The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 2 October 2025 at 09.30 - 13:15
Venue: Kao Park Boardroom, Kao Park, Harlow

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	14
09.35: Staff Story: NHS Graduate Management Training Scheme Experience – One Story, Three Voices					
02 Chair and Chief Executive's reports					
10:00	2.1	Acting Chair's Report	Inform	Acting Chair	15
10:05	2.2	CEO's Report	Inform	Chief Executive	19
		Opportunity for members of the public to ask questions about the board discussions or have a question answered			
03 Risk					
10:15	3.1	Corporate Risk Register	Approve	Chief Medical Officer	25
10:25	3.2	Board Assurance Framework 2025-26 *Diligent Resources: BAF 2025-26*	Review/ Approve	Director of Corporate Governance	29
04 Patients					
10:35	4.1	Reports from Quality and Safety Committee 26.09.25 including Terms of Reference • Part I • Part II	Assure/ Approve	Committee Chairs	34 42 47
10:45	4.2	Inpatient Survey	Assure	Interim Chief Nurse	54
10:55	4.3	Maternity Reports: • Maternity Patient Safety Incidents (MPSIs)	Assure	Interim Chief Nurse/ Director of Midwifery	59
11:05	4.4	Nursing, Midwifery and Care Staff Levels	Assure	Interim Chief Nurse	62
11:15	4.5	Learning from Deaths (Mortality) Report	Assure	Chief Medical Officer	80
		BREAK 11:25 to 11:35			

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05 People					
11:35	5.1	Report from People Committee 29.09.25	Assure	Committee Chair	87
11:40	5.2	Annual Report on Medical Revalidation and Compliance Statement	Approve	Chief Medical Officer	92
11:45	5.3	Workforce Race Equality Standard (WRES) 2024	Inform	Chief People Officer	112
11:50	5.4	Workforce Disability Equality Standard (WDES) 2024	Inform	Chief People Officer	122
11:55	5.5	PAHT Equality, Diversity & Inclusion Annual Report 2024-2025	Approve	Chief People Officer	136
06 Performance/Pounds/Places					
12:00	6.1	Report from Performance and Finance Committee 25.09.25	Assure	Chair of Committee	160
12:05	6.2	Finance Update	Assure	Chief Finance & Infrastructure Officer	170
12:15	6.3	Integrated Performance Report (IPR) including • Appointment Slot Issues • National Oversight Framework Improvement Actions	Discuss	Acting Chief Operating Officer	178 198 202
12:35	7.1	Report from Audit Committee 08.09.2025 including Terms of Reference	Assure	Chair of Committee	205 208
12:45	7.2	Report from West Essex Health and Care Partnership Board 18.09.25	Assure	Chair of Committee	215
12:50	7.3	Report from Executive Board Meeting 16.09 2025	Assure	Chair of Committee	218
12:55	7.4	Corporate Trustee: Report from Charitable Funds Committee 09.09.25	Assure	Chief Finance & Infrastructure Officer	223
13:00		*Opportunity for members of the public to ask questions about the board discussions or have a question answered.*			
08 Closing administration					
13:10	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	Discuss	All	

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		(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)			
13:15		Close			

Date of next meeting: 11 December 2025

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

Board Membership and Attendance 2025/26			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Acting Trust Chair	Darshana Bawa	Chief Executive	Thom Lafferty
Non-executive Director and Senior Independent Director (SID)	Elizabeth Baker	Interim Chief Nurse	Jo Ward
Non-executive Director	TBC	Acting Chief Operating Officer	Camelia Melody
Non-executive Director	Colin McCready	Chief Medical Director	Andrew Kelso
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
Assocaite Non-executive Director	Bola Johnson	Chief People Officer	Giovanna Leeks
Associate Non-executive Director	Ben Molyneux	Chief Clinical Transformation Officer	Jim McLeish
Associate Non-executive Director	Parag Jasani	**Other Directors (non-voting)**	
		Director of Corporate Governance	Heather Schultz
		Director of Communications and Engagement	Marcel Berenblut
Corporate Secretariat			
Board & Committee Secretary	Lynne Marriott		

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 5 June 2025 from 10.00 to 12:45

Present:

Darshana Bawa	**Acting Trust Chair (ATC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO)
Ralph Coulbeck (non-voting)	Associate Non-Executive Director (ANED-RC)
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)
Stephanie Lawton	Chief Operating Officer (COO)
Giovanna Leeks (non-voting)	Chief People Officer (CPO)
Sharon McNally	Chief Nurse (CN)
Colin McCready (via Teams)	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)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)

In attendance:

Andy Dixon (Patient Story)	Lead Nurse Enhanced Care & Falls Prevention
Shahid Sardar (Patient Story)	Associate Director Patient Engagement & Experience
Linda Machakaire (item 4.2)	Director of Midwifery

Observing:

Marcel Berenblut	Director of Communications
Ann Nutt	Chair of Patient Panel
Erin Walters (left after item 4.2)	Associate Director – Clinical Quality & Governance

Members of the Public
n/a

Apologies:

Liz Baker	Non-Executive Director (NED-LB)
George Wood	Non-Executive Director (NED-GW)

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.
1.4	The ATC informed members it was the Medical Director's last Public Board meeting and the CEO offered to say some words. He commented that the MD had been one of the most emotionally intelligent colleagues he had worked with. She put the patient at the heart of everything she did, and he commended the MD for her work around the medical culture since she had joined PAHT, and the significant turnaround that was now evident. She had also

	successfully led the work to exit GMC enhanced monitoring. She would be a huge loss to the organisation and very big shoes to fill.
1.5	The MD thanked the CEO for his kind words. She said it had been an absolute privilege to work at PAHT and also with the Executive team. She stated that she had every confidence in the new incumbent and wished him well in the role.
1.3 Minutes of Previous Meeting	
1.6	These were agreed as a true and accurate record of the meeting held on 01.05.25 with no amendments.
1.4 Matters Arising and Action Log	
1.7	There were no matters arising. In terms of the action log the following were noted: <u>Action Ref: TB1.03.04.25/04 – Charity Funding for Sexual Safety</u> The Chief Finance & Infrastructure Officer (CFIO) informed members there had been some stories presented at the Charitable Funds Committee (CFC) evidencing educational elements that the charity could support with. The CFC would meet again in June so he would update Board members further in July.
1.8	<u>Action ref: TB1.03.04.25/02 – Sexual Safety Training</u> The CEO informed members it had been agreed at People Committee (PC) in May that Sexual Safety training would be included in the essential suite of training . The Chief People Officer (CPO) added that her team would be taking this action forward to include it as part of the Trust's training programmes.
Patient Story: Falls: Reducing the Risks	
1.9	The Chief Nurse (CN) introduced the Lead Nurse for Enhanced Care and Falls Prevention (LN-ECFP), the Deputy CN (DCN) (as his portfolio included falls) and the Associate Director of Patient Engagement & Experience (AD-PE&E).
1.10	The CN informed members the focus that day would be on falls, including the opportunities presented in the move towards taking on the Lead Provider role for adult community services.
1.11	By way of context the AD-PE&E informed members that falls were the most common cause of death from injury in over 65s.
1.12	Two patient stories were then presented to the Board by way of video clips. The first was a short video clip about Don, an 89 year old resident of Harlow who had experienced a buckling knee at home, had called 111 and been admitted to OPAL ward. Don spoke passionately about clarity and transparency of communication which, for him, was paramount. He spoke about being able to navigate the ward independently on sticks, and that this had been important to him. He had been supported to do this by the staff on OPAL Ward.
1.13	The second story was about Jez, a 64 year old with a learning disability who lived in supporting housing and was fairly independent. He had come to Penn Ward for planned care as he had a long-term muscular weakness which could lead to risk of a fall. Jez had been thankful to Penn Ward and how he had been supported to maintain his independence following admission. He highlighted the assessments he had needed to achieve that, including equipment that had been identified for him.
1.14	The LN-ECFP then informed members that the Trust's falls 'vision' was for a fully integrated and modern falls service, working with community partners to minimise the risk to patients. This would be delivered through the 'mission' which included patients receiving high quality evidence-based falls prevention interventions, which met all national requirements.
1.15	In terms of Trust data for falls, there had been an overall downward trend over the previous two years, with a drop from July 2024 to December 2024 (6.5 to 4.0). This suggested improvement efforts were having an impact. Falls with significant harm were also trending downwards, but more remained to be done.
1.16	The aims for 2025/26 were noted and opportunities going forward were highlighted.
1.17	In response to the above, the Medical Director (MD) asked where the focus would be in the future. The LN-ECFP responded this would be around unwitnessed falls and the reasons for those.

1.18	The Chief Clinical Transformation Officer (CCTO) asked if the use of technology would be part of the falls strategy. The LN-ECFP responded that currently falls sensors and bed sensors were used however, there was evidence that technology made a difference but was not currently conclusive on falls prevention.
1.19	The CEO then asked about a reference to decaffeinated drinks supporting a reduction in falls and also about the community response to an individual falling at home.
1.20	The LN-ECFP responded that in West Essex there was a very robust falls retrieval service which could determine whether or not a conveyance to hospital was required. In terms of decaffeinated drinks, most patients involved in the pilot fed back that they couldn't tell the difference, and if they had been aware of the benefits previously, they would have reduced their caffeine intake.
1.21	Associate Non-Executive Ben Molyneux (ANED-BM) asked whether there was a direct link between staffing levels and numbers of falls. He also asked whether there was training for staff in areas outside of care of the elderly, for example in the ED. The LN-ECFP confirmed that training was available and bespoke sessions were also arranged In terms of the correlation between staffing numbers and falls, he believed there was a link but it was more about how staff were utilised to support patients at risk of falls. Some targeted work had been undertaken the previous year which had actually shown that most falls did not happen when areas were short-staffed.
1.22	The Chief Finance & Infrastructure Officer (CFIO) asked if the Trust could support Community Services to do more preventative work around falls. The LN-ECFP responded that there were opportunities such as joint clinics and more could also be done at discharge planning in terms of strengthening balance. The LN-ECFP acknowledged that there were, services in the community which the Trust was not entirely aware of and he would welcome a more integrated way of working.
1.23	ANED Anne Wafula-Strike (ANED-AWS) highlighted at this point the need for more education in the community on self-care, at the same time ensuring that the places patients were discharged to were safe and appropriate in terms of supporting their recovery. The LN-ECFP responded that in West Essex patients could be referred for a home assessment and NICE guidance also focussed on patient education.
1.24	The CN then commented there was a huge amount organisations could continue to do. As referenced above there was a significant opportunity now with the Trust becoming host and lead provider to develop more integrated ways of working.
1.25	The ATC thanked the LN-ECFP for a very informative presentation.
DCN/AD-PE&E leave the meeting.	
02 Chair and Chief Executive's Reports	
2.1 Acting Chair's Report	
2.1	The ATC presented her report. She informed members it would have been NED George Wood's last Board meeting that day. She acknowledged his invaluable contribution to the Board over the years of his tenure and extended her thanks to him .
2.2	The CEO then commented that whilst he had only worked with NED-GW for a few months, he had welcomed his sincere commitment to patients ensuring they were at the heart of every conversation.
2.3	With reference to the section in the paper around the Ambassador Programme that ANED-AWS was leading on the organisation's behalf, the CEO commented that this programme would work in conjunction with the Patient Panel and would include public events. With that in mind he then highlighted the recent event the Patient Panel had hosted in May in Harlow. This had also been attended by himself, the MD and the Chief Strategy Officer (CSO) where the public had been updated on future hospital plans. It had since been agreed a similar event would be held in Bishop's Stortford in September.
2.4	In response to the above, ANED-AWS commented that she was very excited to be leading the Ambassador Programme. Two potential candidates had been put forward for the role of Community Ambassador and she would keep the Board updated as the initiative developed.

2.2 CEO's Report	
2.5	The CEO firstly welcomed Giovanna Leeks to her first Public Board meeting as the substantive Chief People Officer (CPO). He also informed members that since the last meeting, a new Medical Director had been appointed (Andrew Kelso). He was currently a consultant neurologist/medical director at South & North East Essex ICB. It was hoped he would join the Trust informally in July and work alongside Fay Gilder as part of his transition into the role. The organisation was also part way through appointing a new Chief Operating Officer (COO) and colleagues would be kept updated on this.
2.6	In terms of his report the CEO highlighted the recent media coverage around the Trust's estate and associated funding. He was pleased to confirm the Trust had received £2.6m for improvements to infrastructure.
2.7	In response to the above the CFIO commented that whilst the additional capital was very welcome, it would not cover all the costs of required backlog maintenance.
2.8	ANED Parag Jasani (ANED-PJ) asked how elements of backlog maintenance would therefore be prioritised. The CFIO responded that the capital programme for the year was currently oversubscribed but a risk based approach would be adopted to ensure high risk elements were prioritised.
2.9	The CEO also noted that the organisation had recently increased parking charges in line with both inflation, and benchmarked with charges in place at other organisations. The CFIO continued that in terms of parking he acknowledged that this had been a difficult decision and one that had an impact on patients. He explained that parking charges had not been raised for many years and were now in line with inflation and other local hospitals.
2.10	ANED Ben Molyneux (ANED-BM) asked whether the organisation would monitor patient experience related to the changes in costs. The CFIO responded that the changes would be kept under review, and positively, it appeared to be less busy now on site.
2.11	The CEO then continued with his update. He informed members that the organisation had been proud to mark its 60th anniversary that year on 27.04.25 and to celebrate this a number of things had been lined up to coincide with 'This Is Us Week' in June.
2.12	The CPO then stated there was lots of change/uncertainty currently for staff. An output of the recent Staff Survey had been that colleagues wanted to feel valued and appropriately rewarded. The opportunity therefore was being taken as part of the hospital's 60th anniversary celebrations to thank colleagues and a number of events were planned.
2.13	The CEO then reminded members that in relation to operational performance, the Trust had been placed in NHSE tier 1 for elective, cancer and diagnostic performance. The previous day PAHT had hosted a visit from the regional team as part of this oversight and he commended the COO for her coordination of this. The COO added that year to date performance had been discussed and the good work around the validation of waiting lists had been highlighted. The Trust had been trending as number one nationally for this (and was now number two). Robust plans were in place to support trajectories going forward.
2.14	Questions from the Public The CoPP offered support in relation to the 60th anniversary hospital celebrations. She also thanked the Communications team for actioning the Panel's request for posters to highlight the increase in parking charges.
03 Risk	
3.1 Corporate Risk Register (CRR)	
3.1	This update was presented by the MD. She informed members there were three risks scoring 16. These were newly approved risks, one of which had previously been scoring 20.
3.2	The ATC asked about the challenges currently in relation to gleaning good business intelligence post the implementation of Alex Health. The COO responded this now came under her portfolio. She explained that the Associate Director of BI had developed a work plan identifying areas of risk/concern. Some additional temporary resource had been approved and NHSE had also agreed to undertake a review of the Trust's BI function.
3.3	The MD then flagged a specific new risk around chemotherapy preparation. There was a risk

