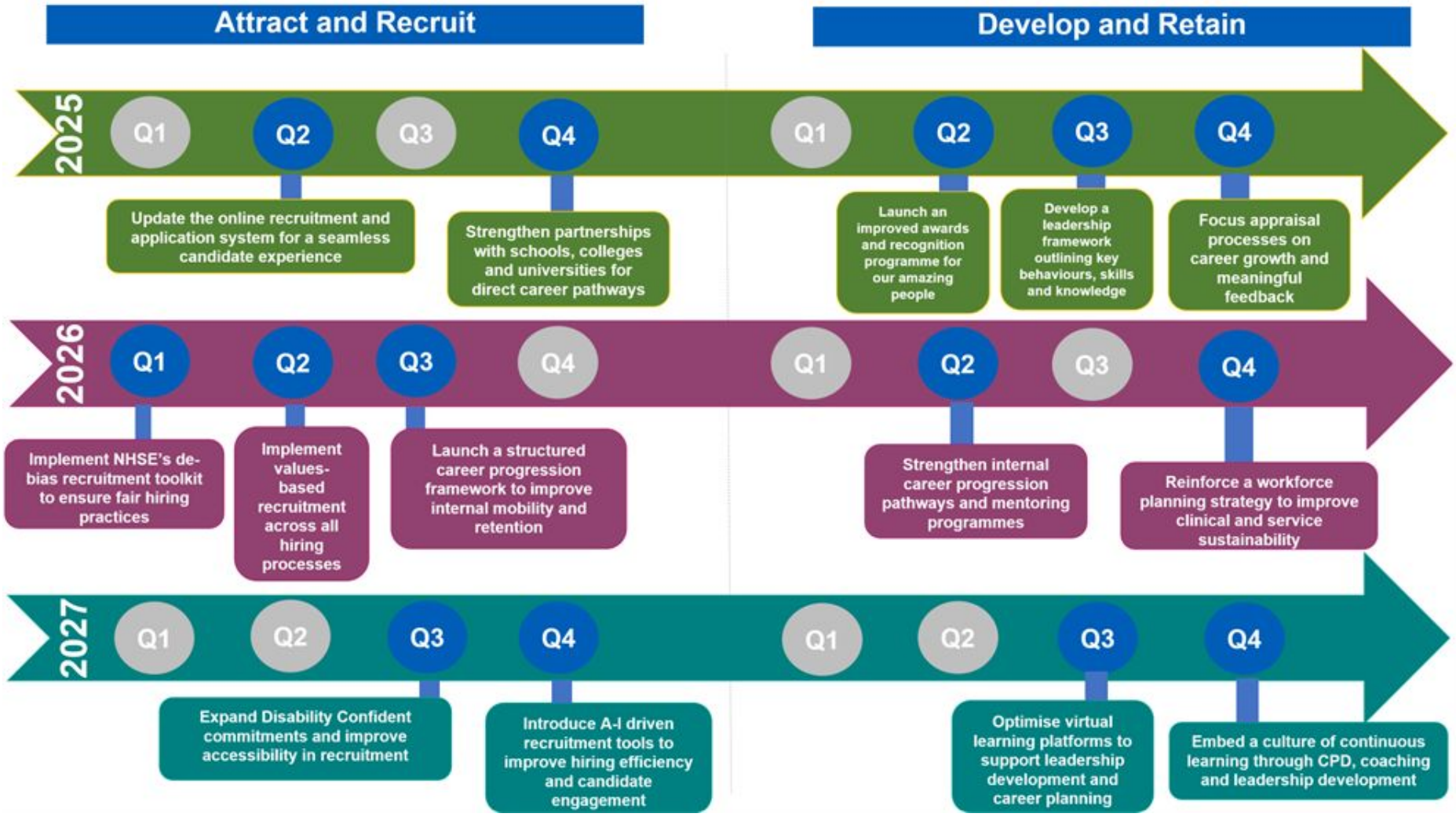
Personal growth and career development

We will create **personal growth and career plans** tailored to individual aspirations, linking career opportunities to **diversity** and various life experiences. Our **workforce planning** will focus on developing future-proof, trust-wide and service-specific plans to ensure **clinical sustainability, retention, recruitment**, and **quality** while promoting **cost-effectiveness**. We will recognise outstanding people by reviewing and enhancing our **recognition approaches**, both internally and externally, expanding our **people awards** and increasing the visibility of our team's achievements.

Develop & Retain

Actions that underpin	
People planning	• Create a leadership framework outlining the competences to be an outstanding leader • Review leadership development programmes and implement improvements to align with NHS expectations • Support senior leaders in adopting progressive leadership principles based on compassion, curiosity, and collaboration (aligned with the NHS Leadership Way) and communicate strategic progress effectively • Engage and strengthen the core behavioural framework, ensuring all staff understand expectations around how we treat each other and our patients • Improve the quality of appraisals by enhancing the effectiveness of discussions and personal development planning • Enhance education and learning governance, ensuring robust frameworks around mandatory, statutory, role-specific, and professional development training • Strengthen career support by developing a framework of supportive learning, mentoring and coaching methods • Create personalised career growth plans that reflect individual aspirations • Develop future-proof workforce and service plans to support sustainability, retention, recruitment, cost-effectiveness, and quality • Recognise and celebrate amazing staff by reviewing existing recognition frameworks, expanding people awards, and raising the profile of staff achievements internally and externally
Equality, Diversity, Inclusion & Belonging	• Take positive action to ensure diverse leadership at all levels by developing and promoting underrepresented groups • Drive a culture of belonging by embedding inclusion into leadership, development, and workplace strategies • Tackle inequality and discrimination through a bold Equality, Diversity, Inclusion & Belonging Strategy; addressing bullying, harassment, discrimination, and sexual safety concerns • Encourage a just and learning culture by fostering an environment where staff feel safe to speak up and learn from mistakes • Expand training in appreciative inquiry techniques to identify and replicate success across the organisation • Work with external partners to strengthen our inclusion and belonging initiatives
Staff Wellbeing	• Thrive at work by fostering an inclusive environment where everyone feels valued, respected, and empowered to bring their whole selves to work • Promote psychological safety and civility, ensuring staff feel safe, supported, and confident in raising concerns or ideas • Develop leadership programmes that embed inclusion and belonging at all levels, ensuring a values-driven workplace
Sustain ability	• Ensure workforce sustainability by creating trust-wide and service-level workforce plans that support recruitment, retention, and quality improvement • Embed leadership development as a long-term investment, ensuring PAH builds a resilient and adaptable leadership pipeline
Digital	• Review digital skill needs and explore AI, machine learning, and emerging technologies • Optimise virtual learning environments to enhance appraisals, one-on-one conversations and professional development • Use digital tools to improve staff engagement and recognition, ensuring easy access to career growth and learning opportunities

Our road map of key milestones



modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Measuring success

We will measure success through clear key metrics based on high performing organisations across the NHS. These will be monitored through our governance mechanisms, through People Committee and reported to Board and regional oversight groups.

Our metrics are a blend of people experience measures and quantitative numbers based on measures. They may evolve over time and may be informed by wider priorities such as the NHS Long Term Plan.

Attract & Recruit				
Metric	Source	Current*	Target 25/26	Target 26/27
Staff recommending PAH as a place to work	NHS Staff Survey	50%	55%	61%
Time to hire (working days)	Workforce information	51	45	42
Vacancy rate (%)	Workforce information	6.90%	To remain below 9%	To remain below 9%
Leavers in first 12 months (%)	Workforce information	30.37%	25%	19%
Diversity of new hires (WRES & WDES improvements)	Workforce information	61.24%	To remain stable	To remain stable
Use of temporary staffing (% of workforce cost)	Workforce information	13.33%	12%	10%
Apprenticeships intake (placements per year)	Workforce information	103	150	200
Early careers intake (work experience placements per year)	Workforce information	184	210	250
Develop & Retain				
Metric	Source	Current*	Target 25/26	Target 26/27
NHS Staff survey completion rate	NHS Staff Survey	49%	60%	65%
Turnover rate (%)	Workforce information	9.49%	To remain below 12%	To remain below 12%
Internal promotions and career progression (%)	Workforce information	10.21%	15%	20%
Appraisal completion rate (%)	Workforce information	78%	90%	90%
Staff participation in leadership development	Workforce information	308	340	380
Staff participation in CPD	Workforce information	948	1000	1050

**Data for from March 2025*

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BOARD OF DIRECTORS:	**Trust Board (Public) – 5 June 2025**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**29.05.25**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.6 PAF Annual Effectiveness Review 24/25	Y	Y	N	From the review, the following question scored a 3 (requires improvement): • Quality of papers – overall improvement acknowledged but some papers continue to be too detailed. Revision of the IPR will be helpful. *Action: Ongoing review of papers and education of report authors.* The following comments were also discussed: • Does the committee lack clinical input? *This has been addressed with the appointment of Associate NED Parag Jasani who is now a member of PAF.* • On occasion the committee has been asked to retrospectively approve business cases/contract awards. *This will be addressed by ensuring there is oversight and scrutiny of the pipeline for business cases and the contracts register for expiring contracts*.

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Suggestion that the agenda is structured to enable a focus on finance, performance and estates in rotation. *This will be actioned by the corporate governance team.* Some changes were also approved to the PAF terms of reference (in particular future reporting on Alex Health/New Hospital Programme given the Strategic Transformation Committee had been dissolved) which are attached as **appendix 1.**
2.1 Report from Health & Safety Committee	Y	Y	N	Items for noting included: • The meeting on 16.04.25 had focused on critical issues including recent incidents, fire safety, estates compliance, and violence and aggression management. • The Committee had also reviewed compliance with Health Technical Memoranda (HTM) across various domains, emphasising the need for recruitment of Authorised Persons (APs) to improve compliance. • The recent campaign to reduce violence and aggression had led to increased reporting and better incident management. The major incident plan was reviewed, with a commitment to regular testing and alignment with upcoming Martin's Law requirements.

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Health & Safety Annual Report	Y	Y	N	During 2024/25, the Trust had faced a dynamic operational environment marked by leadership changes and increasing regulatory demands. Key safety and compliance risks had been actively managed. HTM compliance required continued capital investment, policy updates and staff training. Incident reporting had highlighted the need for improved follow-up. COSHH and sharps safety audits had identified areas for safer practices, while manual handling and emergency preparedness had benefited from enhanced training and cross-team collaboration. Violence and aggression remained a priority, with improved reporting and committee oversight. Risk areas had been monitored through the risk register, with mitigation actions underway. Governance had been strengthened through collaboration across departments, and the introduction of digital tools and updated policies now aimed to improve consistency, audit readiness, and accountability moving forward.

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Estates & Facilities Annual Report	Y	Y	N	In 2024/25, the Trust had invested over £8 million in estates and facilities to enhance patient care, staff wellbeing and infrastructure resilience. Key achievements had included upgrades to emergency and inpatient areas, the establishment of a new Community Diagnostic Centre and improvements to ventilation, fire safety, and power systems. Staff environments had been enhanced through refurbished facilities and the creation of a new EHR training hub. Sustainability initiatives had been advanced with LED lighting, waste segregation and recycling schemes, supported by £431,000 in national funding. These efforts aligned with the Trust's long-term strategy and preparation for the new hospital by 2035. It was agreed the report would be revised to include the current estates risks and a tracker for recruitment of Authorised Persons/Authorised Engineers.
2.4 BAF Risk 3.1 (Estate & Infrastructure)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 BAF Risk 3.5 (New Hospital)	Y	Y	N	This risk was now being overseen at PAF. It was noted the risk narrative had been amended to reflect the likelihood of remaining on the current site for longer, and the wait for confirmation that NHP funding can be used for activity to de-risk the site acquisition position. The target risk score had also now been staggered from 15 (2026/27) down to 10 (2032) to reflect site acquisition and approval . In line with the recommendation it was agreed that the risk score would remain at 20.

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Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.1 M1 Integrated Performance Report (IPR)	Y	Y	N	Key headlines were: **ED 4 Hour Standard:** Performance of 68.4% in April 25 against a trajectory of 67%. However performance at 15.05.25 reduced to 64.19%. **Referral to Treatment:** Total PTL reduced to 2800 patients since March. The improvement in performance partly attributed to the Trust's validation efforts. PAHT was currently number one in the region for outcomes from validation and in the top five nationally. **Cancer:** 28 day faster diagnosis performance in March was 70.2% against a trajectory of 77%. The unvalidated position for April was currently 72.5%. **Diagnostics:** Diagnostics performed within 6 weeks of referral had increased slightly for January to 62.7%. MRI remained at 100% with no waits over 6 weeks and CT was at almost 95%. Recovery plans were in place for other modalities. **Un-outcomed Clinics in Alex Health:** Teams were working through the issues but there was good oversight on a daily basis and performance was improving. It would however take time for some areas to get back to zero.