	that pharmacy would not be able to prepare the required chemotherapy each day for the William's Day Unit. This had been caused by an increase in demand on the Pharmacy Technical Services Unit outweighing the capacity for the current staffing template to safely and aseptically prepare compounded chemotherapy. Actions to mitigate this were detailed in the paper.
3.4	The MD then highlighted the new ED risk related to the 'right care right person framework' which described responsibilities in relation to the delegation of care. Under this framework, if a patient absconded, the police would only help if the position was deemed to be life-threatening.
3.5	In terms of the chemotherapy risk, the Chief Strategy Office (CSO) flagged that the organisation had invested significantly in the Aseptic Unit two years previously. He asked therefore whether the risk related to staffing or the infrastructure. The MD responded that in the main the issues related to staffing but she needed to follow-up further on the detail of this.
3.6	ANED-PJ asked whether demand for chemotherapy had risen. The MD responded that it had in part. The COO agreed to look into this further. A review of cancer services was planned so she would include this risk in that review.
ACTION **TB1.05.06.25/05**	**Corporate Risk Register: Clarify the details of the chemotherapy risk.** **Lead: Medical Director/Chief Operating Officer**
3.7	NNED-BJ asked whether the ED risk was a local change. The MD responded that it was a national change some months previously and it had taken a while to understand this risk and to word it correctly. The Chief Nurse (CN) added the process had been in place across the Met' and London for some time. There would be some enhanced training now for ED staff.
3.2 Board Assurance Framework 25/26	
3.8	This item was presented by the Director of Corporate Governance (DCG). There were two risks that required Board approval: • New BAF risk 1.3 (as set out in the paper) which replaced 3 existing risks and scoring 15. • BAF risk 5.1 (finance), revised for 2025/26, scoring 16 (previously scoring 12).
3.9	BAF risk 3.2 (System Pressures) had previously been reviewed at STC and was attached that day for review by the Board. There were no changes. The CSO commented that success in terms of the move to lead/host provider would support in terms of influencing this risk.
3.10	In line with the recommendation, the Board: • Approved the new BAF risk 1.3 and the revised finance risk (Risk 5.1). • Reviewed BAF risk 3.2 System Pressures. • Noted the remaining BAF risks.
04 Patients	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	<u>Report from QSC.31.05.25</u> NED-OA informed members the focus remained on PALS/complaints numbers which remained significant in some divisions. QSC had therefore requested a future deep dive on this. The draft Quality Account had been presented and an increase in incidents of staff abuse had been noted including staff-on-staff incidents. QSC had requested the People Committee (PC) look into this.
4.2	ANED-RC asked about the incidents of staff abuse, highlighting another local hospital that had a visible anti-abuse campaign. The CN responded that PAHT had recently launched such a campaign which would be evaluated in terms of its visibility and impact to date.
4.3	The Director of Communications (DoC) stated he was also aware of a specific campaign to tackle issues of prejudice/violence in a positive way and he planned to bring a version of that to PAHT.
4.4	NED-OA responded she would very much welcome this as some forms of abuse were based on, for example, the colour of one's skin.
4.5	<u>Report from QSCII.31.05.25</u>

	ANED-RC informed members that QSCII had received the interim dashboard it had been requesting with data up to the end of January 2025. He was optimistic about the prospect of the Trust exiting the Maternity Safety & Support Programme (MSSP).
4.6	The DoM then informed members that in relation to the MSSP, a paper would be submitted to the national team that day and she was confident about exiting from the programme.
4.7	As a final point the CEO asked the CN whether there was a plan for mock CQC inspections to continue. The CN responded there was, and there was a programme of peer reviews across services, the outputs of which would feed back into QSC.
4.2 Maternity Reports	
4.8	This update was presented by the DoM. She informed members no new maternity PSIIs had been declared in-month. No SIs had been closed since the last report in April and there were seven investigations currently ongoing (two on the previous SI framework, three on the PSII framework and two were with MNSI).
4.9	In relation to the indirect maternal death declared in January that year, the DoM provided assurance that the outputs of the MNSI investigations had already been picked up by the Trust and work had already started on implementing those.
4.3 Nursing Midwifery and Care Staff Levels	
4.10	This update was presented by the CN and had previously been presented to People Committee (PC). She was pleased to update that the position was fairly stable with a sustained overall registered fill rate of >95%. The mid-year establishment review, which informed roster templates, had concluded and was currently under review. Once concluded this would be presented to the Board to provide assurance that establishments were correct.
4.11	In response to an earlier question around the correlation between staffing levels and falls, the CN provided assurance the organisation was not currently seeing any link there.
4.4 Learning from Deaths Update	
4.12	This update was presented by the MD. She informed members that the HSMR position remained stable and for November 24 (figure 4) SMR had gone up. Colleagues were currently looking into this but it was likely linked to Alex Health go-live.
4.13	The MD continued there had also been more SMR significant diagnosis group alerts and one that was unusual was Glaucoma. Glaucoma was not a 'cause for admission' so this patient record would be reviewed. The position was the same for 'acute and unspecified renal failure' and 'senility and organic mental disorders' and again these records would now be reviewed.
4.14	The organisation remained 'within expected' for the 12 month rolling HSMR+.
4.15	ANED-PJ asked for some additional detail on death certificates. The MD responded that the national approach had been to code on what the patient initially presented with for the first two episodes of care. There had now been a change in how those episodes were calculated.
4.16	ANED-BM asked for some additional detail around the SMR position for November 2024. The MD responded that in November 2024 the in-month figure had been 'above expected'. This could relate to the quality of care, documentation or coding, or to Alex Health implementation. Colleagues had met with the system provider earlier that week to discuss the issues.
4.17	ANED-BM then drew members' attention to the upward trend in the 12 month rolling SMR (Jan to Dec 24) and asked whether there were any concerns about this. The MD responded that this was still within normal variation and she would not routinely investigate further until performance was in special cause variation.
4.18	The ATC thanked the MD for her update which provided assurance that colleagues were currently asking the right questions about the data presented.
Break 1134 to 1145	
05 People	

5.1 Report from People Committee (PC)	
5.1	This update was presented by the ATC. She informed the Board that PC had undertaken its 24/25 effectiveness review and noted some actions around the quality of papers, follow-up on actions and future face-to-face meetings. Revised terms of reference (ToR) were presented for approval. The majority of People metrics were currently rated green, and in terms of the Freedom to Speak Up Guardian Report, there had been a slow but positive increase in referrals. The reasons for approaching the FTSU service remained constant (with the highest reported concerns related to behaviours experienced by staff). Following a recent request from the Board, she was pleased to confirm that Sexual Safety had now been approved as essential (not mandatory) training. The Committee had also received the Communications update. This had highlighted that current internal communications were not reaching a sufficient number of staff and a review of communication channels would now be undertaken.
5.2	With reference then to the Committee's ToR, the Director of Communications (DoC) highlighted the following section: '*Keep under review the development of a Communications Strategy and monitor its implementation'*. His view was this needed to be revised in line with the revised terms of reference and his suggested wording was '*Keep under review the development of the internal communications element of a Communications Strategy and monitor its implementation'*. It was also agreed that the Chief Clinical Transformation Officer would be added to the membership.
5.3	In response to the recommendation, the Board approved the Committee's revised terms of reference noting the two revisions described above.
5.4	In response to the above the CEO highlighted that whilst there had been some improvement actions identified in the effectiveness review, he had attended the last PC and his view was the meeting had been the best to date. He then referenced the People Report where the metrics presented were some of the best in the region. He congratulated the Chief People Officer (CPO) and her team on this achievement. In terms of the Guardian of Safer Working Report, and the lack of templates on medical staffing, he provided assurance this was now being addressed.
5.5	In response to a final question from NED-OA, the CPO confirmed that the result of the Resident Doctors' ballot would be available on 07.07.25.
5.2 People Strategy	
5.6	This update was presented by the CPO and reflected the vision for the next three years to support the Trust's people in terms of being ready for the future. Considering the current NHS landscape and proposed ICB/ICB boundary changes, her recommendation would be for the Strategy to be dynamic and reviewed as and when required.
5.7	The CPO continued that the format was slightly different to that of a traditional strategy in that it was more of a presentation. This was by design and in an effort to engage the Trust's people, to understand the vision and for everything to be led via the five key drivers. 58% of the organisation's workforce were residents of Harlow so it was about investing in people and investing in the community.
5.8	ANED-RC then commented that the presentation style was helpful and the goals were ambitious. He noted the positive performance against some of the goals and suggested the next step would be about how the interventions delivered the goals as some of those were ambitious.
5.9	The ATC thanked the CPO for her update.
5.3 Fit & Proper Persons Annual Submission	
5.10	This update was verbal and presented by the CPO. She informed members that the remaining final checks on the submission would be concluded by the end of the day and the organisation would be fully compliant. The process now was for the ATC to sign this off and for the document to then be submitted declaring full compliance. The final deadline for this was the end of June.
5.11	Members agreed with the above sign-off process.

06 Performance/Pounds/Places	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This update was presented by NED-CM. The Committee had noted the outputs of the 24/25 effectiveness review and in particular that some papers were still too detailed. The Committee's revised terms of reference were presented for approval that day. The rotation of the agenda in terms of having either Finance or Performance as the first item was working well.
6.2	PAF had noted some improvements in some areas of the estate but some additional detail had been requested around recruitment and the tracking of this. There had been a detailed discussion around the Alex Health sustainment case with PAF broadly supportive of the case (with some caveats). The corporate cost reduction submission had also been discussed and a future deep dive had been requested on performance.
6.3	In line with the recommendation the Board approved the Committee's revised terms of reference.
6.2 M1 Finance Update	
6.4	The CFIO presented his update. He was pleased to update the Trust had achieved its Month 1 position; a planned £1.5m deficit. 2025/26 would be challenging in terms of PQP targets and the national environment in general.
6.3 Integrated Performance Report	
6.5	This update was presented by the COO and the paper was taken as read. She highlighted the improvements in statutory/mandatory training compliance and the clear trajectories for appraisal compliance that had been set for the divisions. There were some concerns in relation to UEC which were being addressed, and as stated previously there would be an external review of Cancer Services. Some additional capital monies had been forthcoming in relation to the estate.
6.6	Going forward the IPR would be aligned to the new national performance metrics which were due to be published that day.
6.7	The ATC thanked the COO for her update.
07 STRATEGY/GOVERNANCE	
7.1 Report from Audit Committee (AC)	
7.1	This update was presented by the CFIO and the key areas were noted. The Trust had been commended as ever for highlighting to internal audit colleagues the areas of concern for further review. The process to finalise the 24/25 annual report and accounts was now well underway.
7.2 Report from West Essex Health & Care Partnership Board	
7.2	This update was presented by the CEO. This had been the first time the West Essex Health & Care Partnership Board had met as a formal sub-committee of the PAHT Board. There had been a good presentation on the Care Closer to Home programme being rolled out across West Essex. There had also been updates from the three locality leads for Harlow, Uttlesford and Epping Forest and the opportunities there related to community based hubs.
7.3	The CEO continued that the delegation framework for host provider had been formally signed off by all stakeholders at the meeting. In relation to the terms of reference, whilst there were technically three localities in West Essex, two East Hertfordshire PCNs would be included (Stort Valley and Hoddesdon). Sian Stanley would also be added to the membership of the HCP Board and would also rotate as a member of the PAHT Executive Board.
7.4	The meeting had also discussed local governance re-organisation and changes to the ICB interface with what was expected of local authority changes. The HCP Board continued to receive reports from its current sub-committees, but after the transition period those sub-committees would cease to exist and would be subsumed into PAHT Board Committees.

7.5	In response to a question from ANED-RC, the CEO responded that what had felt different at that first meeting had been how much support there had been for the host/lead provider plans and there had been agreement on the Delegation Framework.
7.6	NED-OA asked about any impact of the East Hertfordshire PCNs being included in the membership. The CEO responded the commissioning arrangements would be different but they needed to remain part of the system given PAHT was the hospital of choice for their patients.
7.7	In response then to a question from ANED-PJ in relation to Care Closer to Home, the CEO confirmed that the aim would be to bring the integrated neighbourhood teams closer and include secondary care as part of that conversation. The CCTO was working on this aspect which would pre-empt conditions locally and avoid elderly admissions into hospital.
7.8	In response then to a request from the ATC, it was agreed to circulate the West Essex Health & Care Partnership Integrated Delivery Plan 2025/28 and to then discuss this further at PAF.
ACTION TB1.05.06.25/06	**Circulate the West Essex Health & Care Partnership Integrated Delivery Plan 2025/28 to members. Lead: Board & Committee Secretary**
ACTION TB1.05.06.25/07	**West Essex Health & Care Partnership Integrated Delivery Plan 2025/28 to be discussed at PAF. Lead: CFIO**
7.9	In line with the recommendation, the Board approved the WE HCP Board revised terms of reference.
7.3 Report from Executive Board Meeting	
7.10	The CEO introduced this item. The report was taken as read and members noted that this had been the first meeting with representatives from EPUT and Primary Care, both of whom had found the meeting informative.
7.4 Questions from the Public	
7.11	The CoPP thanked the CEO for his recent television interview highlighting the aging estate and also congratulated colleagues on securing recent funding to address some of the estates risks.
7.12	The CoPP then raised a concern in relation to the move of Phlebotomy to the old physiotherapy gym which, in her view, was not a suitable location for this service. The CEO responded the requirement for this move demonstrated the poor hospital infrastructure but provided assurance this was a short-term measure and other options were currently under discussion. The CSO also added that he was now the SRO for the relocation of Phlebotomy Services.
7.5 Questions from the Public	
7.13	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	No new issues/risks were noted.
8.5 Any Other Business (AOB)	
8.5	There were no items of AOB.
8.6 Reflections on Meeting	

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8.6	Members reflected on the level of challenge at the meeting and the ATC, CEO and DCG agreed to meet offline to discuss this.
8.7	ANED-RC commented that in terms of the patient story that day, there had been more of a focus on the 'management' response than the actual patient stories.
8.8	The meeting closed at 12:35.