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Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
3.2 BAF Risk 1.3 (Operating Plan)	Y	Y	N	Following a review of the performance BAF risks it was proposed to close the existing risks (Recovery Programme, Seasonal Pressures and ED 4 Hour Target) and replace them with one overarching performance risk as follows: *BAF risk 1.3 Operating Plan:* *Risk of poor outcomes and patient harm due to inability to deliver the national access standards.* PAF approved the new risk and mitigated risk score of 15 alongside the closure of the three risks mentioned above.
3.4 BAF Risk 1.5 (Cyber)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
4.1 M1 Integrated Finance Report	Y	Y	N	At M1 the Trust was reporting achievement of the M1 plan – a £1.5m deficit. Temporary staffing reductions would be a key focus area for 2025/26 with agency expenditure at its lowest level (£0.5m in M1) which was 2.2% of the in-month pay expenditure compared to 3.3% in 24/25. The cash balance at the end of April had been £18.9m. PAF commended the sustained reductions in agency spend. In summary, a very positive start to the year.

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Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.2 Capital and Capital Projects Update	Y	Y	N	Capital expenditure at M1 had been £1.0m against a full year plan of £29.9m.
4.4 Alex Health Sustainment Phase 1 Delivery Plan	Y	Y	N	PAF considered the funding request to enable the completion of the remaining go-live scope, core upgrade, delivery of six pathway developments and support for core BAU resources in reporting and training. Members were broadly supportive of the case and recommended it to Board subject to clarification on *the amount of investment within the 25/26 plan currently, the gap to be covered and how this would be achieved, assurance on elements for capitalisation and the plan going forward if the additional resource required was not approved under current processes (double lock/triple lock)* . The Board will consider the case in the private session.
4.5 BAF Risk 1.4 (EHR)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16 but it was noted if the planned sustainment investment was not approved, the score may be increased to 20.

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Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
4.6 PQP Update	Y	Y	N	PQP delivery had been achieved in M1 with the plan of £1.7m being delivered. PAF noted the 25/26 PQP Plan was phased to increase throughout the year. The value without clear plans was currently at £9.8m and being reviewed with the divisions.
4.7 Quarterly Procurement Update	Y	Y	N	Key headlines for Q4 24/25 included: • Savings delivery for FY24/25 was £947k, above baseline target. • FY25/26 savings forecast is £1.59m, higher than FY24/25. • Further savings opportunities will continue to be pursued. • The service came under budget for FY24/25 - £14k returned to PAHT. • Overall operational performance continues to be strong - KPIs. • Inventory Management System progressing well. Assurance was provided in terms of a 'forward look' to avoid retrospective contract approvals and further work was requested around the potential impact on the procurement regime of PAHT moving to a greater Essex ICB.

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4.8 Update from Business Case Review Group	Y	Y	N	The paper provided a summary of business cases in development being considered by the Business Case Review Group. In addition to the cases currently under consideration, there was ongoing work to support business case creation through updated templates, training material and discussions at PQP sessions.
4.9 BAF Risk 5.1 (Finance – Revenue)	Y	Y	N	It was agreed that the narrative and risk score would both be reviewed prior to Board, given the 9m PQP gap and Alex Health sustainment investment requirements.
Any Other Business	Y	Y	N	**Corporate Cost Reductions:** The Trust was required to make its submission with exceptions the following day. This would be reviewed by the Board in the private session.
Items for Deep Dive	Y	Y	N	It was agreed to provide a deep dive on performance against the operating plan from a tiering perspective and any highlights from the June tiering visit.
Other items discussed:	Dark Trace 6 Monthly Update			

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PERFORMANCE AND FINANCE COMMITTEE

TERMS OF REFERENCE 2025/26

PURPOSE:

The purpose of the Performance and Finance Committee (PAF):

- Consider, challenge and recommend the Trust's Operating Plan to the Board.
- Scrutinise operational and financial performance and monitor achievement of national and local targets and recommend any re-basing or re-forecasting of operational and financial performance trajectories to the Board;
- Assure the Board of Directors that the Trust has robust processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable.
- Recommend the Trust's Patient Quality and Productivity Programme (PQP) to the Board and monitor its delivery including investigating reasons for variance from plan and recommending any re-basing or re-forecasting of the Plan to the Board;
- Monitor the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities;
- Review and monitor the management of finance, performance and contracting risks.

DUTIES:

The following comprise the PAF's main duties as delegated by the Board of Directors:

Financial Management

1. Consider the content of, planning assumptions, key risks and principles underpinning the Operating Plan prior to submission to the Board for approval.
2. Where there is variance against plan, agree any re-base or re-forecast and ensure appropriate actions are put in place for recovery.
3. Approve the Capital Programme as part of the budget setting process and monitor progress against the plan.
4. Approve the process for the submission of the National Reference Cost Return prior to submission and review the results.
5. Review the implementation of the Trust's plans for Service Line Management.
6. Review compliance with agency cap and spend.
7. Review financial performance and forecast against income, expenditure, working capital and capital and seek assurance that the position is in line with approved plans, targets and milestones and that any corrective measures that are being taken are effective
8. Review significant risks associated with the forecast outturn.
9. Review the Treasury Management Policy, receive reports in accordance with the Policy and approve institutions.
10. Review arrangements for effective compliance reporting in respect of loans and other requirements

Operational Performance

1. Agree the annual operational performance plan
2. Recommend any re-basing or re-forecasting of annual performance trajectories to the Board.
3. Advise the Board of any penalties likely/due to be incurred as a result of performance variance.
4. Monitor the strategic and operational systems and processes to ensure the competent performance management of the organisation

Cost Improvement

1. Agree the level of the Patient Quality and Productivity Programme and recommend to the Board.
2. Monitor delivery of PQP including the investigation of reasons for any variance from plan.
3. Recommend any re-basing or re-forecasting of the Programme to the Board and advise of the reasons why this is necessary;
4. Provide the Board with assurance on the progress and delivery of the programme.

Contract Management

1. Review the Trust's negotiating position prior to annual contracting round with commissioners.
2. Review financial and performance activity against contracts and if corrective action is required, receive assurance that the measures being taken are effective.

People

1. Maintain oversight of expenditure on temporary staffing.
2. Ensure that there is a link between recruitment and the reduction in temporary staffing costs.

Procurement

1. Oversee the implementation of the Trust's Procurement Strategy.
2. Receive an annual report in respect of the Annual Procurement Plan.
3. Receive regular updates on the Procurement pipeline.

Business Cases, Benefits Realisation and Return on Investment

On behalf of the Board:

1. Undertake a robust appraisal of new business cases (capital and revenue) valued at over ~~£500,000~~£600,000, ensuring that the outcomes and benefits are clearly defined, measurable, support the delivery of key objectives for the Trust and that they are affordable.
2. Review benefits realisation and return on investment of major projects.

Capex

1. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.
2. Monitor the implementation of the Trust's Information Technology strategy and Estates Strategy.
3. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.

Estates, Facilities & Sustainability

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1. Oversee the implementation of the Trust's Carbon Reduction and Sustainability Strategy.
2. Receive an annual report in respect of the Trust's Sustainable Development Management Plan.
3. Review the Trust's arrangements for estates and facilities management
4. Oversee the development of the site development control
5. Oversee the progression of the Trust's New Hospital Programme

Health and Safety:
Maintain oversight of Health & Safety including radiation use and protection guidelines (IR(ME)R), fire safety and decontamination.

Information Management, Data Quality and Coding

1. Oversee the Trust's information management systems including Alex Health, coding and data quality arrangements and review progress against key metrics.

Resilience & Business Continuity

1. Undertake an annual review of the Trust's resilience & business continuity arrangements,
2. On behalf of the Board, review how the Trust is upholding its duties to fulfil its duties as a Category 1 responder under the Civil Contingencies Act 2004 and recommend a report to the Board in respect of these.

Risk

1. Monitor and review any risks allocated to the PAF.
2. Review and monitor finance, performance and contracting risks and seek assurance that plans/actions are in place to mitigate identified risks.

Annual Work Plan and Committee Effectiveness

1. Every year, set an Annual Work Plan and conduct an effectiveness review (which will include the achievement of the Annual Work Plan and a review of the terms of reference) and report this to the Board.

ACCOUNTABLE TO: Trust Board.

REPORTING A Committee report shall be provided to the next meeting of the Board of Directors. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the PAF meeting and advise of progress against the PAF's Annual Work Plan.

CHAIRMAN: Non-Executive Director.

COMPOSITION OF MEMBERSHIP: The PAF is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed membership is:

- Chair - Non-Executive Director
- Non-Executive Directors/Associate Non-Executive Directors
- ~~Director of Finance~~ Chief Finance and Infrastructure Officer
- Chief Operating Officer
- ~~Director of Strategy~~ Chief Strategy Officer

- Chief Information Officer

The Chair of the PAF shall be appointed by the Chair of the Trust Board; s/he shall have recent and relevant finance or business or commercial experience.

If not already a member of the PAF, the Audit Committee Chair may attend any meeting of the PAF.

At least one of the Non-Executive Director/ members of the PAF shall also be a member of the Trust's Audit Committee.

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

All members will have one vote. In the event of votes being equal, the Chair of the PAF will have the casting vote. Deputies attending the PAF on behalf of a member of the Committee are not entitled to exercise a vote.

ATTENDANCE: Members are expected to attend all meetings of the PAF. An attendance register shall be taken at each meeting.

The Chair and Chief Executive in their capacity as ex officio members are expected to attend five out of eleven meetings in each reporting period.

In addition to the members of the Board, the following shall be expected to attend each PAF meeting:

- Deputy Director of Finance
- Director of Information & IT
- Deputy Chief Operating Officer

To ensure appropriate accountability, others will be invited to attend when the PAF is discussing areas of risk or operation that are their responsibility.

Internal Auditors to attend meetings by exception, as required to present reports of any audits conducted by them in respect of issues within the scope of the PAF.

DEPUTISING ARRANGEMENTS In the absence of the Committee Chair, another Non-Executive Director member of the PAF will chair the meeting.

Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance. In the absence of an Executive member his/her designated deputy may attend with the permission of the Chief Executive Officer.

QUORUM: The quorum for any meeting of the PAF shall be the attendance of a minimum of two Non-Executive members and two Executive members or their deputies (who may attend with the permission of the Chief Executive Officer).

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DECLARATION OF INTERESTS:	All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.
LEAD EXECUTIVES:	Chief Finance and Infrastructure Officer
MEETING FREQUENCY:	Meetings of the PAF shall be held monthly
MEETING ORGANISATION:	• Meetings of the Committee shall be set before the start of the financial year. • The meeting will be closed and not open to the public. • The Director of Corporate Governance shall ensure there is appropriate secretarial and administrative support to the Committee. • All final Committee reports must be submitted six clear days* before the meeting. • The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting. *'clear day' is a day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY	The PAF is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary. The PAF is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the PAF. The PAF is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary.
TERMS OF REFERENCE:	The terms of reference of the PAF shall be reviewed at least annually and presented to the Trust Board.
DATE APPROVED:	By PAF: 29 May 2025 By Trust Board:

6.1

The Princess Alexandra Hospital NHS
NHS Trust

6.1

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 June 2025

Agenda item:	6.2
Presented by:	Tom Burton, Chief Finance and Infrastructure Officer
Prepared by:	Beth Potton, Deputy Director of Finance
Date prepared:	27 May 2025
Subject / title:	Month 1 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 achievement of the month 1 plan which was a £1.5m deficit. Temporary staffing reductions are key focus areas for 2025/26 with agency expenditure at its lowest level (£0.5m in M1) which is 2.2% of the in-month pay expenditure compared to 3.3% in 24/25. PQP delivery has been achieved in month 1 with the plan of £1.7m being delivered. The plan is phased to increase throughout the year; the value without clear plans is currently at £9.8m and being reviewed with Divisions. The cash balance at the end of April is £18.9m. Capital expenditure in month 1 is £1.0m against a full year plan of £29.9m.								
Recommendation:	The Board is asked to note the month 1 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:	n/a
Risk / links with the BAF:	BAF risks 5.1.
Legislation, regulatory, equality, diversity, and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

April - Month 1

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a deficit of £1.5m in month 1 of 25/26 against a planned deficit of £1.5m, this is a positive start to the financial year, with PQP being delivered in full in month 1.

- Agency expenditure in month is at its lowest level (£0.5m in M1) which is 2.2% of the in month pay expenditure. This is a significant achievement from M1 of 24/25 when it was £1.3m and 5.7%. Bank costs however remain high; having seen a reduction in 24/25 they have now crept back up to April 24 levels. This increase is in part due to a movement of agency to bank. The PQP on bank requires the Trust to reduce bank spend by 10% in 25/26, this has not been achieved in M1.

- In month 1, the Trust has reported an adverse income position of £236k against plan driven by:
  - £127k prior year impact of the pathology stock recharge accrued gross not net of VAT at year end.
  - £87k for Specialised Services vascular transfer to ENHT, and ERF for associate ICBs.
  - £95k unrealised income PQP
  - £68k favourable variance on overseas visitors
  - £35k favourable variance on non-emergency patient transport due to no plan for 25/26.

- The Herts & West Esssex ICB (H&WE) elective recovery fund (ERF) plan for 25/26 is 128% of 19/20 values. This will be a block payment for the year and has been reported as per plan in M1. The achievement of the block is tied to trust RTT performance.

- The Trust had a PQP target of £1.7m in month 1 of which £1.7m was delivered, therefore PQP was delivered in full. The PQP plan is phased to increase in the latter part of the financial year therefore requiring continued focus from divisions on identifying and implementing schemes to ensure full delivery by the year end.

Summary financial results

The Princess Alexandra Hospital NHS Trust

	FY Budget £'m	Apr-25 Budget £'m	Apr-25 Actual £'m	Apr-25 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	408.5	33.1	32.8	(0.3)	33.1	32.8	(0.3)
Pass through Income	20.3	1.7	1.7	0.0	1.7	1.7	0.0
Income Total	**428.8**	**34.8**	**34.5**	**(0.2)**	**34.8**	**34.5**	**(0.2)**
Pay							
Substantive	(274.5)	(23.0)	(20.5)	2.5	(23.0)	(20.5)	2.5
Bank	(6.2)	(0.5)	(2.5)	(2.0)	(0.5)	(2.5)	(2.0)
Agency	(3.1)	(0.3)	(0.5)	(0.3)	(0.3)	(0.5)	(0.3)
Pay Total	**(283.8)**	**(23.8)**	**(23.5)**	**0.3**	**(23.8)**	**(23.5)**	**0.3**
Non-Pay							
Drugs & Medical Gases	(11.5)	(0.9)	(0.9)	0.1	(0.9)	(0.9)	0.1
Pass through expenditure	(20.7)	(1.7)	(1.7)	0.1	(1.7)	(1.7)	0.1
Supplies & Services - Clinical	(14.9)	(1.2)	(1.2)	0.1	(1.2)	(1.2)	0.1
Supplies & Services - General	(6.3)	(0.5)	(0.4)	0.1	(0.5)	(0.4)	0.1
All other non pay costs	(68.6)	(6.1)	(6.5)	(0.3)	(6.1)	(6.5)	(0.3)
Non-Pay Total	**(122.0)**	**(10.5)**	**(10.6)**	**(0.1)**	**(10.5)**	**(10.6)**	**(0.1)**
Financing & Depn							
Depreciation	(17.8)	(1.5)	(1.5)	(0.0)	(1.5)	(1.5)	(0.0)
PDC & Interest	(5.5)	(0.5)	(0.4)	0.1	(0.5)	(0.4)	0.1
Financing & Depn Total	**(23.3)**	**(1.9)**	**(1.9)**	**0.1**	**(1.9)**	**(1.9)**	**0.1**
Total	**(0.3)**	**(1.5)**	**(1.5)**	**0.0**	**(1.5)**	**(1.5)**	**0.0**
Technical Adjustment	0.3	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Grand Total	**0.0**	**(1.5)**	**(1.5)**	**0.0**	**(1.5)**	**(1.5)**	**0.0**

The income plan for the year includes system support funding of £24.7m aligned to funding received in 24/25. There is a further £15m income assumption based on delivery of system efficiency and required to achieve break-even.

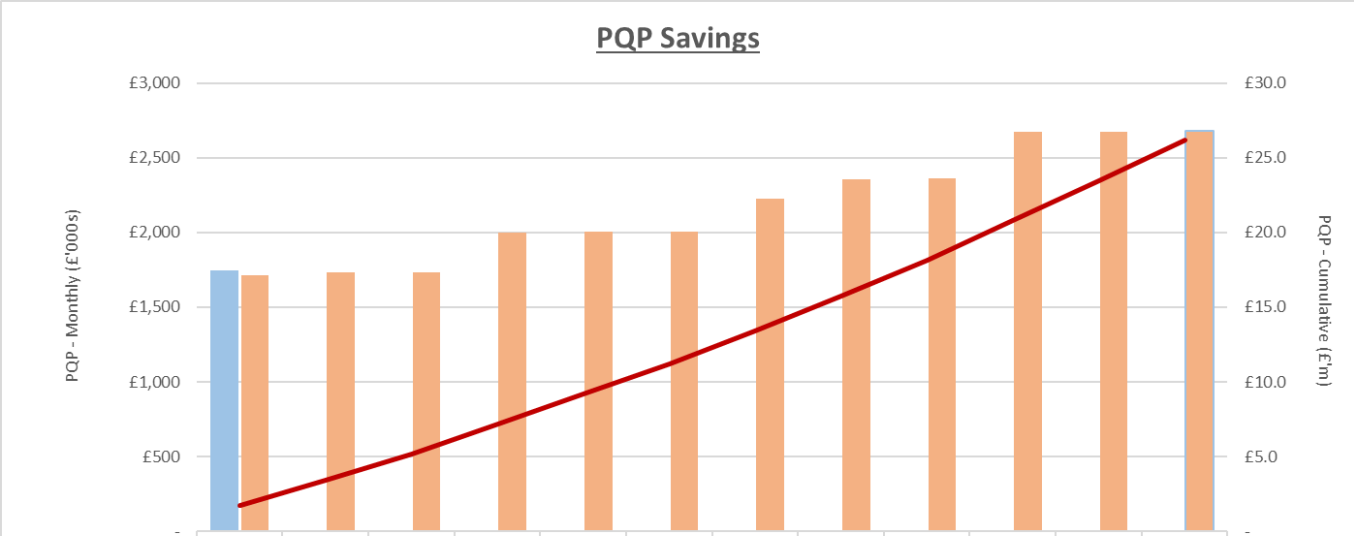
For M1 £3.3m (1/12th of the total) has been included in the budget along with assumed income to match whilst system efficiencies are identified.

PQP

The Princess Alexandra Hospital NHS Trust

The Trust PQP plan for the year is £26.2m, phased to increase throughout the year.

In month 1, the Trust delivered £1.7m PQP against a plan of £1.7m, therefore delivering the plan in full. The target will get more challenging throughout the year with the increased phasing towards the latter part of the financial year. Divisions need to work on identifying recurrent schemes to ensure continued delivery as the year progresses. There will be a continued focus on this in divisional PQP sessions.



	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	£1,744											
Plan - Mthly	£1,711	£1,730	£1,733	£2,000	£2,004	£2,004	£2,225	£2,357	£2,360	£2,672	£2,674	£2,680
Plan - Cuml	£1,711	£3,441	£5,174	£7,174	£9,178	£11,182	£13,407	£15,764	£18,124	£20,796	£23,470	£26,150

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

Statement of Financial Position

Statement of Financial Position	Mar-25 £'m	Mar-25 £'m	Apr-25 £'m	Movement In Month £'m	Movement YTD £'m
Non-current assets					
Property, plant & equipment	189.1	189.1	189.0	(0.1)	(0.1)
Right of use assets	43.1	43.1	42.9	(0.2)	(0.2)
Intangible assets	32.1	32.1	32.0	(0.2)	(0.2)
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**265.4**	**265.4**	**264.9**	**(0.5)**	**(0.5)**
Current assets					
Inventories	4.2	4.2	4.2	-	-
Trade & other receivables	10.5	10.5	12.8	2.3	2.3
Cash & cash equivalents	28.6	28.6	18.9	(9.7)	(9.7)
Current assets	**43.3**	**43.3**	**35.9**	**(7.4)**	**(7.4)**
Total assets	**308.7**	**308.7**	**300.8**	**(7.9)**	**(7.9)**
Current liabilities					
Trade & other payables	(46.1)	(46.1)	(39.9)	6.2	6.2
Provisions	(1.2)	(1.2)	(1.2)	-	-
Borrowings	(2.7)	(2.7)	(2.7)	-	-
Current liabilities	**(50.0)**	**(50.0)**	**(43.8)**	**6.2**	**6.2**
Net current assets/ (liabilities)	**(6.6)**	**(6.6)**	**(7.8)**	**(1.2)**	**(1.2)**
Total assets less current liabilities	**258.7**	**258.7**	**257.1**	**(1.7)**	**(1.7)**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.0)	(1.0)	(1.0)	-	-
Borrowings	(40.2)	(40.2)	(40.0)	0.2	0.2
Total non-current liabilities	**(41.2)**	**(41.2)**	**(41.0)**	**0.2**	**0.2**
Total assets employed	**217.5**	**217.5**	**216.1**	**(1.5)**	**(1.5)**
Financed by:					
Public dividend capital	384.6	384.6	384.6	-	-
Income and expenditure reserve	(172.6)	(172.6)	(180.8)	(8.3)	(8.3)
Other reserves	(8.3)	(8.3)	(1.5)	6.8	6.8
Revaluation reserve	13.8	13.8	13.8	-	-
Total taxpayers' equity	**217.5**	**217.5**	**216.1**	**(1.5)**	**(1.5)**

Non-Current Assets PPE has decreased by £0.1m and is due to current depreciation. A decrease of £0.2m in ROU assets is mainly due to ROU depreciation charge during the year. A decrease of £0.2m in intangible assets relates to amortisation.

Trade and Other Receivables have increased by £2.3mduring the reporting period. This movement is primarily driven by the raising of invoices to HSL (FM) LLP including agreed Abbott price increase cost pressure funding of £1m and agreed stock purchase under the pathology contract of £0.8. An increase of £0.5m for Non-NHS prepayments.

Cash balances has decreased by £9.7m, primarily due to the payments made to NHS LA of £1.4m, Morgan Sindall of £2.7m, Softcat PLC of £1m, T&B Contractors of 0.9m, Eta Projects of 0.7m, Oracle Corporation of 0.6m, Cornerstone Contractors of £0.4m, Artic Building Services of £0.4m, and other various invoices

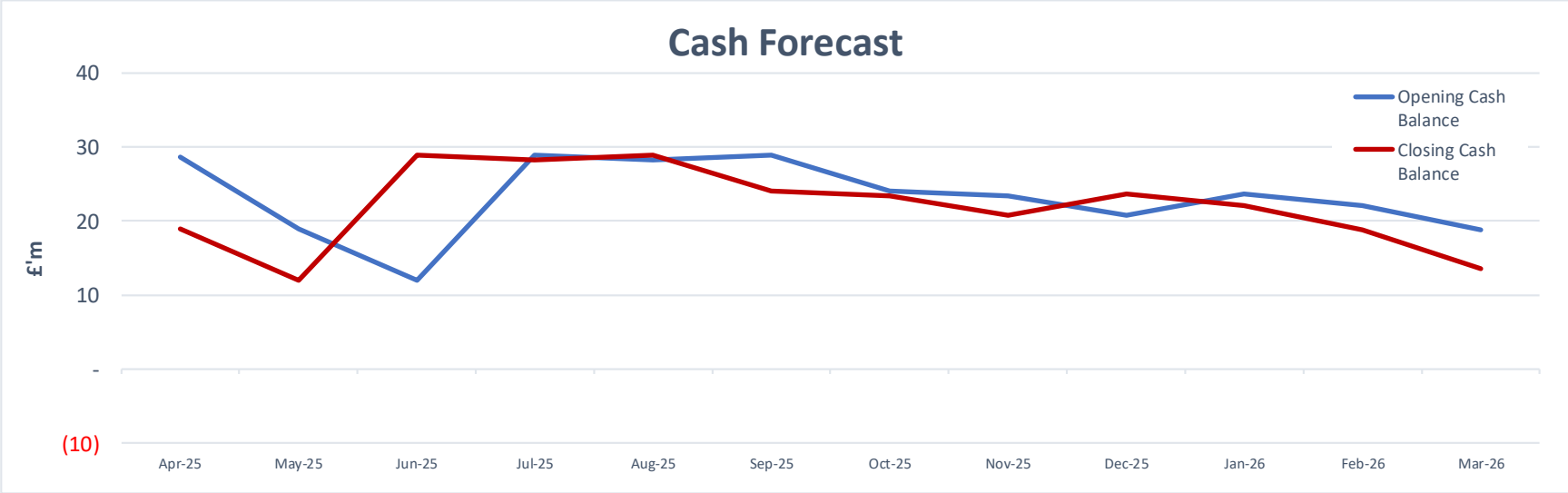
Trade and Other Payables has the decrease of £6.2m due to the payments made to Morgan Sindall of £2.7m, Softcat PLC of £1m, T&B Contractors of 0.9m, Eta Projects of 0.7m, Oracle Corporation of 0.6m and Alliance Healthcare of £0.3m.