Signed as a correct record of the meeting:	
Date:	02.10.25
Signature:	
Name:	Darshana Bawa
Title:	Acting Trust Chair

ACTION LOG: Trust Board (Public) 02.10.25

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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~~ BD.06.11.25	Item not yet due.	Open
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	The charity is prepared to receive an application and would consider at the December CFC, in line with any other available charitable funding.	Open
TB1.05.06.25/05	Corporate Risk Register	Corporate Risk Register: Clarify the details of the chemotherapy risk.	MD COO	TB1.02.10.25	The issue is around staffing numbers for the unit (to prepare chemotherapy) and staffing numbers to clinically screen oncology prescriptions and the uncontrolled work that is coming into pharmacy with year on year increases in workload.	Open
TB1.05.06.25/06	West Essex Health & Care Partnership Integrated Delivery Plan	Circulate the West Essex Health & Care Partnership Integrated Delivery Plan 2025/28 to members.	B&CS	06.06.25	Actioned.	Closed
TB1.05.06.25/07	West Essex Health & Care Partnership Integrated Delivery Plan	West Essex Health & Care Partnership Integrated Delivery Plan 2025/28 to be discussed at PAF.	CFIO	PAF.26.07.25	Actioned	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 2 October 2025

Agenda item:	2.1							
Presented by:	Darshana Bawa, Acting Trust Chair							
Prepared by:	Darshana Bawa, Acting Trust Chair							
Date prepared:	26.09.25							
Subject / title:	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 lead 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.

1.0 Purpose/issue

This report outlines my activities since my last report (4 months ago), and also coincides with the half way point of my tenure 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 Interviews:

We have been busy with executive and non-executive interviews over the last few months, having recruited a Chief Medical Officer and a Chief Operating Officer.

Last week, we successfully recruited a non-executive director from a good field of diverse candidates. He has a financial background with extensive experience in the NHS and is suitably qualified to chair PAF. The appointment will be confirmed once all the usual checks have been completed.

3.0 System involvement:

I continue to attend the HWE ICB Chairs' meetings, which keep me up to date and provide some good discussion on current changes and how we are being affected. Some of our HWE colleagues are working closely with charities and organisations to extend reach into community care.

The recent E of E Regional CEO & Chairs meeting provided an opportunity to meet colleagues from the Essex ICB. There were several interesting presentations focussing on health inequalities, maternity/maternal care, and a financial review focussing on productivity. However, the section that grabbed my attention was the paper on children and young people and just how much there is to tackle. As leaders, it is within our gift to address these issues so that we strive to create a healthier generation for the future.

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. Attached is a summary with any actions arising.

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.

On Wednesday, we held our AGM at the Civic Centre in Harlow, which went very well and generated some really good questions at the end. A big thank you to everyone that contributed to making it a success.

I am half way through the Aspiring Chairs Programme, it's been a very useful source of support running alongside the practicalities of the day to day role.

The Board is asked to note the report.

Author: **Darshana Bawa**
Acting Trust Chair

Date: 26.09.25

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

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Chair's action matrix: version 6.0 | Team: PAHT Chair and Non-executive Directors | Updated: September 25

Non-Executive Directors initials:		Key for others
DB: Darshana Bawa (Chair) CM: Colin McCready OA: Oge Austin-Chukwu LB: Liz Baker	AWS: Anne Wafula-Strike MBE (Assoc.) RB: Ralph Coulbeck (Associate.) BJ: Bolanle Johnson (Assoc.) PJ: Dr Parag Jasani (Assoc.) BM: Dr Ben Molyneux (Assoc.)	PP: Patient Panel FTSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Due	Action
24/06/2025	DB, OA	Theatres	Estates challenges, overcome by tenacious team	HoN		NA
17/07/2025	DB, BM, BJ	Maternity	Exceptional outcomes despite challenges.	CD and DoM		NA
25/07/2025	PJ	ED	Doctors strike, no issues	UEC ADO		Corridor visits per 2025 plans
18/09/2025	LB, HH	Herts & Essex Hospital	Report to be shared	Matron/ HoN		To follow

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2.2

Trust Board (Public) – 2 October 2025

Agenda item:	2.2							
Presented by:	Thom Lafferty - CEO							
Prepared by:	Thom Lafferty - CEO							
Date prepared:	1 October 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 (Public)
2 October 2025

1.0 Personal Reflections

The NHS 10-Year Plan, issued by the Government earlier in the year, boldly stated that the NHS needed to 'reform or die'. At Princess Alexandra Hospital (PAH), and across the West Essex health and care system, it would be accurate to say that we have accepted this challenge.

The writing of this report highlights the extent of change currently affecting the organisation, both externally and internally driven. In my view, PAH and West Essex is in an ideal position to be 'fast followers' with regard to the 'three shifts' envisioned within the Plan:

- Acute to Community
- Sickness to Prevention
- Analogue to Digital

At the same time, we realise that intra-organisational changes need to take effect, to improve patient outcomes, patient experience and staff experience at PAH. As ever, the leadership challenge we face is being able to drive progressive, continuous improvement whilst ensuring sufficient stability within the organisation.

Throughout all of this change, I have been grateful for the support of my Board colleagues, external partners, our fantastic Patient Panel and our amazing, dedicated Trust staff.

2.0 Our Patients

Infrastructure issues: requirement for significant additional funding to maintain our estate to support patient care

Following the Government announcement on 30 May of further infrastructure funding of £2.58m, we have focused on fire safety works and improvements to the hospital's energy and electrical infrastructure.

However, the ageing hospital estate continues to face significant and ongoing issues, and we require funding of around £120 million to maintain the estate ahead of the new hospital, with £70m of this above what we would expect to receive over the next 10 years. You may have seen recent regional (ITV Anglia) media coverage as part of our work to raise the profile of this issue. Our absolute priority is patient safety and continuing to provide services effectively.

Care Quality Commission (CQC) Adult Inpatient Survey 2024 results

The Care Quality Commission (CQC) Adult Inpatient Survey 2024 results were published on 9 September.

The inpatient survey was conducted in November 2024, which coincided with the first month of implementation of Alex Health, our new electronic health record (EHR). That month, our patients experienced unusual cancellations and delays, while the Trust took on a massive transformation. This greatly impacted on the perception of patient care.

However, notwithstanding this, we know we need to do better for our patients and, in the forthcoming months, we will be reviewing and enhancing how we provide the 'fundamentals of care' for our patients: clear communication, sufficient nutrition/hydration, cleaning and privacy and dignity. As part of this, we will be asking our clinical leaders to lead by example and model best practice, undertaking clinical shifts as part of their leadership responsibilities.

In more positive news, our monthly Friends and Family Test results returned to a recommendation rate of 85% in February 2025 and we are thoroughly committed to doing more to enhance how patients experience our care.

Hosting our Annual General Meeting

We were delighted to welcome patients, staff, partners, stakeholders and members of the public to our Annual General Meeting (AGM) at the Council Chambers, Harlow, on 24 September.

At the event, we took attendees through a review of the year and our operational and financial performance. Our clinicians updated on significant service developments including the benefits of the Community Diagnostic Centre at St Margaret's Hospital. This will support quicker and more local access to diagnostic tests close to patients' homes. Our clinicians also discussed improvements to frailty services for our community.

Sharing our vision for the future of healthcare at community event

We invited patients, local residents, and visitors to a public meeting where future plans for healthcare at PAHT were shared, including key developments at Herts and Essex Hospital in Bishop's Stortford.

The event took place on 30 September at Birchwood High School in Bishop's Stortford.

Attendees heard about:

- Progress on the New Hospital Programme and how hospital sites will evolve to serve growing local communities
- The impact of the NHS 10-Year Plan on services at PAHT
- Our commitment to strengthening patient and public engagement
- PAHT's role within the Hertfordshire and West Essex Integrated Care System

This event was the second in a series of meetings organised by the Patient Panel who are supporting us to engage with local people about how services are evolving, including the development of Neighbourhood Health Hubs.

As always, to meet the needs and expectations of our local communities, engagement and understanding is critical and, to this end, further public events will be planned for the forthcoming months.

3.0 Our People

Executive Changes

Sharon McNally, chief nurse and deputy chief executive, will be seconded to the role of chief nurse at Mid and South Essex NHS Foundation Trust (MSE FT) from 29 September for an initial 6 months. This is a role of significant size and scale and reflects Sharon's many achievements at PAH over the last few years, improving the quality of care, clinical governance and professional nursing leadership across the Trust.

I am hugely grateful for the role that Sharon played as acting CEO prior to my commencement in post at PAH in November 2024. As my deputy, Sharon's balanced and reassuring presence has helped ensure stability and continuity amidst an otherwise rapidly evolving landscape. I wish Sharon the very best in her secondment.

I am delighted to announce that, during Sharon's secondment, Tom Burton, our chief finance and infrastructure officer, will act as deputy chief executive, following an internal Expression of Interest process.

We will be running a similar process to appoint our acting chief nurse and I will update the Board at the time of our meeting as to the outcome of this process.

I would also like to take this opportunity to welcome Anna Jebb as our new chief operating officer to the organisation. Anna will formally commence in post with us as of 6 October. I am very grateful for the sterling efforts of Camelia Melody over the past few months as acting chief operating officer. Camelia has stepped up during a time of considerable operational pressure and external scrutiny and I am grateful for her dedication to the Trust and its patients.

Organisational change update

One of the key changes we have needed to make internally is the restructuring of our clinical divisions within the Trust. This to ensure that we:

- Incorporate our neighbourhood ambitions into our internal formal structures;
- Are genuinely clinical led;
- Consolidate clinical service provision, breaking down barriers and silos to collegiate working internally;
- Reduce the number of 'management tiers' that exists between the executive team and the clinical frontline;
- Improve our recurrent financial position.

We completed the consultation process relating to the restructuring on 12 September and we are now reviewing the feedback received.

We will then update our staff on what we have learnt and how and when we will implement changes. We are providing a variety of support options for colleagues during this time.

Following the restructuring process, we will be investing in two important areas of external support:

- Leadership Development & Support;
- Cultural Change Programme

I am excited by what we can achieve together, establishing the right structures, clinical leadership support and driving positive, cultural transformation.

Our Operational Performance

Our dedicated teams have been working hard with partners to improve the experience for our patients by reducing waiting times. We are delighted to have seen significant progress with our 18-week waiting time target, continuing to improve from 41.8% in December 2024 to 52.8% in August 2025, with a reduction of 9,900 patients in the waiting list since March 2025. This has resulted in one of the strongest improvements in the country. This is particularly notable considering the ongoing infrastructure issues we face with our ageing hospital estate.

We are also seeing an improvement in our 4-Hour Standard. We achieved 75% in August against a trajectory of 71%, with a September month to date (MTD) position of 79.6%.

We are absolutely focused on continuing to reduce waiting times for treatment, working towards achieving the national standard – this is just the start of our improvement journey. There has been a significant improvement in our cancer 62 day performance in July's submitted position is 57.7% compared to June performance of 41.8% - a 16% improvement. To build on this improvement on waiting times, we held a cancer summit this month to bring together the teams in cancer services to address some of the challenges and how we can address them together as one team.

We recognise the impact for patients who are waiting for care and we are enhancing integration and collaboration with our partners to ensure that patients can access the right care, in the right place, at the right time.

4.0 Places and Partnerships

UK Health Security Agency (UKHSA) announcement

The move of UKHSA to Harlow is fantastic news for Harlow and its continued regeneration.

This development will bring new jobs, representing a massive investment in our local economy in Harlow, and plays an important part in our collective efforts for community regeneration. The expected population growth and the synergies between our work and that of the new campus, reinforces and accelerates the need for a new hospital, on a new site, delivered in the quickest and most cost-effective way.

We have commenced discussions with the UKHSA with regard to potential joint local initiatives that span the health and life sciences domains.

Smoke-free PAHT

We are reinforcing a zero-tolerance approach to smoking and vaping on the hospital site, which includes the buildings, entrances and car parks.

Smoking or vaping on the hospital site is illegal and a risk to the health and safety of patients, visitors and colleagues from second-hand smoke or vapour and the risk of fire.

You can read more on our website >

Patients invited to help improve hospital environment

We are inviting patients, visitors and members of the public to take part in this year's Patient-Led Assessments of the Care Environment (PLACE), taking place on 7 and 9 October.

PLACE assessments give people a vital voice in shaping the environment, helping ensure that care is delivered in a clean, safe, and dignified setting. Volunteers, known as patient assessors, visit the hospital to evaluate areas such as privacy and dignity, food quality, cleanliness, and the general condition of the buildings.

This important initiative is about listening directly to those who use the hospital's services and using that feedback to drive real improvements.

You can read more on our website >

5.0 Host Provider

Our Host Provider arrangement is now in place with the Health and Care Partnership (HCP) Board and official subcommittee of PAH (the first report is on the agenda). We are continuing our work with Essex Partnership University NHS Foundation Trust (EPUT) to discuss how we can make the future integration of services as seamless as possible by exploring the best delivery model.

The ICB has set out a two year, phased, scheme of delegation of commissioning budgets to the HCP. This starts with the community and frailty contracts (c£50m), followed by the majority of acute contracts (c£270m) and finally children's and young person's services (c£6m). The detail of this delegation is still being work through, but the principle was agreed at the HCP Board.

Finally, I am proud to announce that our bid to be part of the National Neighbourhood Health Improvement Programme (NNHIP) was a resounding success, with only 42 out of 141 applications being approved. The response to our bid was outstanding:

"*Your application stood out in what was an incredibly competitive process, with 141 high calibre applications received (covering approximately 83% of Places across England), representing every region and system. The response was nothing short of inspiring, showcasing the breadth and depth of innovation already underway across neighbourhoods. Your commitment to improving health and wellbeing at neighbourhood level – backed by local leaders and grounded in community – truly resonated with us."*

We are proud to be part of the programme but, more importantly, we can now use the programme to both showcase what we are doing and accelerate the delivery of outcomes for our patients.

6.0 Our Pounds

We're reporting achievement of the month 5 plan, with the Trust delivering a deficit of £0.5m against a planned deficit of £0.6m for M5. This is £0.1m favourable to the submitted plan for the month. Year to date, the plan was for a £2.6m deficit which we are achieving. This continues the positive start to the financial year, with Patients, Quality, Productivity (PQP) being delivered in full in month 5 and year to date though risk remains for the future due to a slightly back ended plan and winter has adversely impacted on performance in prior years. We will continue to robustly monitor our financial position.

Agency expenditure in month 5 is currently at 3.0% of the total pay bill, which is below the NHSE target of 3.2% though is slightly up against recent trends. This overall improvement reflects the ongoing focus on workforce controls, though bank spend remains high and will need continued attention as agency stabilises.

Capital spend remains on track against target with our 'Business as usual' Capital fully realised against a range of schemes. We have also received additional infrastructure funding which has been allocated to improving fire safety and electrical infrastructure. We are in receipt of funding for several capital programmes, including the Community Diagnostic Centre which is on track to open later this year. We continue to pursue additional funding to support the wider transformation of the estate.

Thom Lafferty
Chief Executive
October 2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 October 2025

3.1

Agenda item:	3.1							
Presented by:	Andrew Kelso – Chief Medical Offieer							
Prepared by:	Lisa Flack – Compliance & Clinical Effectiveness Manager							
Date prepared:	02.07.25 – updated 21.07.25							
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 02.07.25 and following updates made 09.07.25 and 18.07.25. **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 34. **Table 2** details the numbers of risks by category that breach the Trust appetite tolerance. **Section 3** provides a summary of the risk scoring 20: • Risk id 85 relating to emergency access standard **Section 4** - There are two new risk scoring 16 • Risk 743: relating to CPAP machines coming to end of life and equipment being obsolete • Risk 740: relating to the Stroke patients not receiving the medical, nursing or therapist case they need **Section 5** - There are no new risks scoring 15							
Recommendation	• Review and discuss the contents of the corporate risk register							
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	√	√	√	√	√			
Previously considered by:								
	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 02.07.25 and following updates made on 09.07.25 and 18.07.25.

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 34 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 (8)	0 (0)	0 (0)	**8 (8)**
Corp - Estates & Facilities	1 (0)	0 (0)	0 (0)	0 (0)	**1 (0)**
Corp - IM&T	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
CHAWs Child Health	0 (0)	3 (2)	0 (0)	0 (0)	**3 (2)**
CHAWs Women's Health	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Surgery	2 (2)	2 (2)	0 (0)	0 (0)	**4(4)**
Urgent & Emergency Care	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Trust wide	0 (0)	11 (10)	1 (1)	0 (0)	**12 (11)**
Totals	**5 (4)**	**28 (26)**	**1 (1)**	**(0)**	**34(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	21 (18)	65 (66)	9 (8)	15 (19)	2(3)	**112 (113)**
Quality – Patient Experience	≥ 12		10 (10)	0 (0)	3 (3)	0 (0)	**13 (13)**
Quality – Clinical Effectiveness	≥ 12		15 (9)	2 (1)	7 (7)	1 (0)	**25 (17)**
People	≥ 15			1 (1)	3 (3)	0 (0)	**4 (4)**
Statutory Compliance & Regulation	≥ 12		10 (11)	2 (2)	0 (0)	1 (2)	**13 (13)**
Finance	≥ 12		4 (4)	0 (0)	0 (0)	0 (0)	**4 (4)**
Reputation	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**
Infrastructure	≥ 15			0(1)	1 (1)	0 (0)	**1 (2)**
Information and Data	≥ 10	2 (2)	7 (7)	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 New risks scoring 16 added to the corporate risk register – two

4.1.1 CPAP machines

- There is a risk that we will not be able to provide appropriate respiratory support to our patients as the current CPAP machines have approached end of life and machine consumables are now obsolete.
  Risk id 743: This is a neonatal risk
  Actions / mitigations: Three machines are serviced and in use. Optiflow machines are available. Business case going through capital working group.

4.1.2 Stroke patients

- There is a risk that Stroke patients will not receive the medical, nursing or therapist care they need
  Risk id 740: is a Trust wide risk on the corporate risk register

Actions / mitigations: Regular contact with HASU (Hyper-acute Stroke Unit) and local agreement in place to 'swap' Stroke patient with a repatriation candidate. Stroke patients referred to Therapies Team. Neuro Therapy MDT in place. Pathway being developed.

5.0 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

Author: Lisa Flack – Compliance and clinical effectiveness manager

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 October 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 September 2025. There are no changes to the risk scores this month, however two risks are included for noting: - New BAF risk 2.1 – this risk was approved at Private Board in September scoring 12 - BAF risk 3.2 which is assigned to the Board for review however it is not proposed to change the risk score. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Formally note BAF risk 2.1 as a new risk - Review BAF risk 3.2 System Pressures - Note the remaining BAF risks

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

Previously considered by:	QSC, PC, and PAF in September 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 2.1, Appendix B – Risk 3.2 and Appendix C – BAF summary

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2024-25

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 and Actions	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 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF risk 2.1		**Staff engagement and morale:** There is a risk that we fail to improve staff engagement and morale resulting in ineffective leadership, poor staff and patient experience and a deterioration in operational performance and improvement	**Causes:** Lack of leadership capability and capacity to support staff Re-structure launching National directives - Trusts asked to reduce their corporate pay growth when compared with pre-pandemic levels by 50%. The need to formally incorporate PAH's lead/host provider arrangements for Place into divisional management structures **Effects**: i) Low staff morale, high temporary staffing costs, poor patient experience and outcomes ii) Poor operational performance iii) Impact on Trust's reputation. iv) Staff vacancies in some areas	**4X 4 =16**	CPO **People Committee**	1.MARS process and engagement sessions 2. People team and line managers in place to provide guidance and sign post colleagues to support networks and services 3. Different modes of communication in place to reach out to colleagues 4. Training in place for meaningful / difficult conversations 5. Communications Team supporting Trust awareness of change process 6.Staff survey actions and interventions including recognition awards	i) PC, Cabinet and Executive Board ii) People meeting iii) JSCC, JLNC iv) DRMs and divisional board meetings	MARS and consultation reports to Cabinet, Executive Board, Trust Board. Staff survey reports to PC SLF sessions (quarterly)	**4 x 3 = 12**	~~1.Risk that not all staff will be aware of MARS process~~ Consultation feedback to be reviewed and shared during October 2025 2. Risk that not all staff are aware of or can access support in place 3. Not all line managers are equipped to manage difficult conversations 4. Capacity concerns with Comms Team and ability to deliver 5. Capacity concerns with People Team and ability to delivery	None identified.	01/09/2025	**No change to score since approved at Board in September 2025.**	**4 x 2 = 8 April 2026**

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 iiv) PAHT Host provider aramgemtns 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 ix) Development of Neighbourhood health	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) OSC 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 iv) Moving to Greater Essex ICB a potential risk (and opportunity)	i) ICB Boundary changes ii) New Governance framework not yet embedded iii) Place performance dashboard not in place	01/09/2025	**Risk score to remain at 16.**	**4x3=12** **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	16					↔	12	ICN CMO
1.3 PAF	Operating Plan: Risk of poor outcomes and patient harm due to inability to deliver the national access standards.		15	15					↔	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 and adoption by clinicians of Alex Health post go live	16	16	16					↔	12	CCTO
1.5 PAF	Cyber There is a risk of Trust-wide loss of IT infrastructure and systems from Cyber attack	15	15	15					↔	10	CCTO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a culture that supports engagement, recruitment and retention and results in further improvements in our staff survey results as we strive to be a model for equality, diversity and inclusion										
2.1 PC	Staff engagement and morale: There is a risk that we fail to improve staff engagement and morale resulting in ineffective leadership, poor staff and patient experience and a deterioration in operational performance and improvement			**12 NEW RISK**					**NEW RISK**	8	CPO
2.3 PC	Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust	16	16	**Closed at Private Board in September 2025**						8	CPO
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20					↔	8	CFIO
3.2 STC	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16					↔	12	CSO
3.5 STC	New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.	20	20	20					↔	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

Board Assurance Framework Summary 2025.26

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
	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	16					↔	12	CFIO

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**26.09.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.6 Revised Terms of Reference (ToR)	Y	Y	N	QSC approved the Committee's revised ToR and **these are now attached as an appendix.**
2.1. M5 Integrated Performance Report (IPR)	Y	Y	N	Key headlines were: **UEC Performance:** The Trust achieved 75% for the 4 hour standard against a trajectory of 71% following the re-designation of Furthers. **12 hour ED Waits:** % of patients in ED over 12 hours had significantly risen and was above trajectory at 12% for August against a trajectory of 7.4%. **Ambulance Handover:** Handover times had deteriorated to 34.22 minutes against a trajectory of 35 minutes. **Diagnostics:** Diagnostics performed within 6 weeks of referral had slightly decreased for July to 65.49% from 66.26% in June. **Cancer:** For 28-day faster diagnosis standard performance was 73.4% in July, with August's unvalidated position currently at 66.6% against a trajectory of 77%, validations were on-going. The greatest risk to Trust performance sat with Urology, Upper GI, and Lower GI. Diagnostic capacity was the key risk for the 28-day performance. For the 62-day standard finalised performance for July was 57.7%, a marked improvement on the June performance of 41.8% -

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**26.09.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				16% improvement (and August's unvalidated position was 55.0%). **RTT Elective Standards**: The Trust had 27 live 65+ week wait breaches at month end in July 2025, an increase on the 12 breaches in June. The increase was directly linked to ASI drop-offs and pop-ins onto the PTL. For 52-week breaches, the Trust ended July 2025 on a total of 2402 breaches (5.1% of total PTL size) and June on 2265 breaches (4.7% of total PTL size). July performance was behind plan of 2066. This increase was directly linked to ASI drop-offs/pop-ins onto the PTL. The Trust's 18-week RTT week performance had drastically improved in recent months from 41.8% for December 2024, up to 52% in July 2025. **Pressure Ulcers:** Data required validation in terms of inclusion in the paper but it was confirmed there had been an increase in category 3 and 4 pressure ulcers in August. This was unusual for the organisation and it was agreed a regular update on the position would be received by QSC going forward, including data for any patients discharged with tissue damage. **Complaints:** These continued to rise. It was agreed that QSC would receive an update on the Cancer Strategy in October along with EM-SDEC metrics.

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REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**26.09.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Report Against Operating Plan	Y	Y	N	Covered in the discussion at the item above (IPR).
2.3 Paediatric Auditory Brainstem Response (ABR) Update	Y	Y	N	A national Paediatric audiology desktop review had identified some concerns relating to a sample of ABR (Auditory Brainstem Review) cases at PAHT. These concerns could potentially trigger a full look-back exercise of ABR cases undertaken at PAHT over a 5-year period The ICB had sent a letter alerting PAH to the issue and next steps in understanding the position and support required (10th July 25). The Trust believed that a full review may not be necessary and had asked for clarification. The results on those clarifications were not anticipated before the New Year.
3.1 Infection Prevention & Control Bi-Monthly Update	Y	Y	N	Key headlines were: **MRSA Blood Stream Infections:** These were higher than usual with three already in the current year. MSSA bacteraemias were also higher than usual. **Winter/Point of Care Testing:** Kingsmoor Ward had been designated as the dedicated ward for respiratory infections

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 4.1**
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REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**26.09.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				during winter, if required. Current thinking was for 2 point of care testing machines at the front door and 2 in Paediatrics. **HDU/ITU and Paediatric ED Works:** The IPC team was heavily involved in these works. **Influenza Vaccination Programme:** This was a nationally run programme and as soon as vaccines were released the Trust would begin its programme of vaccination for staff.
3.2 Learning from Deaths Update	Y	Y	N	Key headlines were: • Mortality indices are deteriorating. • There were increased numbers of SMR mortality outliers. The above deterioration was likely due to data quality, partly as a consequence of Alex Health go-live and investigations would continue in terms of changes required to coding linked to Alex Health.
3.3 Urology Deep Dive	Y	Y	N	Assurance was provided around the service. The MDT and cancer management processes have been externally reviewed. Going forward Urology data would be brought to QSC by exception, for continuing oversight.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**26.09.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.4 Patient Safety Monthly Update	Y	Y	N	This report provided an update on patient safety, incident management, clinical effectiveness, and legal matters for August 2025. It highlighted trends, themes, and areas requiring attention, with a focus on continuous improvement and regulatory compliance. Continued focus was needed on: • Reducing >30/7 incidents – currently 53% in August. • More consistency with National Audit recommendations and NECPOD. • Industrial action incidents reported. The report also included the Internal Audit review of the Trust's response to requests from the Coroner which had been assigned a limited assurance rating and the associated improvement plan agreed.
3.5 Sharing the Learning 4 Monthly Update	Y	Y	N	This quarterly Sharing the Learning report outlined the summary of incidents/events during January to December 2025 period with a focus on learning and any changes in practice as a result. Those included:

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**26.09.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• 7 x Patient safety incident investigations (1 never event) • 1 x MNSI case • 2 x Medication incidents • 1 x Inquest • 1 x safeguarding • 1 x unsafe patient transfer from ED to ward
3.6 Update following Annual Complaints Report	Y	Y	N	Key headlines were the Trust had received 318 complaints in 2024-25. 2025-26 remained challenging with 304 complaints received by mid-September. The paper included an Inpatient Survey action plan which had been developed with action areas based on the ten most significant gaps within three major themes of admission, ward level experience and discharge. This was discussed by QSC and quarterly updates on progress/impact would be received going forward along with FFT data.
3.7 Update from Patient Panel	Y	Y	N	This was an update on the work undertaken by the Panel over the previous two months. Members continued to be recruited and the Panel was now represented at additional

BOARD OF DIRECTORS:	Trust Board (Public) – 2 October 2025			AGENDA ITEM: 4.1
REPORT TO THE BOARD FROM:	Quality and Safety Committee (QSC)			
REPORT FROM:	Oge Austin-Chukwu			
DATE OF COMMITTEE MEETING:	26.09.25			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				meetings including Health & Safety, Fundamentals of Care and Nutrition & Hydration. It was agreed the parking process for Blue Badge users would be reviewed, along with the current Phlebotomy Service in terms of patient experience, particularly for children.
3.8 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. The target date to achieve a reduction in this score had been extended to October 2026 to allow time for the required improvements to be seen.
4.1 Horizon Scanning Update	Y	Y	N	Participants in the National Maternity Investigation had been announced. 14 trusts would take part, including one in the East of England (King's Lynn).
4.2 Medicines Optimisation Annual Report	Y	Y	N	The report provided an annual update on the governance around medicines usage in the organisation over the previous 12 months, and an overview of progress in terms of key strategic elements including omitted doses, antibiotic stewardship and the sharing of information between care services.
4.3 Reports from Feeder Groups	Y	Y	N	Reports were received from:

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 4.1**
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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Strategic Learning from Deaths Group • Patient Safety Group • Clinical Compliance Group • Clinical Effectiveness Group • Vulnerable People Group • Patient Experience Group

BOARD OF DIRECTORS:	**Trust Board 02.10.25**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ben Molyneux, Committee Chair/Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**26 September 2025**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 Maternity Dashboard	Y	Y	N	The Committee reviewed the dashboard data and highlights were as follows: **Positive Trends**: upward trends in bookings, neonatal death rates below regional/national thresholds, and improvements in smoking at delivery rates. **Areas for Improvement**: Challenges remain in meeting the 15-minute maternity triage standard, with ongoing deep dives to address interdependencies. MOH rates (caesarean and vaginal births) exceed regional thresholds, with ongoing quality improvement work. **Stillbirth Rates & Health Inequalities**: Stillbirth rates are above target, especially among minority ethnic groups. The team is working to ensure accessibility and reduce barriers for these populations, collaborating with the MNVP. The importance of qualitative review was discussed due to small numbers **Dashboard Presentation**: The Committee noted the dashboard's raw data could be hard to interpret without narrative, suggesting improvements in data visualisation and use of SPC charts for better trend analysis.