Borrowings decrease representing payment of ROU lease repayment & Interest charge.

Cashflow

The Princess Alexandra Hospital NHS Trust

	<--Actual-->	<----------Forecast---------->										
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Opening Cash Balance	28,628	18,917	12,018	28,914	28,281	28,855	24,047	23,389	20,763	23,679	22,085	18,742
Closing Cash Balance	18,917	12,018	28,914	28,281	28,855	24,047	23,389	20,763	23,679	22,085	18,742	13,532



Cash balances has decreased by £9.7 during the reporting period. This reduction is primarily attributable to scheduled payments made to key suppliers and contractors, including Morgan Sindall of £2.7m, NHS LA of £1.4m, Softcat PLC of £1m, T&B Contractors of 0.9m, Eta Projects of 0.7m, Oracle Corporation of 0.6m, Cornerstone Contractors of £0.4m, Artic Building Services of £0.4m, and other various invoices.

Capital Analysis 25/26

NHS
The Princess Alexandra Hospital

	Month 1			Forecast		
	In-Month Plan £'m	In-month Actual £'m	Variance £'m	Plan & profile £'m	FY FoT	Variance £'m
Internally Funded Schemes						
Estates						
Estates: Domestic Water Risks	42	53	(11)	500	500	-
Estates: Electrical-Distribution-BAU	33	-	33	400	400	-
Estates: Electrical-BAU-Theatre Lighting 5, 6 and 7	10	-	10	120	120	-
Estates: Fire-BAU-Fire door	21	-	21	250	250	-
Estates: Critical AHU Plant Serving Wards-BAU	112	112	-	200	200	-
Estates: Steam Heating-BAU	84	207	(123)	100	100	-
Estates: Fire-CIR- Compartmentation & Fire Doors Match funding	84	37	47	1,017	1,017	-
Estates: Main Tower block-BAY-upgrade of main lifts (3N0)	10	-	10	200	200	-
Estates: Flooring-BAU-Site Wide flooring repairs - slips, trips and falls	4	-	4	100	100	-
Estates: Sitewide boundary fencing upgrade for security-BAU	5	-	5	60	60	-
Estates: Edge protection systems-BAU	4	-	4	50	50	-
CSS						
CDC	31	31	0	11,029	11,029	-
EHR, ICT & Info						
ICT & Information Schemes						
EHR	233	211	22	770	770	-
	-					
Corporate						
Corporate schemes	-	-	-	3,300	3,300	-
Medical Equipment						
Medical Equipment (Surgery)	-	102	(102)	-	102	(102)
24-25 schemes	-	121	(121)	-	-	-
CRL to be allocated to plan	-	-	-	21		21
YTD Total	**673**	**873**	**(200)**	**18,117**	**18,198**	**(81)**
Externally Funded Schemes						
Fire-CIR- Compartmentation & Fire Doors	25	-	25	1,500	1,500	-
Electrical CIR IPS/UPS and Distribution	25	57	(32)	1,083	1,083	-
Chidrens ED	40	-	40	1,750	1,750	-
Phase 2 UTC Corridor Refurbishment	30	19	11	2,000	2,000	-
CDC	-	-	-	3,000	3,000	-
NHP	63	63	-	2,470	2,470	-
YTD spend on External Schemes	**183**	**139**	**44**	**11,803**	**11,803**	**-**
Total - Internal and External	**856**	**1,012**	**(156)**	**29,920**	**30,001**	**(81)**

Awaiting funding from NHSE.
Not expecting to be a pressure.

The Princess Alexandra Hospital NHS Trust

Trust Board Public – 5 June 2025

Agenda item:	6.4
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Informatics Team
Date prepared:	May 2025
Subject / title:	Integrated Performance Report

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

6.3

Key issues: please don't expand this cell; additional information should be included in the main body of the report

Patients		
People	**Sickness Absence**	Deep dives and action plans to triangulate sickness management , rostering and bank / agency are in progress
	Agency Spend	The Trust has been tasked with reducing agency use by 40% and bank. Divisional PQP meetings will include deep-dives into the top three departments with the highest temp usage/cost per division. Action plans will focus on sickness management, financial oversight, recruitment & temp usage and rostering best practices. These are due to start in May.
	Bank Spend	A comprehensive bank reduction plan will be presented at May's People Committee, aligned with the Trust's 2025/26 workforce plan which was submitted in April.
	Statutory & Mandatory Training	Increase on compliance, with the highest compliance recorded since records were added to learning management system was implemented in June 2023
	Appraisal-non medical	New digital appraisals launched however paper versions still available where needed. Workshops and engagement sessions now being run through the year.
Performance	**Urgent and Emergency Care Standards**	4 Hour Standard - In April 2025, the trust achieved 68.4% against a trajectory of 67%. Since April 2025 performance against the standard has declined and MTD in May is currently 64.19% (correct as of 15th May), with a significant risk of achieving the trajectory of 69%. The Trust wide urgent care improvement programme has been restructured with DD SRO leadership. Within UEC division we recognise a dip in the non-admitted performance, and have instigated PDSA's around staff shift times, daily battle rhythm and have also reinstated our divisional tactical meetings. % of patients over 12 hrs in ED - 1.99% ahead of trajectory in April, achieving 6% against a trajectory of 7.99%. In May, waits to be seen has risen and consequentially there has been a rise in those over 12 hours. May is currently 7%, which remains ahead of the 7.8% trajectory. Average Hand over times - We achieved an average handover time of 21 mins, which is 19 mins ahead of trajectory in April. The ambulance handover improvement group continue to drive the improvements to sustain this.
	RTT Elective standards	The total PTL size has reduced by 2,800 patients since March. This overall improvement in RTT performance can partly be attributed to the Trust's validation efforts following the launch of a new validation strategy involving targeted patient cohorts as recommended by the Validation Sprint programme and re-commencement of the Envoy digital patient survey on 30/04/2025. The Trust is also looking to start using an external AI validation tool in coming weeks which should further contribute to this improvement.
	Cancer Standards	28-day faster diagnosis standard - performance was 70.2% in March, with April's unvalidated position currently at 72.5% against a trajectory of 77%, validations are on-going. The greatest risk to Trust performance sits in urology and the service is being managed closely against its improvement plan. Diagnostic capacity is the key risk for the 28-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	**Capital Spend**	The Trust total Capital resourcing for 2025/26 is £29.9m, this includes external PDC including the new hospital project, CDC, and others. The capital plan was approved at the April 2025 CWG meeting and, also approved at Trust Board due to the amounts involved.
	Cost Improvement Plan (PQP)	The 2025/26 PQP target is £26.2m. £1.7m PQP was delivered in month 1 against a plan of £1.7m, therefore fully delivered. Delivery of the target is to become more challenging throughout the year due to phasing of an increase in the planned savings in the latter part of the financial year.
	Income / Activity	The Elective Recovery Fund weighted value of 128% of 2019/20 baseline. Fixed ERF funding for 2025/26 but this relies on the Trust achieving performance targets submitted including RTT. Fixed payments will help mitigate ongoing data quality issues
	Surplus / Deficit	The Trust reported a deficit of £1.5m in month 1 against a planned deficit of £1.5m. The position includes £3.3m of system support funding, which was planned, this however means there is an underlying deficit of £4.8m in month.
	Cash	The Trust's cash balance is £18.9m. The Trust's cash reserves, which were bolstered by national COVID support, have begun to diminish as we continue to operate at a deficit. Our current focus is on reducing the level of unpaid invoices and maintaining the Trust's improved 30-day BPPC performance.
Places		
	Capital	Submission of BLM funding and other capital funded streams into Finance team via AD EFM/SHofE and awaiting cost codes to place orders for previously tendered schemes and start on new risk-based schemes supporting EFM team. Supporting ED team on UEC funding Phase 1 for new ED SDEC and Phase 2 UTC corridor package
	Estates	Estates Responsiveness (Priority 1 - Emergency) and Estates Responsiveness (Priority 2 - Urgent). 4 Facet survey

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.29.05.25 and QSC.30.05.25
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:	M1 IPR

6.3

Integrated Performance Report:

April 2025

As at 28/05/2025

Executive Summary

The Princess Alexandra Hospital NHS Trust

Patients

Patients

Pounds

Capital Spend	The Trust total Capital resourcing for 2025/26 is £29.9m, this includes external PDC including the new hospital project, CDC, and others. The capital plan was approved at the April 2025 CWG meeting and, also approved at Trust Board due to the amounts involved.
Cost Improvement Plan (PQP)	The 2025/26 PQP target is £26.2m. £1.7m PQP was delivered in month 1 against a plan of £1.7m, therefore fully delivered. Delivery of the target is to become more challenging throughout the year due to phasing of an increase in the planned savings in the latter part of the financial year.
Income / Activity	The Elective Recovery Fund weighted value of 128% of 2019/20 baseline. Fixed ERF funding for 2025/26 but this relies on the Trust achieving performance targets submitted including RTT. Fixed payments will help mitigate ongoing data quality issues following the implementation of Alex Health. However, achieving performance targets will be key otherwise the Trust risks having financial clawback.
Surplus / Deficit	The Trust reported a deficit of £1.5m in month 1 against a planned deficit of £1.5m. The position includes £3.3m of system support funding, which was planned, this however means there is an underlying deficit of £4.8m in month.
Cash	The Trust's cash balance is £18.9m. The Trust's cash reserves, which were bolstered by national COVID support, have begun to diminish as we continue to operate at a deficit. Our current focus is on reducing the level of unpaid invoices and maintaining the Trust's improved 30-day BPPC performance.

Places

Estates	Estates Responsiveness (Priority 1 - Emergency) and Estates Responsiveness (Priority 2 - Urgent). 4 Facet survey
	Submission of BLM funding and other capital funded streams into Finance team via AD EFM/SHofE and awaiting cost codes to place orders for previously tendered schemes and start on new risk-based schemes supporting EFM team. Supporting ED team on UEC funding Phase 1 for new ED SDEC and Phase 2 UTC corridor package

People

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Agency Spend	The Trust has been tasked with reducing agency use by 40% and bank. Divisional PQP meetings will include deep-dives into the top three departments with the highest temp usage/cost per division. Action plans will focus on sickness management, financial oversight, recruitment & temp usage and rostering best practices. These are due to start in May.
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Statutory & Mandatory Training	Increase on compliance, with the highest compliance recorded since records were added to learning management system was implemented in June 2023
Appraisal-non medical	New digital appraisals launched however paper versions still available where needed. Workshops and engagement sessions now being run through the year.