BOARD OF DIRECTORS: **Trust Board 02.10.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ben Molyneux, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **26 September 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.2 Maternity Monthly Report	Y	Y	N	Highlights included: • Midwifery vacancies at 7.6% and maternity support worker vacancies at 8.62%. A mass recruitment day resulted in 29 offers to newly qualified midwives, expected to start in November, which should improve staffing and reduce agency use. A trajectory and more detailed update will be presented in November. • There was a spike in red flag events in August, attributed to summer staffing challenges and increased agency use. Additional training for labour ward coordinators and data triangulation with incident reports are planned to address variability and safety. • The implementation of the "Civility Saves Lives" initiative to improve workplace culture and patient safety was noted • A new pathway will allow babies under 10 days old to be reviewed in the birth centre instead of paediatric ED, aiming to improve patient experience and reduce pressure on ED. • The departure of the complaint's coordinator led to process changes, a new approach was in development. Leadership changes and ongoing consultation are causing some concern among staff, and a deeper discussion on culture and leadership was planned for November.

BOARD OF DIRECTORS: **Trust Board 02.10.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ben Molyneux, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **26 September 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.3 Triage Deep Dive	Y	Y	N	The Committee discussed the deep dive into triage, areas for improvement were noted as follows: • **Leadership and Staffing**: The triage area lacked a ward manager for some time, impacting leadership, staff well-being, and KPI performance. A new internal ward manager with change leadership experience has now been appointed, which is expected to drive improvement. • **Telephone Triage Implementation**: Plans are underway to implement a standalone 24/7 telephone triage system, supported by additional midwives and modelled after a successful neighbouring trust. National e-learning will be adopted to support this change. • **Data and Reporting Challenges**: Gaps in reporting, especially regarding the 15-minute triage assessment standard, were noted due to staffing and leadership gaps. Improvement is expected with the new manager in post. • **User Experience and Estates**: The triage area is experiencing increased demand and is physically constrained, affecting user experience. There is a call for continued support for refurbishment and investment in the estate to create a more welcoming and efficient environment. • **Team Engagement and Change**: Staff in triage have good team relationships but remain challenged. A workshop is planned to involve the team in shaping changes and capturing their ideas. • **Service Model Redesign**: The need to rethink the delivery model to address rising demand within estate constraints, including reviewing referral pathways and ensuring the right patients are seen in the right place was discussed. Collaboration with change teams and community midwives is planned. An update on progress will be presented at a future meeting.

BOARD OF DIRECTORS: **Trust Board 02.10.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ben Molyneux, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **26 September 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 Birth Rate Plus Review	Y	Y	N	The draft review has been reviewed and is being finalised. The report confirms increased complexity and care needs among women, requiring staffing adjustments. The final report will be presented in the November.
2.5 Risk Register	Y	Y	N	The Committee received an update on the current risks on the departments risk register. The risk register is aligned with national sustainability actions, and ongoing support is needed for workforce and estate solutions.
2.6 Maternity & Perinatal Incentive Scheme Update	Y	Y	N	An update on the at risk actions was provided: • Safety Action 1 (PMRT reporting) due to a loss reported outside the expected timeframe, with mitigations in place but compliance may not be accepted. • Safety Action 6 (Saving Babies Lives) faces data auditing challenges from the Alex Health system and gaps in diabetes service provision, especially for women with type 1 diabetes using closed pump systems. • Safety Action 7 (service user involvement) is at risk due to limited MNVP lead hours, but national guidance allows for alternative compliance declaration; the Trust is ahead in some areas but lacks ICB funding for more leads. • Safety Action 8 (multidisciplinary training) is challenged by medical staffing compliance. The Committee acknowledged some risks are outside the Trusts control and will continue to escalate and receive updates on mitigations.
2.7 Maternity Patient Safety Incidents	Y	Y	N	There had been no new maternity incidents declared and one closed since the last report. Maternity services currently have 4 investigations ongoing. PSII's – 2 MNSI – 2
2.8 MNSI	Y	N	N	The Trust has completed 11 MNSI investigations with 2 ongoing, highlighted that the Trust is a small referrer, and discussed themes from recent reports, including recommendations around foetal monitoring, escalation, triage, and documentation.

BOARD OF DIRECTORS: **Trust Board 02.10.25** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Ben Molyneux, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **26 September 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.9 Maternity Safety Champions Update	Y	N	N	The Maternity Safety Champions walkabout on 29 August 2025, accompanied by Tom Burton (Acting CEO), visited all key maternity areas. The team found wards well-staffed, staff highly engaged, and a positive atmosphere. Key issues noted were ongoing challenges in maternity triage and ventilation concerns in the labour ward. Recommendations include maintaining staffing, addressing ventilation, reviewing amenity access, supporting new midwives, and following up on triage issues.
Horizon Scanning	Y	N	N	Highlights included: • Announcement of 14 trusts for the national maternity and neonatal investigation, with Queen Elizabeth at King's Lynn selected from the East of England. • Introduction of the SPEN portal for single-point perinatal event notification, rolling out soon. • Launch of the MOSS (Maternity Outcomes Signal System) for early warning on stillbirths, neonatal deaths, and HIE, piloting now and going live in November. • National rollout of a standardized OPAL system for maternity, with daily data returns, aiming to align definitions and responses across units. • Recent publication of national reports, including the estate survey highlighting significant estate challenges • National communications refuting misinformation about paracetamol safety in pregnancy.

The Princess Alexandra Hospital NHS Trust

4.1

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE 20254/2526

PURPOSE:

The Quality & Safety Committee (QSC) functions as the Trust's umbrella clinical governance committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service under the Health & Social Care Act 2012:

- **Clinical Effectiveness** – consistently achieving good clinical outcomes and high levels of productivity through evidence-based clinical practice.
- **Safety** – achieving high and improving levels of patient and staff safety and identifying, prioritising and managing risk arising from the delivery of clinical care.
- **Patient Experience** – promoting safety and excellence to deliver an excellent patient experience as measured by direct interaction with, and feedback from, those using the Trust's services.

DUTIES:

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

Evidence-Based Clinical Practice

1. To receive assurance on action taken to improve mortality rates as part of the Trust's mortality review process and to receive a monthly update on Learning from Deaths.

2. To ensure there is a well-functioning and effective process for considering and implementing guidance from the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and responding to National Patient Safety Agency (NPSA) Alerts.

3. To receive assurance in respect of the delivery of any action plans arising from reviews or investigations into safety and or quality by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

Compliance

1. To monitor the Trust's compliance with the Care Quality Commission's (CQC) registration criteria and oversee any remedial action required.

2. To ensure the Trust complies with recommendations from the National Quality Board.

3. To receive regular reports on the Trust's infection control arrangements and receive assurance on remedial measures taken to handle the outbreak of infection.

4. To receive regular reports on the Trust's compliance with Safeguarding requirements and matters concerning Liberty Protection Safeguards, Mental Health and Mental Capacity Act.

5. To receive recommendations on the Trust's annual Quality Account priorities and monitor their in-year progress.

6. To maintain oversight of the patient safety metrics in the national oversight framework.

Audit

1. To receive the annual Clinical Audit Programme and ensure that it is in line with the audit needs of the Trust prior to commending it for approval by the Board. Monitor its in-year progress including actions taken to address audit concerns.

2. To make recommendations concerning the annual programme of Internal Audit work to the extent that it applies to matters within the remit of the QSC and consider the major findings of quality related Internal Audit reports (including the management response).

3. To be assured that recommendations from all clinical audits are robustly implemented in practice and desired outcomes are achieved.

Research and Development

1. To ensure the Trust has an effective Research and Development Strategy in place and produces an annual Research and Development Report to the Committee.

2. To review governance arrangements for Research and Development activity within the Trust including Clinical Ethics.

Learning when Things Go Wrong

1. To review the risks allocated to the QSC from the Board Assurance Framework and receive assurance that actions are in place to effectively manage and control the risks identified.

2. To ensure there are clearly defined and well understood processes for escalating safety and quality issues and meeting the Trust's obligations in respect of Duty of Candour with patients and families.

3. To consider regular reports identifying the trends and themes arising from claims, litigation, incidents (including SIs) and complaints and the management actions being taken to reduce risks and learn lessons.

Records and Confidentiality

1. To review, on an annual basis, the Trust's systems for the Management of Medical Records.

Patient Experience

1. To review the Trust's arrangements for managing complaints and PALS contacts.

2. To ensure the Trust has an effective system for patient feedback (including Friends and Family Test, patient environment and amenities) and patient involvement.

3. To undertake a review of the findings of any national patient surveys including any relevant action plans.

General Governance

1. To consider matters referred to the QSC by the Board or by the groups which report to it.

2. To receive assurance on all aspects of patient experience and safety across the West Essex Health and Care Partnership of which the Trust is the host provider.

3. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee's terms of reference) and report this to the Board.

4. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.

5. To review any relevant Trust strategies relevant to the Committee's terms of reference (e.g. those associated with clinical quality, clinical effectiveness, health and safety, patient experience) prior to approval by the Board and monitor their implementation and progress.

6. ~~To consider the arrangements for the assessment by the Medical Director and Director of Nursing, Midwifery & Allied Health Professionals on the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme.~~ To review the PMO governance and utilisation of quality impact assessments to ensure the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme are aligned.

7. On behalf of the Performance & Finance Committee, to consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

Maternity (Perinatal) Oversight Part II:

1. To receive assurance on the clinical and safety aspects of Maternity and perinatal services, reports from the Maternity Safety Champions and the work streams and divisional actions required to respond to national, regional and local improvement priorities in relation to maternity and perinatal services. These include monitoring actions plans from the following (and any future reports and national KPIs)~~but are not limited to.~~ This list is not exhaustive.~~:~~

    - Perinatal Monitoring Tool which includes:
        - CQC action plans
        - Maternity (and Perinatal) Incentive Scheme
        - 3-year maternity for maternity and neonatal services
        - Maternity Self-Assessment Tool
        - Ockenden compliance
        - Reading the Signals: East Kent maternity services report action plan
        - Sixty Supportive Steps to Safety action plan
        - Saving Babies Lives
        - MBRRACE Reports

  - Yearly CQC Maternity Surveys
  - Core Competency Framework

- Sustainability Plan post exit from the Maternity Safety Support with oversight from QSC Part II, Trust board, the Herts and West Essex Local Maternity and Neonatal System. ~~NHSE three year single oversight plan (and other emerging learning from national and local reports)~~
- Maternity (and perinatal) transformation ~~Improvement sustainability plan~~, including:
  - Continuity of Carer Implementation
  - Maternity and perinatal Transformation
  - Learning from Maternity patient safety Incidents
  - Maternity and perinatal Dashboard
  - Maternity culture strategic plan and update
  - ~~Maternity (perinatal) Incentive Scheme~~
  - ~~Care Quality Commission inspection reports~~
  - ~~Health Education England reports~~
  - ~~National Maternity Surveys~~
- Maternity and Newborn Safety Investigations (MNSI)~~HSIB~~ learning and reports

2. Assurance will be presented to a separate session of QSC known as QSC Part II: Maternity (perinatal) Oversight.

ACCOUNTABLE TO: Trust Board.

REPORTING: A highlight report prepared by the QSC Chair supported by the Chief Nurse will be presented to the next meeting of the Board.

A highlight report from QSC Part II will be presented to the next meeting of the Board.

CHAIR: Non-Executive Director/s.

The QSC Part II meeting will be chaired by a Non-Executive Director who is not the Non-Executive Maternity Safety Champion.

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

- Chair - Non-Executive Director
- Non-Executive Director
- Non-Executive Director
- Chief Nurse
- ~~Medical Director~~ Chief Medical Officer
- Chief Operating Officer
- Chief Clinical Transformation Officer ~~Director of Quality Improvement~~
- Director of Clinical Quality Governance
- Associate Medical Director (Quality)
- Deputy Chief Nurse

The agreed QSC Part II: Maternity Oversight membership is:

- Chair - Non-Executive Director
- Chief Nurse
- Chief Operating Officer
- Chief Clinical Transformation Officer
- ~~Medical Director~~ Chief Medical Officer
- Non-Executive Director(s)
- NED & Executive Maternity and Neonatal Safety Champion
- Director of Midwifery
- Deputy Director of Midwifery
- Divisional Director (CHaWS)
- Associate Director of Operations (CHaWS)
- Clinical Director (Obstetrics)
- Director of Clinical Quality Governance
- Associate Medical Director (Quality)
- Deputy Chief Nurse
- ~~Maternity Transformation Programme Manager~~
- Maternity and Neonatal Voices Partnership Chairs (alternating between Maternity and Neonatal Chairs)
- Head of Women's Health Governance and Assurance

The Chair of the QSC and QSC Part II: Maternity (Perinatal) Oversight shall be appointed by the Chair of the Trust Board; ideally s/he shall have recent and relevant experience of NHS quality and safety.