Performance

Referral Elective Standards	The total PTL size has reduced by 2,800 patients since March. This overall improvement in RTT performance can partly be attributed to the Trust's validation efforts following the launch of a new validation strategy involving targeted patient cohorts as recommended by the Validation Sprint programme and re-commencement of the Envoy digital patient survey on 30/04/2025. The Trust is also looking to start using an external AI validation tool in coming weeks which should further contribute to this improvement.
Urgent and Emergency Care Standards	**4 Hour Standard** - In April 2025, the trust achieved 68.4% against a trajectory of 67%. Since April 2025 performance against the standard has declined and MTD in May is currently 64.19% (correct as of 15th May), with a significant risk of achieving the trajectory of 69%. The Trust wide urgent care improvement programme has been restructured with DD SRO leadership. Within UEC division we recognise a dip in the non-admitted performance, and have instigated PDSA's around staff shift times, daily battle rhythm and have also reinstated our divisional tactical meetings. **% of patients over 12 hrs in ED** - 1.99% ahead of trajectory in April, achieving 6% against a trajectory of 7.99%. In May, waits to be seen has risen and consequentially there has been a rise in those over 12 hours. May is currently 7%, which remains ahead of the 7.8% trajectory. **Average Hand over times** - We achieved an average handover time of 21 mins, which is 19 mins ahead of trajectory in April. The ambulance handover improvement group continue to drive the improvements to sustain this.
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Section summaries

NHS
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**
Sickness Absence	Deep dives and action plans to triangulate sickness management , rostering and bank / agency are in progress	For information	
Agency Spend	The Trust has been tasked with reducing agency use by 40% and bank. Divisional PQP meetings will include deep-dives into the top three departments with the highest temp usage/cost per division. Action plans will focus on sickness management, financial oversight, recruitment & temp usage and rostering best practices. These are due to start in May.	For information	
Bank Spend	A comprehensive bank reduction plan will be presented at May's People Committee, aligned with the Trust's 2025/26 workforce plan which was submitted in April.	For information	
Appraisals – non medical	New digital appraisals launched however paper versions still available where needed. Workshops and engagement sessions now being run through the year.	For information	
Statutory & Mandatory training	Increase on compliance, with the highest compliance recorded since records were added to learning management system was implemented in June 2023	For information	

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**
Urgent and Emergency Care Standards	**4 Hour Standard** - In April 2025, the trust achieved 68.4% against a trajectory of 67%. Since April 2025 performance against the standard has declined and MTD in May is currently 64.19% (correct as of 15th May), with a significant risk of achieving the trajectory of 69%. The Trust wide urgent care improvement programme has been restructured with DD SRO leadership. Within UEC division we recognise a dip in the non-admitted performance, and have instigated PDSA's around staff shift times, daily battle rhythm and have also reinstated our divisional tactical meetings. **% of patients over 12 hrs in ED** - 1.99% ahead of trajectory in April, achieving 6% against a trajectory of 7.99%. In May, waits to be seen has risen and consequentially there has been a rise in those over 12 hours. May is currently 7%, which remains ahead of the 7.8% trajectory. **Average Hand over times** - We achieved an average handover time of 21 mins, which is 19 mins ahead of trajectory in April. The ambulance handover improvement group continue to drive the improvements to sustain this.	For information	NA
Diagnostics	**Diagnostics performed within 6 weeks of referral -** performance has decreased slightly for April to 66.51% from 68.36% in March. MRI achieved 95.45% performance which despite being lower than previous months is still meeting the national standard and CT achieved 93%. Echo performance has improved considerably in April to 87.69%. There are recovery plans in place for the other modalities however 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.	For information	
Cancer standards	**28-day faster diagnosis standard -** performance was 70.2% in March, with April's unvalidated position currently at 72.5% against a trajectory of 77%, validations are on-going. The greatest risk to Trust performance sits in urology and the service is being managed closely against its improvement plan. Diagnostic capacity is the key risk for the 28-day performance. In Lower GI staffing gaps within endoscopy continue to delay patients' diagnoses. It is expected that this will improve by June. **62-day standard -** finalised performance for March was 52.2%, with April's unvalidated position currently at 49.0% against a trajectory of 65%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics. The service teams have recovery plans in place to improve performance with Urology being reviewed in a weekly meeting by the COO/Deputy COO and Performance ADOP due to the level of risk. Escalation PTLs are now being held weekly for Urology, Lower GI and Upper GI with both pathway actions and patient level actions being agreed and monitored. 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.	For information	
RTT Elective standards	For RTT performance, the Trust continues to **successfully reduce the number of 65-week breaches**, ending April 2025 on 5 x choice breaches (with 0 x 78+ since November 2024). For **52-week breaches**, the Trust ended April on a total of 2403 breaches, equating to 4.7% of the total PTL size and ahead of target by 345 patients, which is a significant reduction from March. The Trust's **18 RTT week performance has drastically improved** in recent months from 41.8% for December 2024, to 44.3% for January 2025, 44.5% for February, 46.2% for March and 48.8% for April and individual specialty specific trajectories and associated action plans are being finalised. Furthermore, the **total PTL size has reduced** by 2,800 patients since March. This overall improvement in RTT performance can partly be attributed to the Trust's validation efforts following the launch of a new validation strategy involving targeted patient cohorts as recommended by the Validation Sprint programme and re-commencement of the Envoy digital patient survey on 30/04/2025. The Trust is also looking to start using an external AI validation tool in coming weeks which should further contribute to this improvement.	For information	

Introduction

About this pack

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

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

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

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

Contents

- Indicators Summary
- Metrics Reports
- How to use this report
- Supporting Information

Key Performance Indicators of Interest

The Princess Alexandra Hospital NHS Trust

5P Section	KPI	SPC Status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	Complaints		58	1.1	16	12
	Falls per 1000 bed days		7	1.1	16	12
People	Statutory & Mandatory training		88.4%	2.3	16	8
	Vacancy Rate		8.0%	2.3	16	8
	Voluntary Turnover		9.4%	2.3	16	8
	Agency Staff Spend			2.3	16	8
Performance	RTT over 65 week waiters		5	1.3	16	12
	4 hour standard		66.0%	4.2	20	12
	Ambulance Handovers (between 15 & 30 mins)		37.1%	1.3	16	12
	Diagnostics within 6 weeks		68.4%	4.2	20	12
	RTT Incomplete Performance		48.8%	4.2	20	12

Patients section measures of interest

SPC for D.11 - Complaints - New

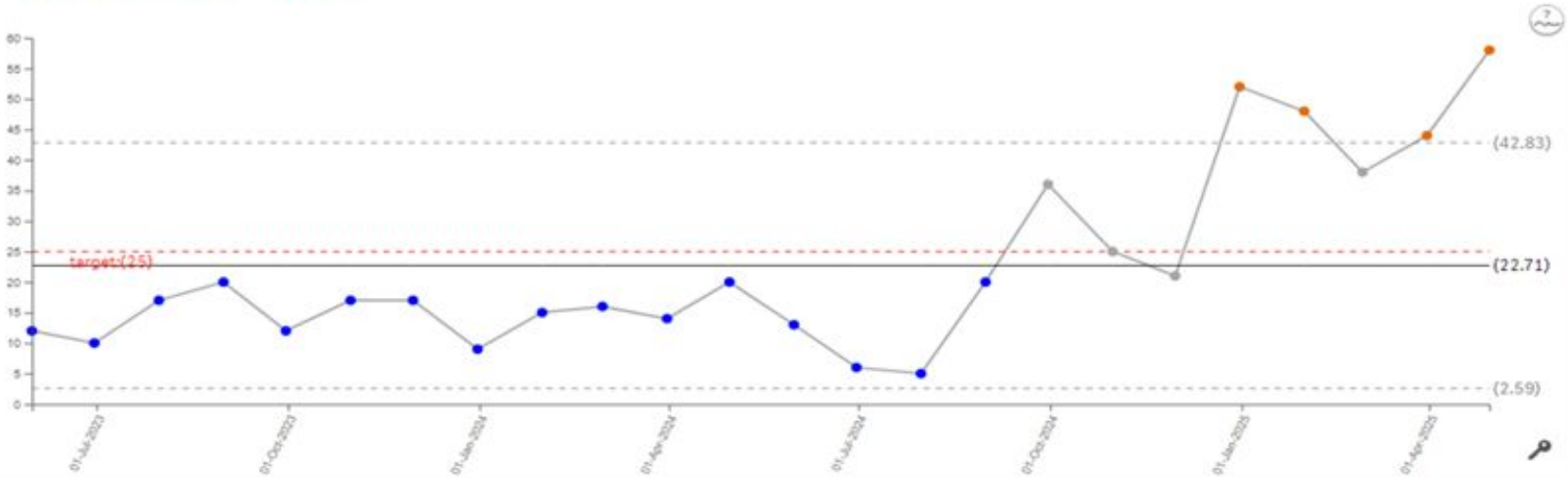
Previous month ...
March-2025

44

Month to date v...
April-2025

58

Target
April-2025
Target is at Trust-wide level



SPC for D.55 - Falls per 1000 bed days

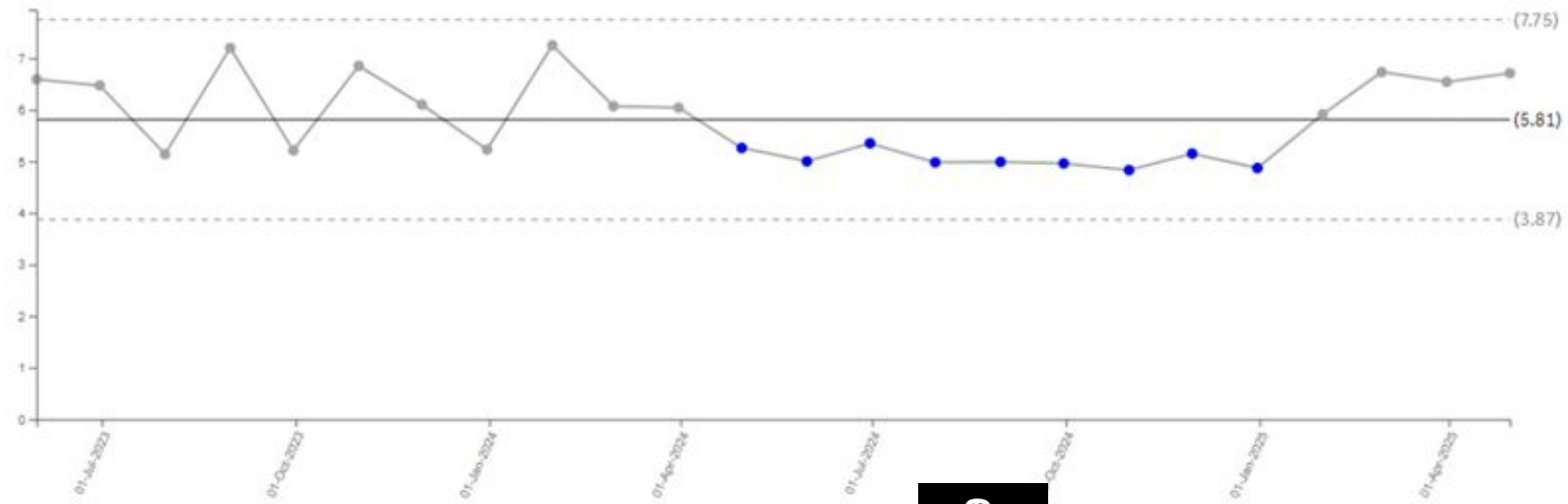
Previous month ...
March-2025

7

Month to date v...
April-2025

7

Target
April-2025
Target is at Trust-wide level



6.3

People section measures of interest

SPC for D.24 - Staff Turnover Voluntary

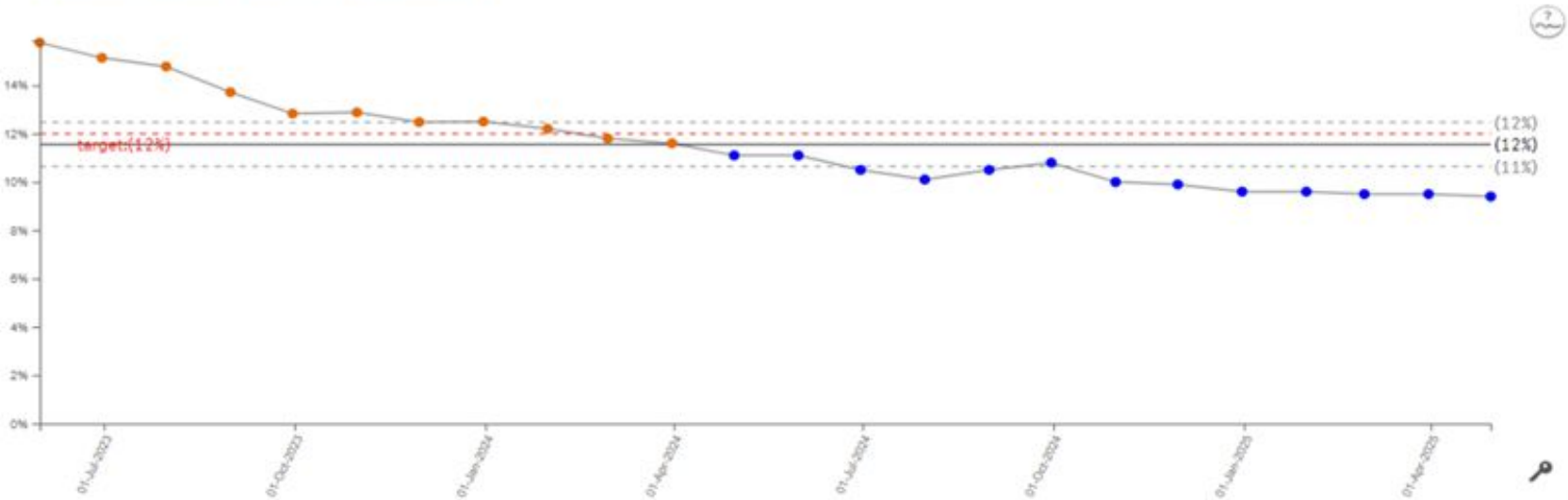
Previous month ...
March-2025

9.5%

Month to date v...
April-2025

9.4%

Target
April 2025
Target is at Trust-wide level



SPC for D.25 - Agency Staffing Spend

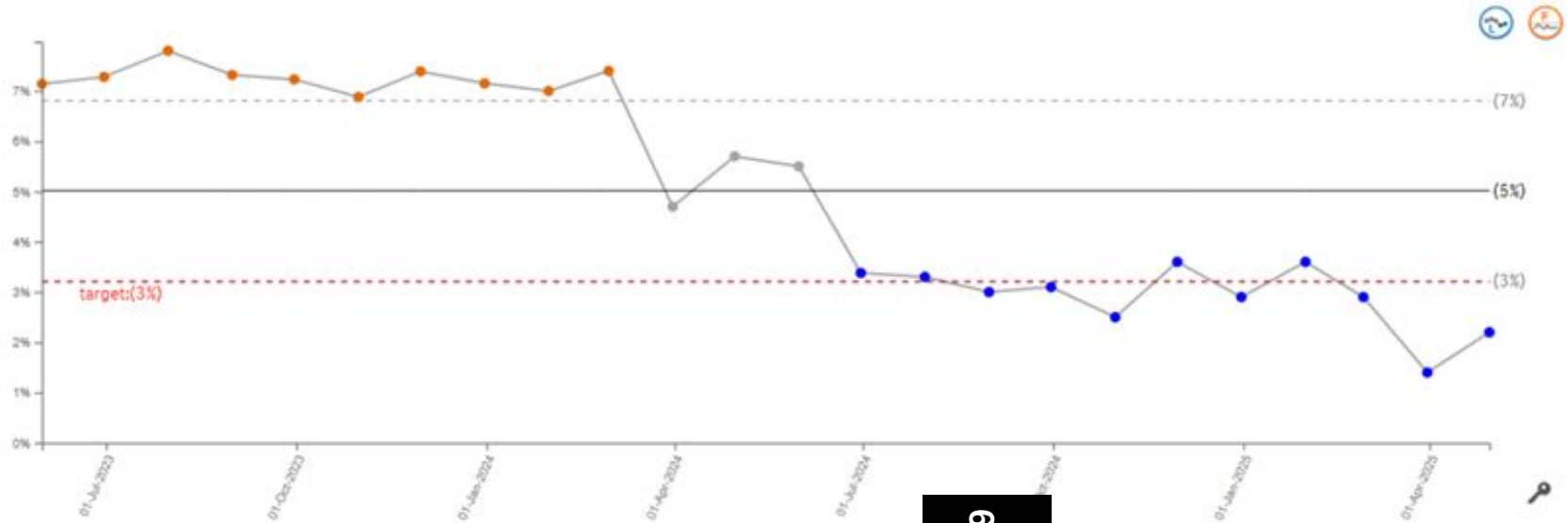
Previous month ...
March-2025

1.4%

Month to date v...
April-2025

2.2%

Target
April 2025
Target is at Trust-wide level



People section measures of interest

SPC for D.27 - Vacancy Rate

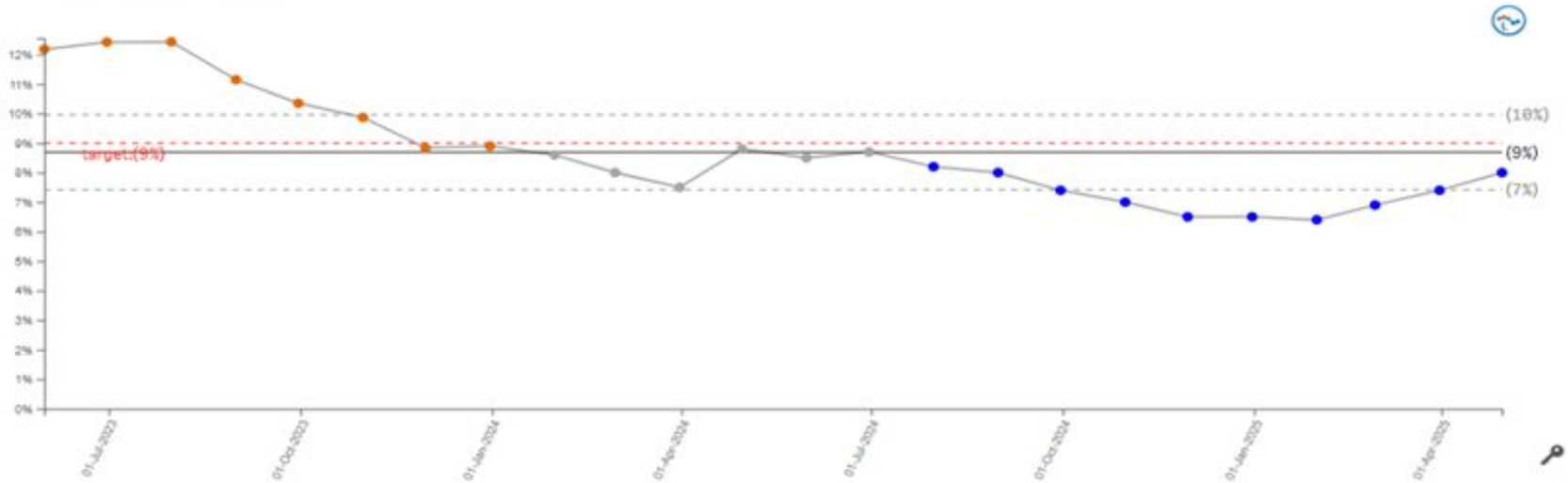
Previous month ...
March-2025

7.4%

Month to date v...
April-2025

8.0%

Target
April-2025
Target is at Trust-wide level



SPC for D.29 - Statutory & Mandatory training

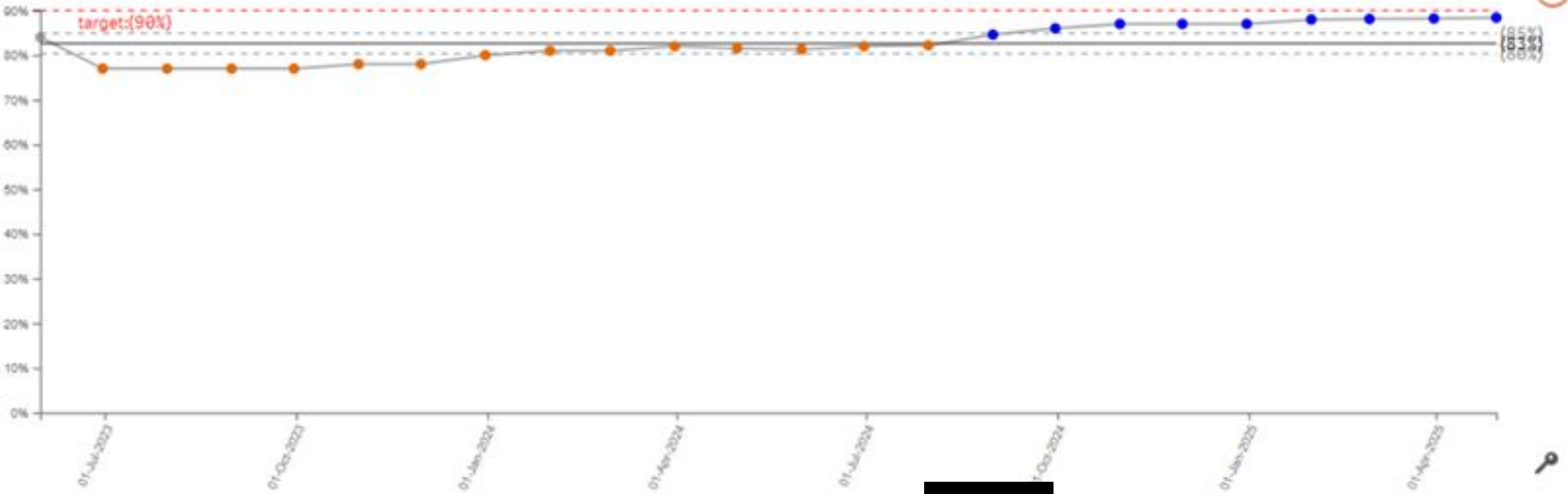
Previous month ...
March-2025

88.2%

Month to date v...
April-2025

88.4%

Target
April-2025
Target is at Trust-wide level



Performance section measures of interest

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

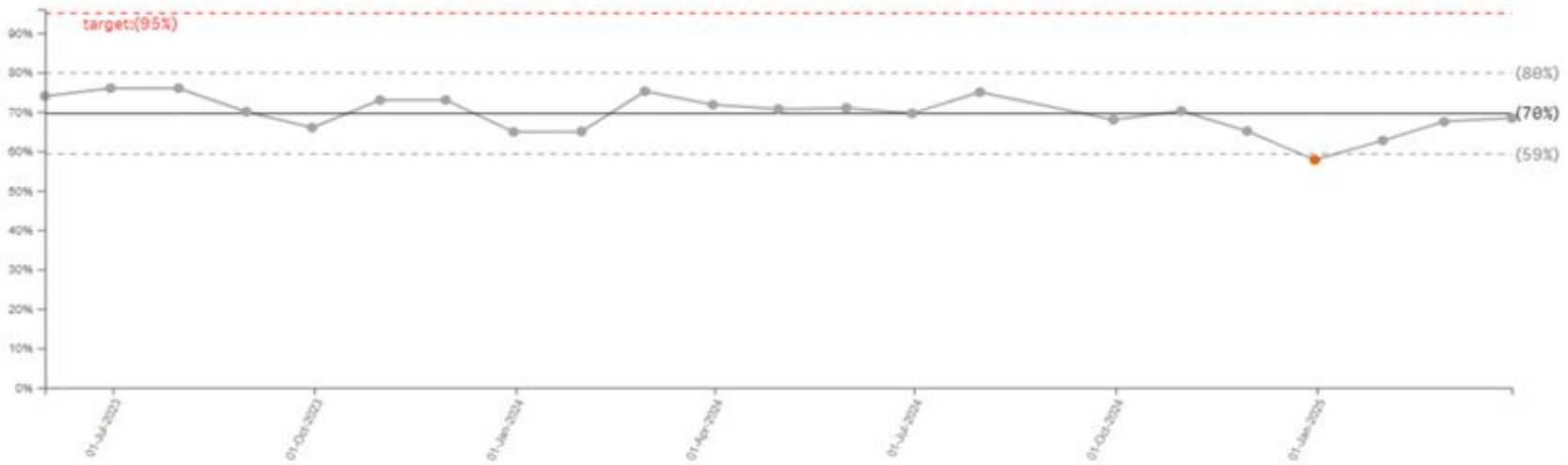
Previous month ...
February-2025

67.5%

Month to date v...
March-2025

68.4%

Target
March-2025
Target is at Trust-wide level



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

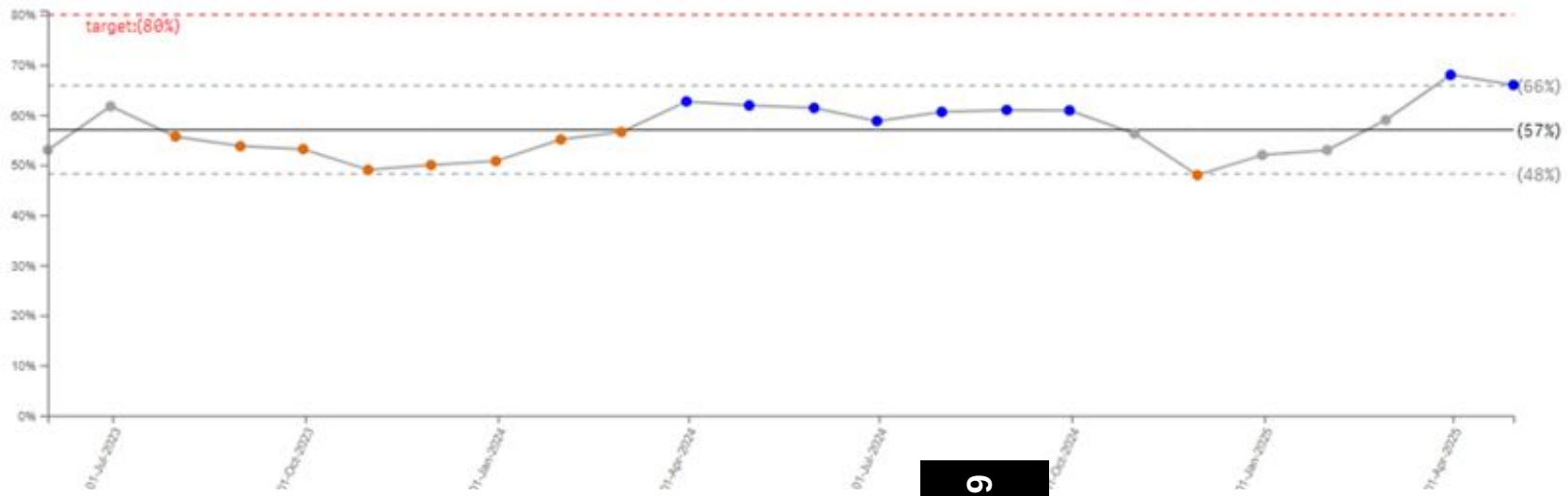
Previous month ...
March-2025

68.0%

Month to date v...
April-2025

66.0%

Target
April-2025
Target is at Trust-wide level



Performance section measures of interest

The Princess Alexandra Hospital NHS Trust

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

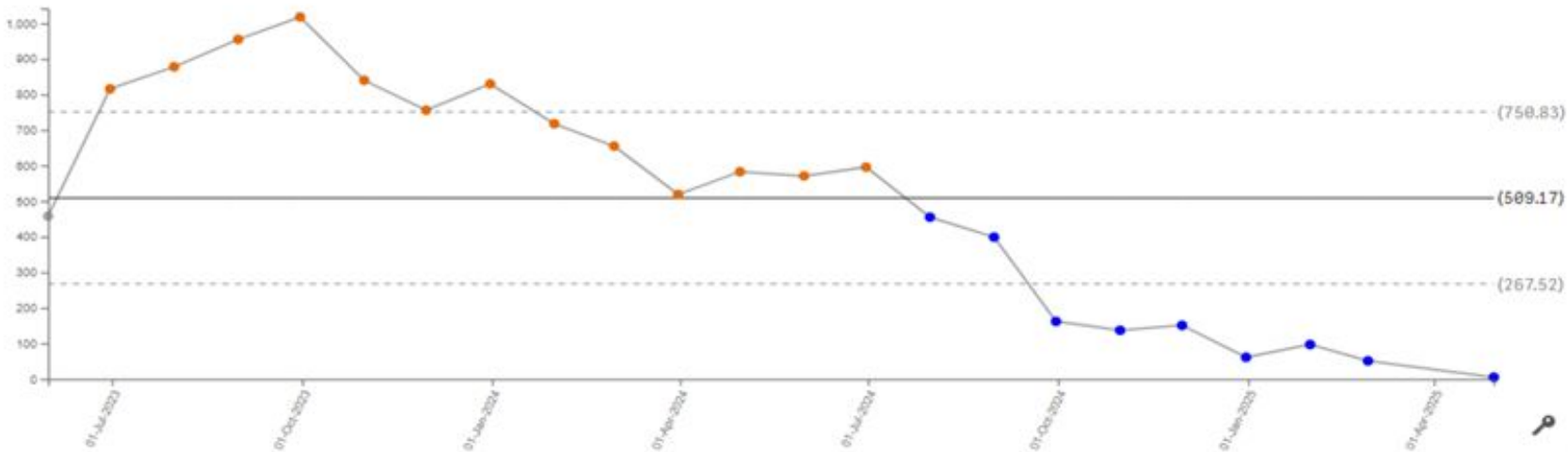
Previous month ...
March-2025

–

Month to date v...
April-2025

5

Target
April-2025
Target is at Trust-wide level



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

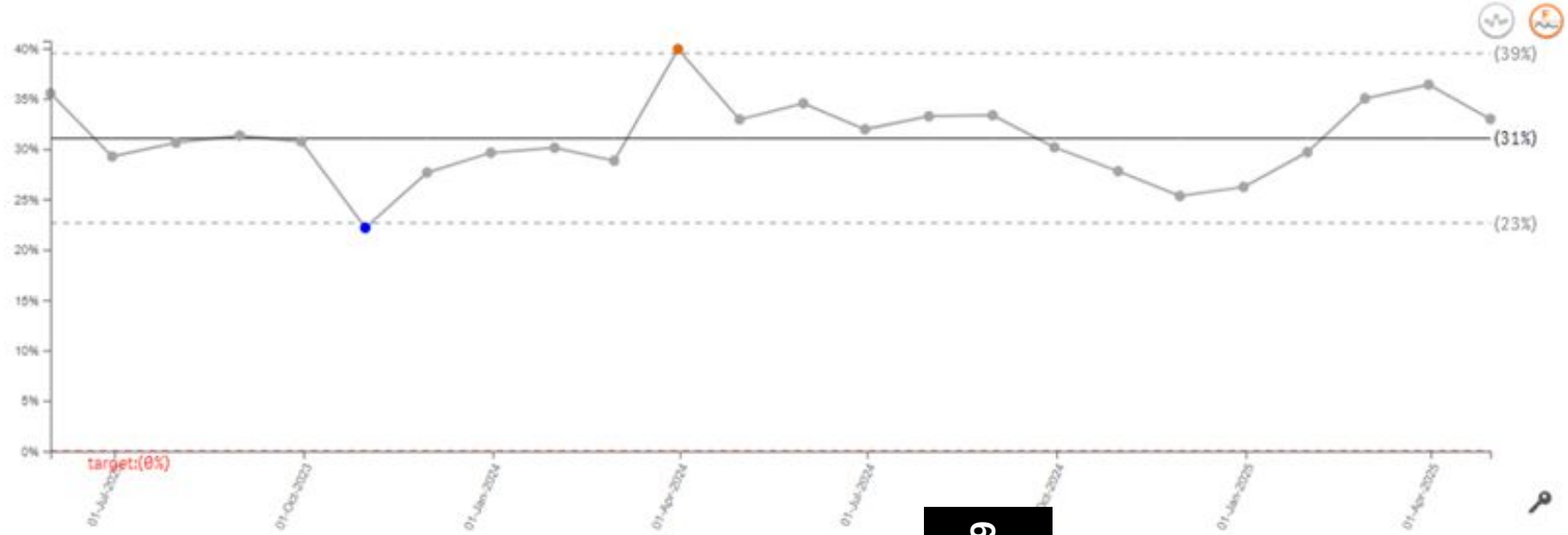
Previous month ...
April-2025

33.0%

Month to date v...
May-2025

37.1%

Target
April-2025
Target is at Trust-wide level



Performance section measures of interest

SPC for E.46 - RTT Incomplete Performance

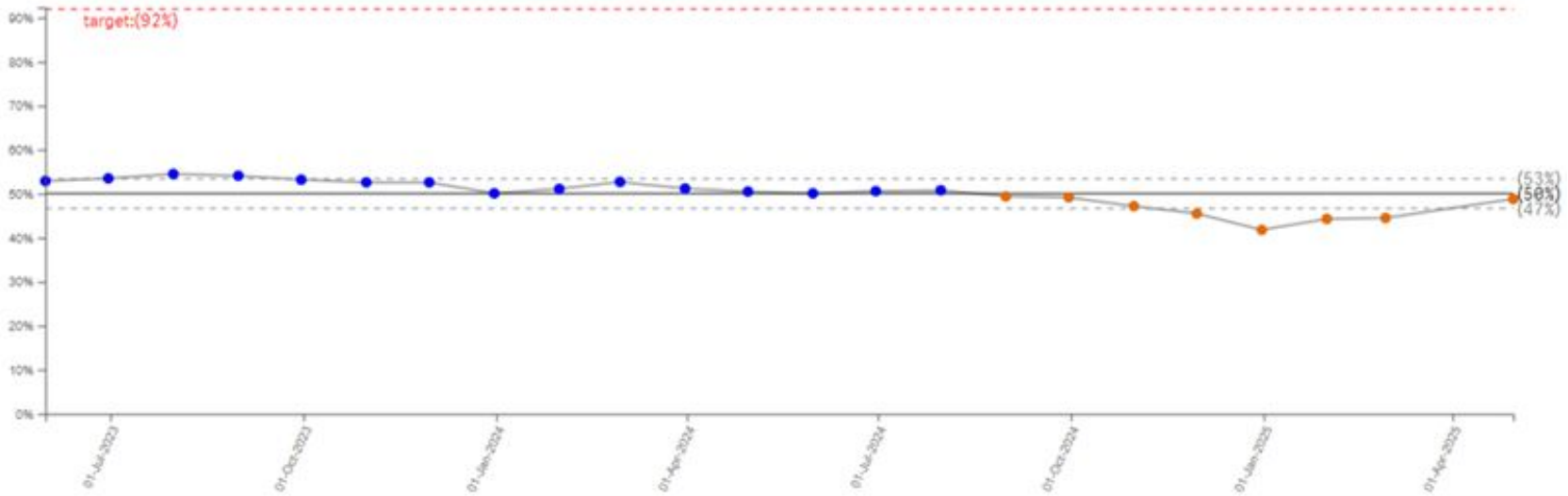
Previous month ...
March-2025

46.2%

Month to date v...
April-2025

48.8%

Target
April-2025
Target is at Trust-wide level



BOARD OF DIRECTORS: Trust Board - 5 June 2025 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Non-Executive Director – Committee Chair

DATE OF COMMITTEE MEETING: 6 May 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 Draft Annual Accounts and financial statements including; • Going Concern	Yes	Yes	No	The draft accounts and going concern assessment were noted in advance of the commencement of the audit. The reported financial performance for the Trust at draft accounts stage is: : • Revenue £1,097k deficit • Capital Resource Limit (CRL) £0k breakeven