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

The Chair and Chief Executive of the Trust shall be ex officio members and will be invited to all meetings.

One of the NED members of QSC shall also be a member of the Trust's Audit Committee.

Other members of the Executive Team or management may be called to attend the meeting if required.

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

ATTENDANCE:

Members are expected to make every effort to attend all meetings of the QSC and it is expected that they will attend nine out of eleven Committee meetings within each reporting year. Once QSCII moves to bi-monthly i.e. 6 in a year, it is expected that members will attend five out of six meetings. An attendance register shall be taken at each meeting and an annual register of attendance will be included in the QSC's annual report to the Board.

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

The Chair of the Patient Panel will be a lay member of the QSC.

In addition to the members identified above , the following will be invited to attend when there is a deep dive into a relevant division or topic discussion

- Divisional Directors

- Associate Directors of Nursing
- Associate Director of Governance & Quality
- Associate Director, Patient Engagement & Experience Team

In addition to the QSC Part II: Maternity (perinatal) Oversight members, the following will be invited to attend:

- ~~Regional Chief Midwife – NHS England, East of England~~
- ~~Maternity Improvement Advisor NHS England~~
- Office of the Regional Chief Midwife
- Regional Obstetric Lead NHS England, East of England
- Head of Children, Young People & Maternity Commissioning (West Essex) Hertfordshire and West Essex ICB
- Clinical Quality Assurance Lead SET CAMHS, Children, Young People and Maternity Services Hertfordshire and West Essex ICB
- Regional Maternity Quality Lead – NHS England, East of England
- Representation from LMNS
- ~~Maternity and Neonatal Voices Partnership Chair~~

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 QSC.

DEPUTISING ARRANGEMENTS:

In the absence of the Chair of the Committee, another Non-Executive Director appointed by the members of the Committee will chair the meeting.

Other deputies may attend on behalf of executive members but must be suitably briefed and, where possible, designated and notified in advance.

QUORUM:

The quorum for any meeting of the QSC shall be the attendance of a minimum of two members of which one shall be a Non-Executive Director and one shall be either the Chief Nurse or the Medical Director.

DECLARATION OF INTERESTS:

All members, ex-officio 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 EXECUTIVE

Chief Nurse

MEETING FREQUENCY:

Meetings of the QSC shall be held:

- Monthly, and in relation to QSC Part II, on exiting the Maternity Safety Support Programme, bi-monthly meetings will be held. Any urgent maternity oversight outwith the timeframe of the committee will be included in the monthly QSC meeting.
- Usually on the last ~~fourth~~ Friday of Board cycle
- At such other times as the Chair of the QSC shall require.

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 (though lay members will be permitted to attend).
- The Director of Corporate Governance ~~Head of Corporate Affairs~~ shall ensure there is appropriate secretarial and administrative support to the Committee.
- A draft agenda shall be developed by the Director of Corporate Governance ~~Head of Corporate Affairs~~ and Lead Executives and agreed

by the Committee Chair at least ten clear days* before the next Committee meeting.

- 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 three clear days* before the date of the meeting.
  *'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.

AUTHORITY:

The QSC 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 QSC 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 QSC.

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

TERMS OF REFERENCE:

The terms of reference of the QSC shall be reviewed at least annually and presented to the Trust Board for approval.

DATE APPROVED:

By QSC: 26 September 2025
By Trust Board:

The Princess Alexandra Hospital NHS Trust

Trust Board October 2025

4.2

Agenda item:	4.2
Presented by:	Jo Ward – Interim Chief Nurse Officer
Prepared by:	Finola Devaney - Director of Clinical Quality and Governance Shahid Sardar – Associate Director of Patient Engagement and Experience.
Date prepared:	29 August 2025
Subject / title:	CQC National Adult Inpatient Survey 2024: Update

Purpose:	Approval		Decision		Information	X	Assurance	

Key issues:	The Board were briefed in September regarding the findings of The Care Quality Commission (CQC) Adult Inpatient Survey (2024). This paper provides an update in public regarding the survey findings and details our committed approach to improving the experience of those that access our services. Of note, national benchmarking data banded our adult inpatient experience much worse than expected.
Recommendation:	To receive the information in this report for information and assurance

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

Previously considered by:	Survey results discussed QSC (July 25), Private Board (September 25) Executive Cabinet September 2025 QSC September 2025
Risk / links with the BAF:	Linked to all CQC fundamental standards
Legislation, regulatory, equality, diversity and dignity implications:	This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.
Appendices:	

1.0 Purpose:

The Princess Alexandra Hospital NHS Trust

4.2

Executive summary:

The Board were briefed in September regarding the findings of The Care Quality Commission (CQC) Adult Inpatient Survey (2024). This paper provides an update in public regarding the survey findings and details our committed approach to improving the experience of those that access our services.

Of note, national benchmarking data banded our adult inpatient experience much worse than expected.

1.0 Introduction

The survey was undertaken in November 2024 with 1250 patients invited to participate - 40% (477) completed the survey. November saw the launch of our electronic patient health record which resulted in a level of service disruption, our FFT data for November 2024 dipped significantly – however the thematic analysis of the valuable patient feedback received during the survey aligns to the patient voice heard through complaints and PALS.

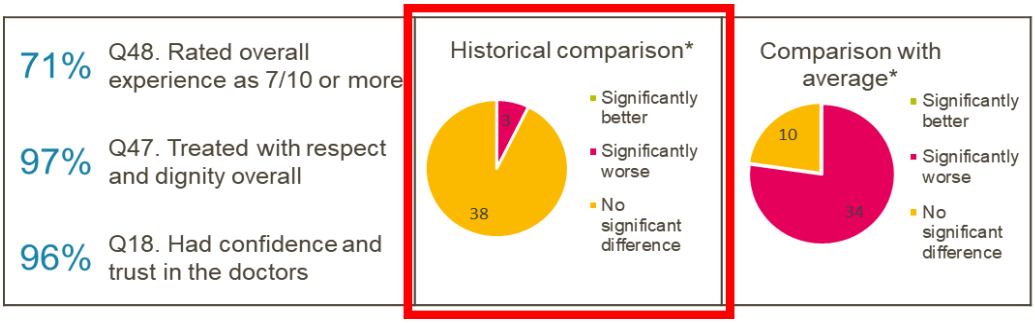
Following receipt of the survey findings, the executive team worked closely with the national team at Picker Europe, through presentations at Executive Cabinet and through ongoing consultation to support the development of a gap analysis based on the Picker Improvement Maps Model™ and based on the lowest rated scores.

This has led to the development of a detailed tactical plan, which has helped determine where to additional pace and actions. In the development of our response, we have worked hard to intersperse the broader strategic work underway that impacts on our staff and patient experience, including a cultural review, our divisional consultation, and our proactive engagement with our local community.

The oversight and delivery of our improvement plan will be through the Patient Experience Gorup and QSC. QSC will receive quarterly updates on progress and impact of our actions alongside our FFT data.

2.0 Survey results: No historical difference

Having recognised the Trust position, the data suggests no significant year on year deterioration, but persistent issues remain. This is effectively illustrated by the pie chart below which shows 38 questions where we remain the same, 3 questions which are significantly worse



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2.1 Results for 2024

The areas of most improved and most declined score as included in the tables below:

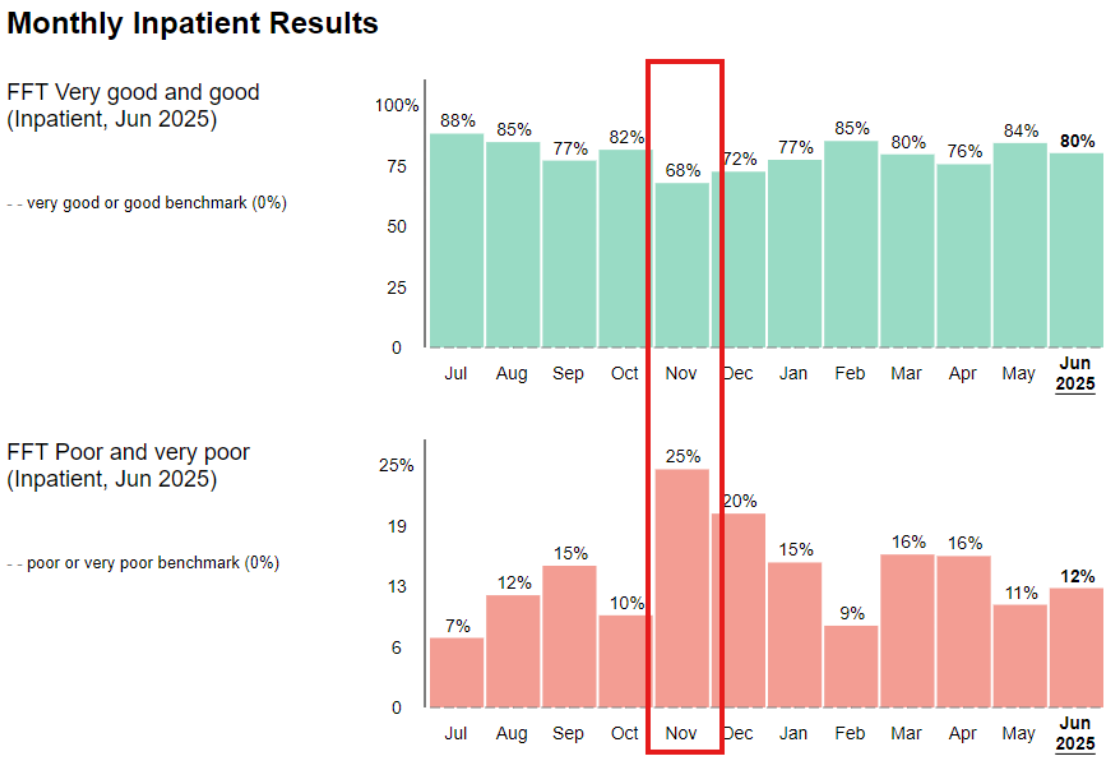
Top 5 scores vs Picker Average	Trust	Picker Avg
Q31_5. Hospital staff took into account dietary needs (Excluding respondents who answered using a smartphone)	81%	79%
Most improved scores	**Trust 2024**	**Trust 2023**
Q33. Information given about the risks and benefits of continuing treatment on a virtual ward	74%	56%
Q42. Before leaving hospital knew what would happen next with care	79%	76%
Q45. Got enough support from health or social care professionals after discharge	72%	68%
Q15. Able to get food outside of meal times	67%	64%
Q12. Got enough help from staff to wash or keep clean	85%	84%

Most declined scores	Trust 2024	Trust 2023
Q34. Enough information given about care and treatment while on a virtual ward	72%	87%
Q2. Did not mind waiting as long as did for admission	39%	53%
Q4. Quality of information given while on waiting list to be admitted was very or fairly good	64%	71%
Q24. Staff did not contradict each other about care and treatment	53%	58%
Q37. Staff discussed need for additional equipment or home adaptation after discharge	76%	81%

There is some evidence of improvement (which does not achieve statistical significance) relating to information on the risks of a virtual ward, understanding what would happen next with care, social care support after discharge, getting food outside of mealtimes and help to provide personal care.

3.0 Friends and Family test results for same time as audit undertaken:

One way of better understanding our National Inpatient Survey result is to look at what other data about patient experience tells us about November 2024, below is our friends and family test (FFT) data for one year, with the period during which the survey takes place, highlighted by a red box. This reveals that November 2024 was the worst rated month in the last 12 months, the first month of our implementation of Alex Health.



Having said that, the results from both the Adult inpatient survey, our patient complaints and our Friends and Friends Test have consistent themes about the need to improve our communication with patients. Specifically long waits for urgent care , address long waits to receive elective care, to improve how we involve communicate with patients and families before, during and after our discharge process.

4.1 Actions in response

Engagement has been ongoing with teams across the organisation to address relevant admission, ward and discharge processes since August when early results were available.

The ten specific questions we intend to target, measure and report back on are listed below.

- Q2. Patients feel that waiting times for (elective) admission are reasonable
- Q5. Urgent care patients feel there are minimal delays in getting to a bed on a ward
- Q8. Patients are not disturbed at night, enabling restful sleep
- Q14. Patients receive adequate help from staff to eat meals
- Q24. Staff provide consistent info w/o contradiction
- Q31.4 Accessibility needs are fully considered and accommodated
- Q35. Patients are involved in decisions about their discharge
- Q36. Family or carers are included in discharge discussions
- Q43. Patients are informed about who to contact if worried (after)
- Q44. Staff discuss the need for further health or social care (after)

In addition to this, a number of enabling workstreams across the organisation will be impacting on the outcomes of this survey including:

- Development of the FFT system to become primary driver for experience reporting and actions, checking and challenging for progress on these metrics;
- In your shoes workshops at speciality level across the organisation beginning in surgery;
- the development of a robust engagement framework and strategy to enable us to be a better partner to our community and citizens;

5.0 Recommendation

Trust Board are asked to

- accept the findings of the survey and assurance regarding the recommendations.
- support that we continue to coproduce this improvement plan, working with our staff and patient stakeholder groups, integrated with our programme for addressing the fundamentals of care.
- support that the action plan developed is monitored and tracked at QSC with quarterly updates on progress and impact of actions along with FFT data.

Author: Finola Devaney - Director of Quality and Clinical Governance & Assistant Chief Nurse
Shahid Sardar – Associate Director of Patient Engagement and Experience

Date: **26 September 2025**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 October 2025

4.3

Agenda item:	4.3
Presented by:	Linda Machakaire – Director of Midwifery and Gynaecology
Prepared by:	Linda Machakaire – Director of Midwifery and Gynaecology
Date prepared:	18 September 2025
Subject / title:	Overview of Patient Safety Incidents within maternity services

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

Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. The Trust has transitioned from the Patient Safety Framework to the Patient Safety Incident Response Framework (PSIRF) and therefore the service has a combination of Serious Incidents (SI's) and Patient Safety Incident Investigations (PSII's). There has been 0 new maternity PSII declared or closed since the last report for August 2025. Maternity services currently have 4 investigations ongoing. PSIIs - 2 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.26.09I25
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden Interim Report that was published in December 2020 with recommendations for maternity services. To also monitor outcomes of those in black and brown ethnicities (known to have poorer outcomes), and vulnerable groups. **Mothers and Babies: Reducing Risk through Audits and Confidential Enquires** MBRRACE Report (October 2023)
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.3

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.