2.2 External Audit plan and strategy for the year ending 31 March 2025 • Health Technical Update	Yes	Yes	No	The report confirmed the revised materiality level for the financial statements as £8.1m; this has increased to reflect the change in the Trust's revenue. Significant risks identified include: 1. Fraud risk – expenditure recognition 2. Management override of controls 3. Valuation of land and buildings. Higher assessed risks include: 4. Capital expenditure recognition 5. Valuation of intangible assets 6. Recognition of New Hospital Programme expenditure. The Health technical updates on the following areas were noted: • Audit and accounting • Risk and compliance • Tax • Cyber security • Neighbourhood health • Use of data to drive digital transformation

BOARD OF DIRECTORS: Trust Board - 5 June 2025				**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM: Audit Committee				
REPORT FROM: George Wood, Non-Executive Director – Committee Chair				
DATE OF COMMITTEE MEETING: 6 May 2025				
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				• Financial sustainability • Workforce impacts • Elective recovery • Global thought leadership
2.3 Draft Annual Report Including: • Annual Governance Statement • Corporate Governance Statement	Yes	No	No	The Committee reviewed the draft documents prior to audit and undertook to provide feedback within 2 weeks of the meeting.
Internal Audit Progress Report, Follow Up Report and Head of Internal Audit Opinion	Yes	Yes	No	The Data Security and Protection Toolkit audit was in progress and planning for the following audits was underway: • Estates – Health and Safety • People Deployment In relation to follow up of recommendations, 3 were overdue however on the whole good progress was noted. BDO provided the committee with a moderate Head of Internal Audit opinion that there are no major weaknesses in the internal control system for the areas reviewed in

BOARD OF DIRECTORS: Trust Board - 5 June 2025 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Non-Executive Director – Committee Chair

DATE OF COMMITTEE MEETING: 6 May 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				2024/25.
3.4 Counter Fraud Progress Report	Yes	Yes - Ongoing	No	The Committee noted the update on counter fraud activity and investigations/referrals received since the last meeting.
4.1 Caldicott Guardian Annual Report	Yes	Yes - ongoing		The committee noted the comprehensive annual report on the Trust's Caldicott Guardian function.
4.2 Waivers, Losses, Special Payments & Debt Write Offs	Yes	No	No	During the period 1st January 2025 to 31st March 2025: • The value of losses and special payments totalled £184k (29 cases). • No additional bad debt was identified in this period • 27 waivers totalled £2,896k of which 4 (£380k) were non-compliant. A year to date position is to be added to future reports.
4.3 Compliance assessment: Code of Governance 2024/25	Yes	Yes	No	This report covered the 'comply or explain' elements of the NHS Code of Governance, and set out the self-assessment undertaken to inform the Trust's compliance declaration in the annual report. The report has been updated following receipt of the auditors' comments and will be presented to Trust Board in June.