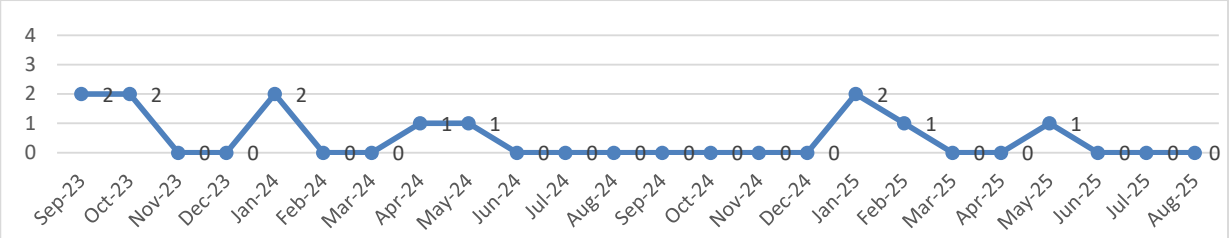
2.0 Background

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 has 4 investigations ongoing, 2 of which are being investigated by Maternity and Neonatal Safety Investigations (MNSI). Table 1 details the trend of declared Patient Safety Investigations within the last 24 months to August 2025.

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



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

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

Investigations			
Number Declared for August 2025			0
Number Submitted for August 2025			0
Number Past ICB Deadline as of August 2025 (Not including MNSI/Approved Extensions)			2
New Investigations declared in August 2025			
Ref	Ethnicity	Summary	Learning Points
No New Incidents			
Investigations closed in August 2025			
No incidents closed			

4.0 Themes

Table 3 details the top themes identified in maternity SIs within the last 24 months to August 2025.

Table 3. Top Themes

Total Number of SI's	Theme	Number
12	Neonatal Death	3
	Maternal Death (includes direct and indirect causes)	2
	Hypoxic Ischaemic Encephalopathy (HIE)	2
	Birth Trauma (e.g. Erbs Palsy, Fracture)	2
	Stillbirth	1
	Retained Swab (Never Event)	1
	Nasogastric Tube Placement (Never Event)	1
	Cardiotocography (CTG) Interpretation	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: Linda Machakaire – Director of Midwifery and Gynaecology
Date: 18 September 2025

4.4

Trust Board (Public) – 2 October 2025

Agenda item:	4.4
Presented by:	Giuseppe Labriola – Deputy Chief Nurse
Prepared by:	Charlotte Collings, Lead Nurse for Staffing and Workforce and Giuseppe Labriola – Deputy Chief Nurse
Date prepared:	17 July 2025
Subject / title:	Report on Nursing and Midwifery staff levels for June 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 multifaced with an increase of enhanced care needs The mid-year nursing and midwifery establishment review is currently following the governance processes and will be approved at board in September 2025							
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.29.09.25
Risk / links with the BAF:	BAF: 2.3 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 June 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 June 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 June 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 had an overall fill rate of <75%

3.2 Wards with > 100% average fill rate

Henry Moore Ward continues to have 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. As part of the mid-year nursing and midwifery establishment review, there are proposed changes to the workforce model which will inform the required establishment for Henry Moore ward.

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. This is reflected with Kingsmoor ward – 125.0%, and Saunders ward – 119.3% particularly this month.

Greater than 100% fill rate for Registered Nurse (RN) 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 mitigate vacant shifts. A proportion of agency shifts have been required for registered mental health nursing and registered midwives. 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
98.0%	102.7%	100.9%	124.4%	99.3%	112.6%	103.6%

Table 2. Inpatient fill rate including Maternity Wards Trend

4.0 Care Hours Per Patient Day (CHPPD)

CHPPD allows comparison and benchmarking 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.

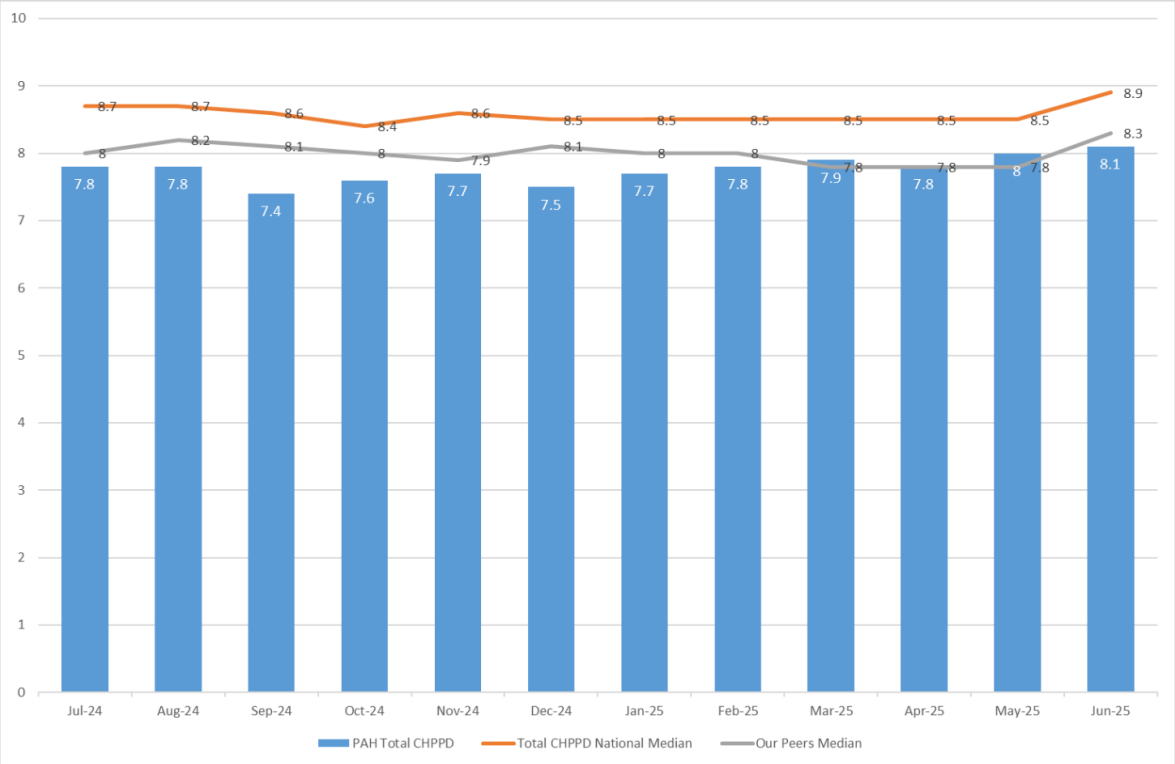
Table 3. Overall Care Hours Per Patient Day (CHPPD) June 2025

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.2	2.9	8.1

The Model Hospital data for June 2025 shows the Trust with a CHPPD of 7.9 against the national median of 8.9**.** 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 June 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 for support workers is due to enhanced care needs.

7.0 Recommendation

The board are 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 June 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	91.3%	100.1%	100.0%	111.6%	94.9%	105.6%	98.7%
Henry Moore	133.4%	148.7%	180.3%	148.3%	152.2%	148.5%	150.6%
ITU & HDU	89.6%	81.5%	94.5%	118.5%	92.0%	99.2%	92.7%
John Snow	101.3%	70.7%	100.0%	50.6%	100.7%	61.1%	87.5%
Penn	101.6%	119.2%	100.0%	166.4%	100.9%	137.1%	113.9%
Saunders	102.3%	114.9%	128.2%	158.1%	112.0%	131.3%	119.3%
Surgery Total	***98.0%***	***102.7%***	***100.9%***	***124.4%***	***103.5%***	***121.8%***	***108.8%***
Fleming	92.8%	92.2%	99.2%	109.1%	95.5%	100.3%	97.0%
Harold	95.3%	90.5%	100.0%	111.0%	97.4%	100.3%	98.3%
Kingsmoor	110.3%	122.7%	131.0%	151.4%	118.1%	136.4%	125.0%
Lister	99.2%	124.7%	100.8%	153.6%	99.9%	138.6%	115.3%
Locke	96.6%	105.6%	100.0%	136.9%	98.0%	120.6%	107.0%
Nightingale	100.3%	85.1%	98.3%	100.0%	99.3%	92.2%	95.8%
Opal	114.7%	110.6%	70.2%	103.3%	93.4%	107.1%	98.9%
Ray	103.2%	98.7%	105.8%	151.8%	104.3%	118.8%	109.5%
Tye Green	90.4%	100.4%	97.4%	128.3%	93.5%	111.8%	100.6%
Winter	98.2%	105.2%	98.9%	129.3%	98.5%	116.7%	105.8%
Medicine Total	***98.0%***	***102.7%***	***100.9%***	***124.4%***	***100.0%***	***115.8%***	***105.9%***
AAU	92.1%	132.9%	97.6%	146.6%	94.6%	139.5%	104.0%
Charnley	94.6%	141.7%	101.3%	167.4%	97.8%	154.0%	113.9%
UEC Total	***98.0%***	***102.7%***	***100.9%***	***124.4%***	***95.9%***	***146.7%***	***108.2%***
Birthing	92.2%	89.3%	88.8%	96.7%	90.5%	92.8%	91.3%
Chamberlen	99.0%	84.6%	95.5%	90.0%	97.3%	87.2%	94.8%
Dolphin	95.7%	66.0%	101.5%	100.0%	98.3%	77.3%	93.0%
Labour	92.4%	87.3%	90.9%	95.9%	91.7%	91.4%	91.6%
Neo-Natal Unit	99.7%	46.7%	93.3%	93.3%	96.5%	70.0%	92.1%
Samson	100.9%	73.2%	94.3%	81.2%	97.7%	77.0%	85.9%
CHAWS Total	***98.0%***	***102.7%***	***100.9%***	***124.4%***	***95.2%***	***81.6%***	***91.1%***

Total	***98.0%***	***102.7%***	***100.9%***	***124.4%***	***99.3%***	***112.6%***	***103.6%***

John Snow Ward – The HCSW shifts are often under template by 1 WTE, this is due to fluctuating capacity throughout the month in addition to the HCSW being re-deployed to other areas through the daily safe staffing meetings.

Critical Care – Have recently had 2 WTE HCSW join their team and have seen an improvement of fill rate for unregistered staff as a result. There are current recruitment plans for band 6 nurses with interviews scheduled in August. The division is currently reviewing the establishment in support of the Level 1 unit in Henry Moore Ward and anticipate moving 15.8 WTE to achieve this.

OPAL Unit – Have been trialling a new shift pattern which isn't currently reflected in their template, this accounts for the over fill for RN's on a day shift, and under fill for the Night shift.

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. Birthrate Plus have been commissioned to review the workforce and the workforce intentions will be available within the full year nursing and midwifery establishment review starting in September 2025.

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

Paediatrics – Shows a low overall fill rate for HCSW's and higher than template for RN's in ED. Following discussions with the divisional team and reviewing SNCT data, it has been identified that creating a middle shift should mitigate some of these figures as the key driver is improving the workforce efficiency, this is being worked on by their Head of Nursing. Recently, new HCSW were appointed for both Dolphin and ED and this should be reflected on future data collections.

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.

Appendix 1a: ED data and narrative: fill rates June 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
98.7%	91.7%	110.7%	111.4%	104.1%	100.5%	103.0%

Appendix 1b: Paediatric ED data and narrative: fill rates June 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
126.1%	62.0%	139.9%	98.0%	132.3%	80.0%	116.2%

Appendix 2: Ward level data: CHPPD June 2025

Care Hours Per Patient Day (CHPPD)			
Ward	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total	**5.2**	**2.9**	**8.1**
Harvey Ward	3.9	2.5	6.4
Henry Moore Ward	4.7	3.5	8.2
ITU & HDU	18.1	2.0	20.0
John Snow Ward	5.8	1.7	7.5
Penn Ward	3.9	3.0	6.9
Saunders Unit	4.1	2.9	7.1
Surgery Total	**5.7**	**2.8**	**8.5**
Fleming Ward	3.8	1.8	5.6
Harold Ward	4.8	2.3	7.1
Kingsmoor General	4.3	3.0	7.3
Lister Ward	3.8	3.5	7.2
Locke Ward	3.7	3.0	6.7
Nightingale Ward	2.8	2.6	5.4
Opal Unit	5.7	4.4	10.1
Ray Ward	4.0	2.5	6.5
Tye Green Ward	4.1	3.1	7.2
Winter Ward	3.7	2.9	6.5
Medicine Total	**4.0**	**2.8**	**6.9**
AAU	6.8	2.7	9.5
Charnley Ward	4.8	3.0	7.8
UEC Total	**5.8**	**2.8**	**8.6**
Birthing Unit	15.2	7.8	23.0
Chamberlen Ward	8.0	2.4	10.4
Dolphin Ward	11.0	2.9	13.9
Labour Ward	25.0	7.1	32.1
Neo-Natal Unit	10.4	1.5	11.9
Samson Ward	3.0	3.2	6.2
CHAWS Total	**9.0**	**3.3**	**12.3**

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 10 occasions in June 2025 to 72. The majority of these shortfalls continue to be in Maternity, which had 31. 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 June 2025