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board (WE HCP Board)**			
REPORT FROM:	**Thom Lafferty - Committee Chair**			
DATE OF COMMITTEE MEETING:	**15.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Proactive Care – a patient's experience	Y	Y	N	Presentation illustrating a patient & carer experience of urgent care this year and the improved experience in 2025/26 with the Care Closer to Home & Proactive models of care that are in place and being enhanced with partnership working.
Integrated Delivery Plan	Y	Y	N	The Integrated Delivery Plan is the West Essex 3 year prioritised transformation plan, created & delivered collaboratively across the partnership, to be monitored through the partnership governance structure, at locality & place level. Standardised reporting and an outcomes dashboard being developed. The Board discussed specific actions for the partners to deliver swift transformation to deliver proactive care closer to patient's homes. The WE HCP Board approved the Integrated Delivery Plan.
Priorities Highlight Report – review of 24/25 delivery	Y	Y	N	The locality clinical leads described the progress made during 24/25 on the delivery plan, successes and learning.
Delegation Framework	Y	N	N	The PAHT Board approved Delegation Framework (DF) was approved by the WE HCP Board. The locality governance structure that underpins the DF was presented to the Board and it was agreed to add additional details to support future levels of delegation to localities.

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board (WE HCP Board)**			
REPORT FROM:	**Thom Lafferty - Committee Chair**			
DATE OF COMMITTEE MEETING:	**15.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
WE HCP Board Terms of Reference	Y	N	Y	The Terms of Reference for the WE HCP Board were discussed and two changes requested – remove the exclusion regarding mental health and include the E&NHerts GP clinical lead representative in the membership. These amended Terms of Reference are recommended for approval by the PAHT Board. (See Appendix)
ICB Operating Model	Y	Y	N	Verbal updated from the WE Place Director on the future ICB structure and reorganisation timetable.
Local Government reorganisation	Y	Y	N	Verbal update from Head of Integration & Partnerships at Essex County Council highlighting initial comments from the national team on the proposed model are being responded to. There will be two business cases submitted, 5 unitary authorities and 3. UK government decision expected February 2026.
13 Sub-committee reports	Y	Y	N	Quality & Transformation Committee is focussing on the development of a quality dashboard and refining the role of the committee. No escalations from the Operational Delivery & Performance Committee Finance & Commissioning Committee are developing effective partnership finance reports that reflect both the organisations' financial position and the interconnected partnership finances.

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board (WE HCP Board)**			
REPORT FROM:	**Thom Lafferty - Committee Chair**			
DATE OF COMMITTEE MEETING:	**15.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
HCP Communications	Y	Y	N	Discussed the development of a WE HCP communications plan for both staff and the public including sharing of events and making every opportunity of public events to share prevention work and opportunities.

The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital NHS Trust

West Essex Health & Care Partnership Board

Terms of Reference 2025 v6

1. Constitution

1.1 As the NHS statutory organisation in West Essex, PAHT take on the host provider role for West Essex Health & Care Partnership (the HCP) enabling effective partnership working between health & care organisations in West Essex.

1.2 The Delegation Framework between Hertfordshire and West Essex ICB and The Princess Alexandra Hospital NHS Trust sets out the accountability and responsibility for hosting the WE HCP Board.

1.3 The HCP Board has been constituted as a committee of the PAHT Trust Board. This committee functions to enable the HCP to adopt an integrated approach to healthcare delivery, having delegated responsibility for the commissioning and management of NHS services from the ICB for the population of West Essex and the population in Hertfordshire that accesses PAHT for the majority of its urgent and elective care. The HCP acts as central coordinator to enable integrated care whilst avoiding duplication and fragmentation of services for all patients, not just those accessing care at PAHT.

1.5 These Terms of Reference (ToR) will be published on the ICB website and the PAHT website and set out the membership, the remit, responsibilities and reporting arrangements of this Committee and may only be changed with the approval of the HCP Board.

2. Authority

2.1 The West Essex Health and Care Partnership ("the HCP") has the following vision: "To help everyone in our area live long and healthy lives by supporting independence and providing seamless care".

The role of the West Essex Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP. The detailed responsibilities are set out in the Delegation Framework between HWE ICB and PAHT.

In time it is expected that the HCP will take on full delegation ('category 3 delegation') for all services commissioned on behalf of the population of WE only, ~~with the exception of any services that will be fully delegated to the Mental Health, Learning Disability and Autism HCP. The HCP will take on partial delegation ('category 2' delegation) for the services currently commissioned jointly on behalf of the population of West Essex and/or the ICB.~~

In year one the HCP will take on full delegated responsibility ('category 3' delegation) of a range of community services which are commissioned on behalf of the population of WE. Delegation will be for both statutory responsibilities and operational responsibilities for these services.

2.2 In summary the HCP Board is authorised by the PAHT Boards to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the PAHT Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. The key responsibilities of the HCP Board are:

Core Business

- To take accountability for the development and delivery of the overall financial plan for West Essex within the specified delegated budgets of the HCP.
- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions up to £1 million (or up to £2 million if the contract exceeds 12 months). And recommending to the ICB Commissioning Committee contracts or services up to £2.5 million (or up to £5 million if the contract exceeds 12 months).
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in West Essex.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in West Essex.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

In addition in 2025/26 the HCP will take on full delegated responsibility ('category 3' delegation) of a range of community services which are commissioned on behalf of the population of WE. Delegation will be for both statutory responsibilities and operational responsibilities for these services.

The HCP responsibilities for this sub-set of services are:

Statutory responsibilities:

Improving population health and reducing inequalities: The HCP will plan and commission services with the express intention of improving population health and reducing inequalities, including inequalities in terms of access to and outcomes from health and care services.

Quadruple aim: The HCP has four aims to improve health and care outcomes, reduce inequalities in outcomes, experience, and access, increase productivity and value for money and help the NHS support broader social and economic development within its strategic priorities and are embedded within the HCP's core values.

Planning and funding services: The HCP will plan services around the health and care needs of the population it services, allocating resources according to need. In doing so the HCP will be responsible for achieving value for money and operating within its delegated budgets (achieving a breakeven position) such that it exercises its delegated functions effectively, efficiently and economically

Engaging with partners and communities: The WEHCP Board will be responsible for designing and delivering services and the Board comprises representatives of health and care partners across the HCP, including county and district council partners.

Involving patients and public in planning and decision making: The HCP will seek active public and patient involvement for through a newly developed patient engagement process. This process will ensure that the HCP is seeking appropriate involvement for planning and decision making with regard to all delegated services.

Promote innovation, research, education and training: The HCP will actively promote innovation, research, education and training through its transformation work and such promotion will be actively considered in reviewing all service developments.

Climate Change: Climate change will be a key consideration for any commissioning decisions and service transformations within the HCP

Safeguarding and Quality assurance: The HCP will promote safety and quality of commissioned services and will actively manage provider performance through the HCP's quality and performance committee.

Supporting the NHS workforce: The WEHCP Board Committee will ensure an HCP-wide approach to workforce planning, recruitment and retention through establishment of a single workforce.

Regulatory compliance: The HCP will ensure compliance with all legal and policy requirements including (but not limited to) the Equality Act and GDPR data regulations, the management of Conflicts of Interest, the National Oversight and Assessment Framework (NHSE) and the requirements of the Care Quality Commission. The ICB will continue to hold overall responsibility for regulatory compliance of the system in the areas dictated by statute or NHS England, but the HCP will ensure compliance within delegated areas.

Operational responsibilities:

Contract oversight: The HCP will evaluate performance against financial, quality and performance metrics as set out in contracts, address challenges and make provision for necessary adjustments to meet objectives.

Performance and quality monitoring: Assurance of performance through the HCP's Quality and Transformation Committee which will include evaluation of performance against performance metrics and KPIs as specified in contracts with provider partners, as well as against specific outcomes measure developed for the population of South and West Hertfordshire

Population health management and insights: Analysis of population health data to identify trends risks and priorities. Determining opportunities for reducing health inequalities

Financial and Resource management: Managing delegated budgets, monitoring financial performance and ensuring productivity and efficiency measures are implemented

Digital and data transformation: The HCP will ensure use of digital tools to improve access to care, managing data-sharing agreements and using data analytics and improving system performance

Delivery of the ICS Medium Term Plan: The HCP will continue to implement the Medium-Term Plan for Hertfordshire and West Essex.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board through the contract between the ICB & PAHT. Membership shall comprise the following roles: • HCP Senior Responsible Officer (CEO PAHT) • Non-Executive Member of the Integrated Care Board • Non-executive member of PAHT Board • ICB Place Director for West Essex • Chief Finance & Infrastructure Officer of PAHT • PAHT Medical Director or Director of Nursing • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (GP Care Closer to Home Clinical Lead) • ECC Partner Member (Adult) • ECC Partner Member (Children) • District Council leads • Four GP locality leads • Healthwatch • VCSFE • Director of Community Services EPUT Members from partner organisations within the Health Care Partnership and West Essex HCP Place Director. Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend but may not exercise a vote. When determining the membership of the Board, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Board will also be attended by the following individuals who are not members of this Board: • Development Director for West Essex HCP

	• Chief Strategy Officer PAHT • Chief Transformation Officer • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • Director of Corporate Governance PAHT • Secretariat The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The PAHT Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the PAHTs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. A quorum will be at least 50% of membership and include at least one member from each of the • ICB, • Primary Care, • PAHT • ECC, • and includes a member from each locality. If any member of the Board has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the PAHTs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters, all members have one vote, and a majority will be conclusive. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 Values

Members will be expected to conduct business in line with the PAHT & ICB values and objectives.

Members of, and those attending, the HCP Board shall behave in accordance with PAHT & the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance, as reflected in the ICB & PAHT Standards of Business Conduct.

PAHT reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in PAHT's Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

6. Accountability and Reporting

The Board is accountable to the PAHT Board and shall report to the PAHT Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7. Administration and Review

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the PAHT Board.
Updates	The PAHT Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the PAHT Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 24 May 2024	HWE ICB Board	Annually	N/A
V2	March 2025			Change of accountability of the Board from the ICB Board to PAHT Board.
V3	April 2025			
V5	May 1st 2025	PAHT Board	6 months	Change of accountability of the Board from the ICB Board to PAHT Board reflecting the TOR requirements from the Delegation Framework.
V6	May 19th	WE HCP Board	6 Months	Removed reference to Mental Health, 4 GP locality leads to include E&NH border

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Executive Board (EB)**			
REPORT FROM:	**Committee Chair – Thom Lafferty**			
DATE OF COMMITTEE MEETING:	**20th May 2025**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
CEO Strategic update	Y	Y	N	The inaugural meeting of the HCP Board operating as a subcommittee of the Trust took place earlier this month. Progress on horizontal integration and the developing relationships with MSE & Colchester Trusts were noted by Executive Board (EB). The COO from EPUT and GP Lead from Old Harlow attended the meeting for the first time as part of an ongoing rotation of system partners who will be joining the meeting.
Clinical Strategy	Y	Y	N	EB noted the initial review undertaken of all clinical services delivered by the Trust, identification of fragile services and the next steps which include a more detailed analysis using all data sets and engaging community partners.
System Performance including Community Diagnostics Centre	Y	Y	N	Good progress is being made on the CDC build and the space can now be visualised. The Trust has been placed into Tier 1 for cancer, diagnostics and elective recovery. NHSE visit planned for the 4th June with national & regional colleagues in attendance to review tier one status and progress.

Integrated Delivery Plan (IDP)	Y	Y	N	The HCP Board signed off the IDP and it was noted at EB.
Corporate Cost Reductions inc MARS Draft	Y	Y	Y	The Trust developed a MARS scheme that was review by EB and some minor changes noted.
Draft Quality Account	Y	Y	Y	EB noted the draft quality account. Comments were requested prior to the final version being approved.
Unoutcomed Clinic Appointments	Y	Y	N	Progress on reducing the number of Unoutcomed appointments on Alex Health is being monitored via the DRMs. Alex Health will be updated to ensure outcomes take place in real time.
Finance Update including Capital	Y	N	N	EB noted the month 1 plan was a deficit of £1.5m and this was achieved. PQP in month 1 was delivered.