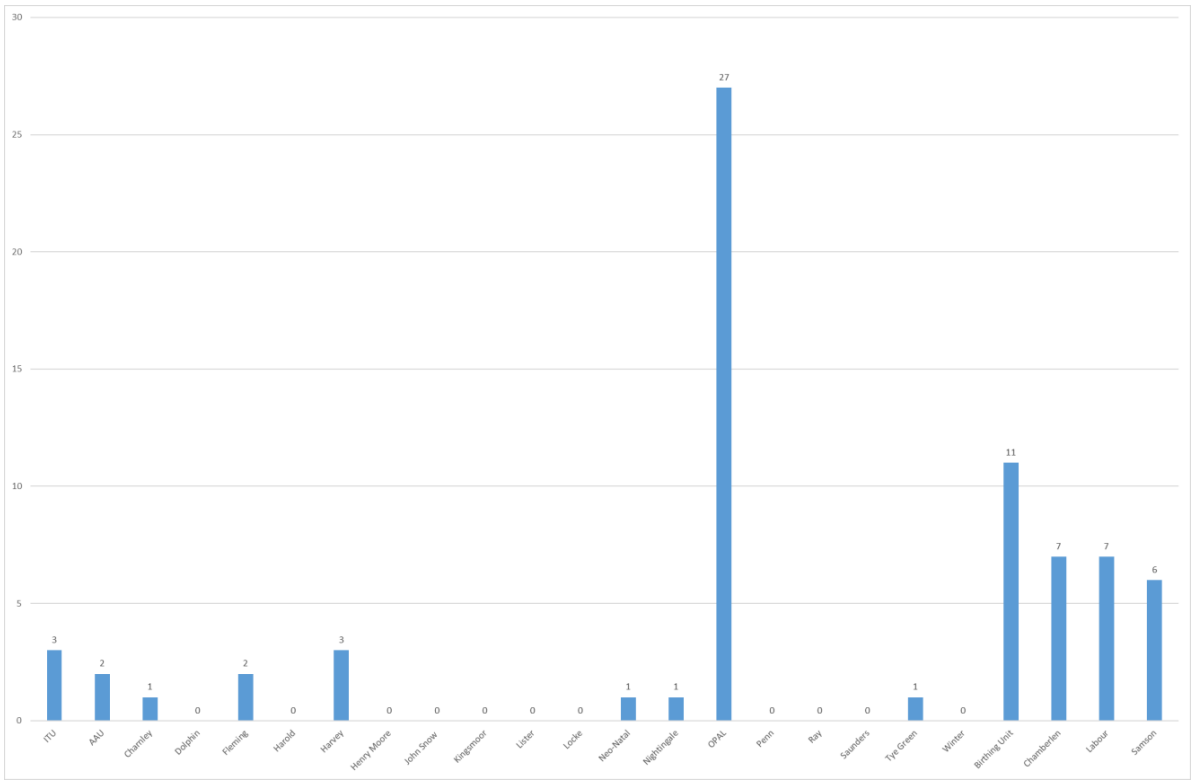
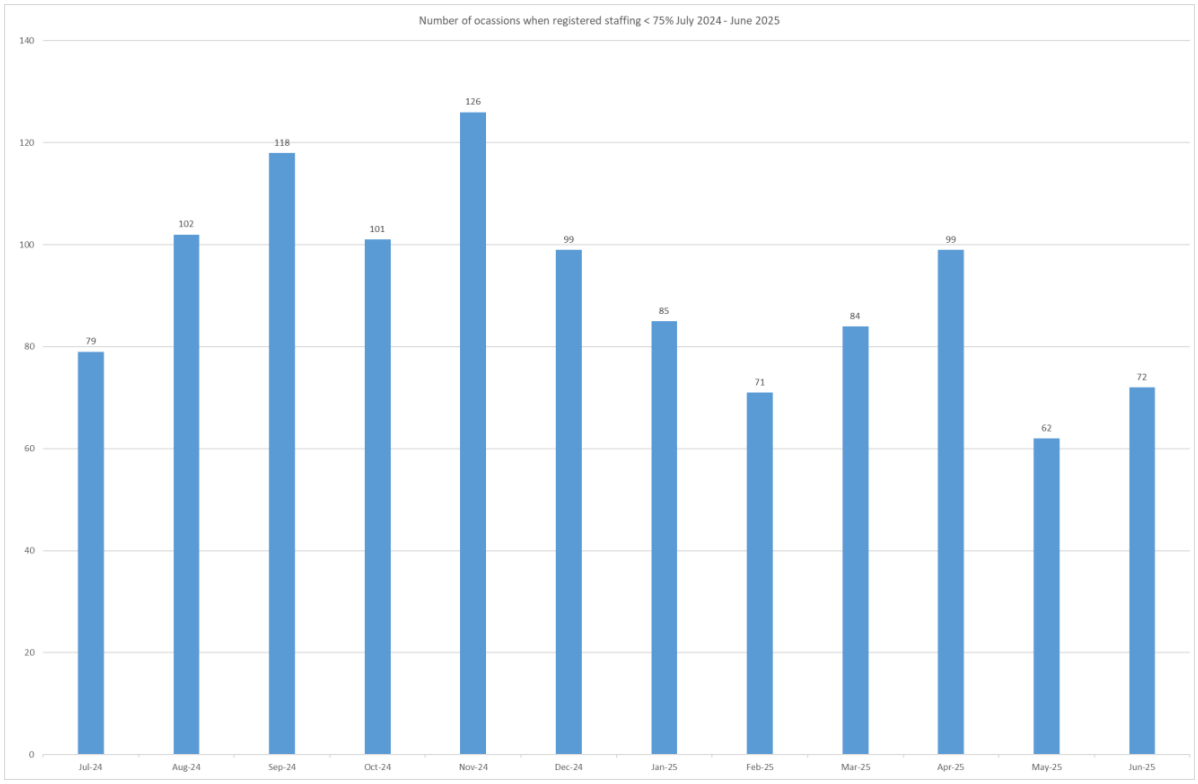


Table 2. Occasions when registered staffing fell below 75% of standard template Trend Data July 2024 – June 2025



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 in Spring 2025. Table 3a shows the Red Flags reduced through SafeCare in June 2025. Table 3b shows the number of Red Flags raised for adult inpatient wards has decreased with 42 raised in May against 22 for June.

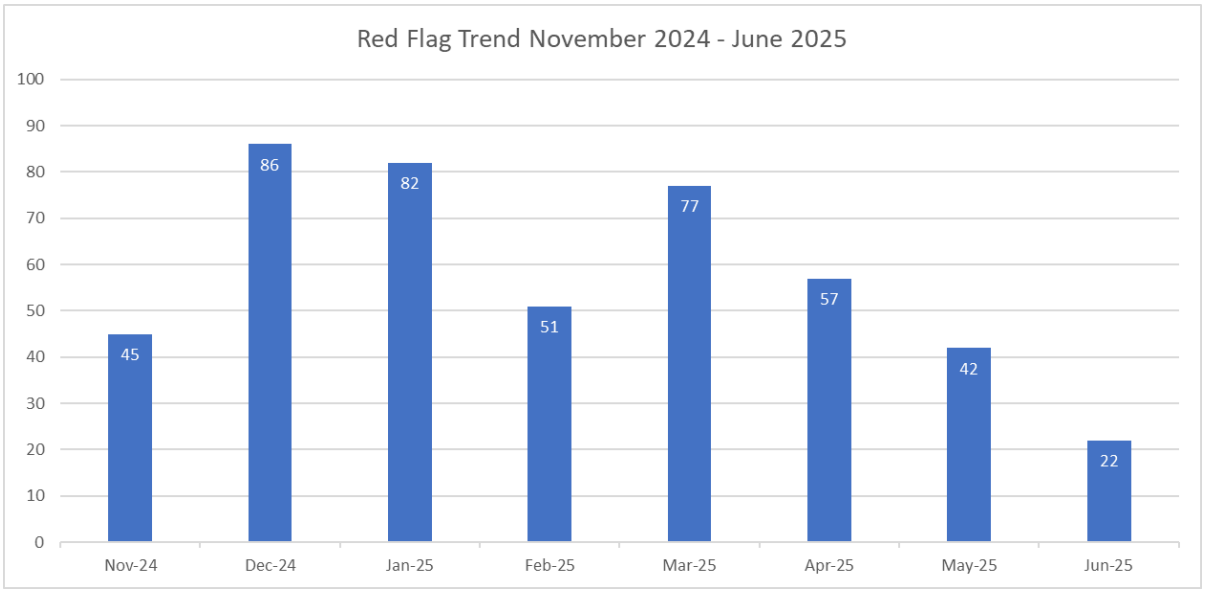
To improve oversight into how many incidents relating to when Enhanced Care could not be provided, the Trust has also added a local Red Flag highlighting when this occurs in SafeCare. This and the addition of Enhanced Care Level 3 Patient task will also enable the Trust to provide data to the Enhanced 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 June 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	Change
Nov-24	1		3	22	12		7	45	
Dec-24	4	3	7	37	33	1	1	86	41
Jan-25			6	24	52			82	-4
Feb-25		2	11	10	27		1	51	-31
Mar-25			4	14	59			77	26
Apr-25	0	1	3	6	47	0	0	57	-20
May-25			1	5	36			42	-15
Jun-25				3	19			22	-20

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 June 2025 with Lister redeploying the highest number of substantive staff with John Snow being the next highest. The highest net receiver of staff was A&E followed by Locke and Charnley. Table 5 demonstrates the number of substantive staff redeployments per month trend

Table 4. Hours of substantive staff redeployed June 2025

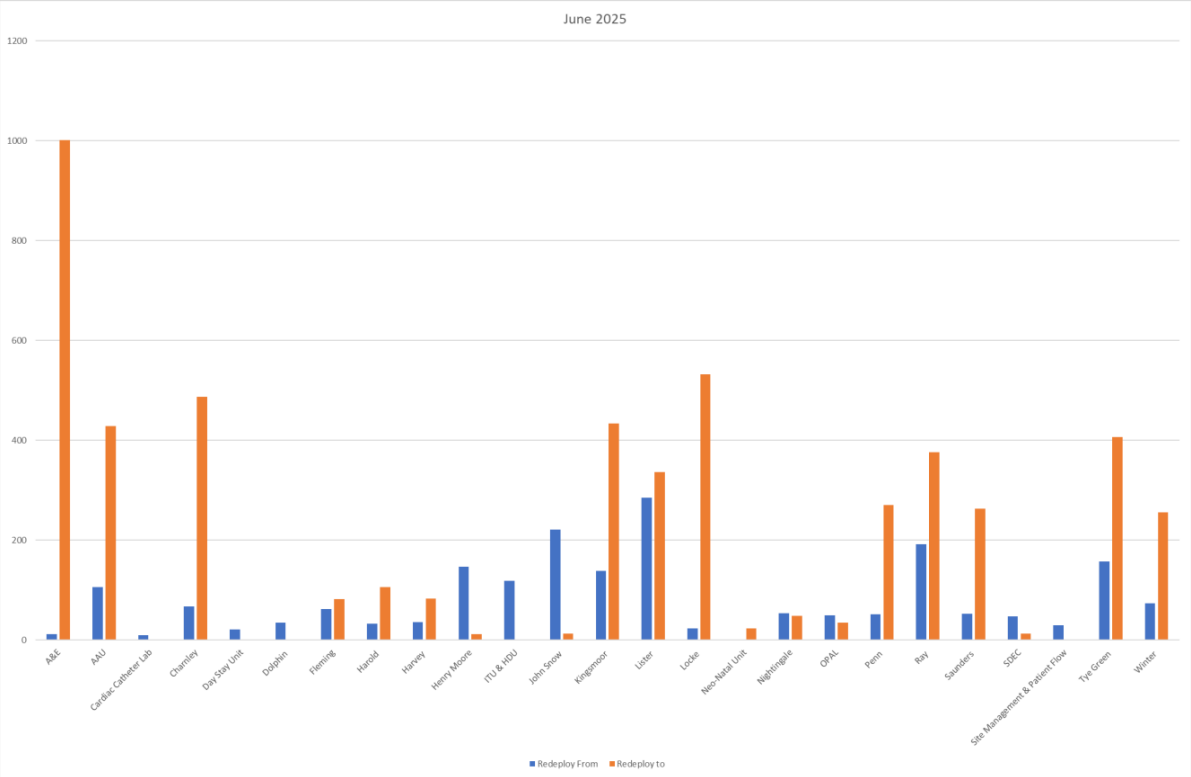


Table 5. Substantive staff redeployment trend

This reports looks at the number of shifts substantive staff working are redeployed, 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
1892	137229	1.37%

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)
2020	137299	1.47%

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

Appendix 4: Nursing quality indicators

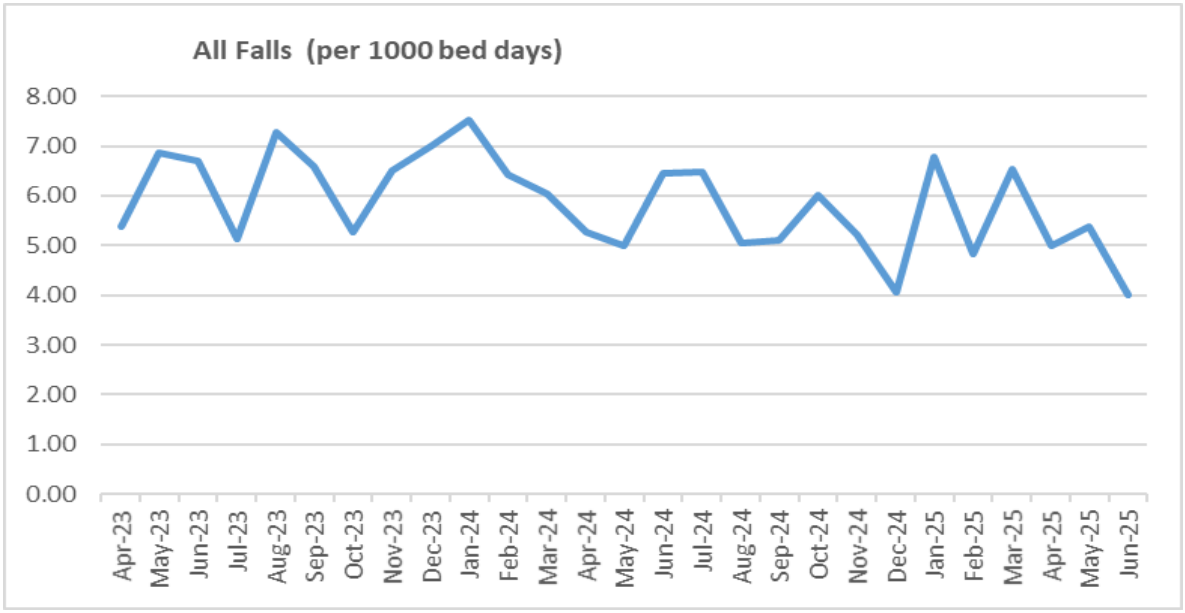
Table 1. Number of falls, unwitnessed falls and falls with harm in June 2025, with the top 3 wards being highlighted

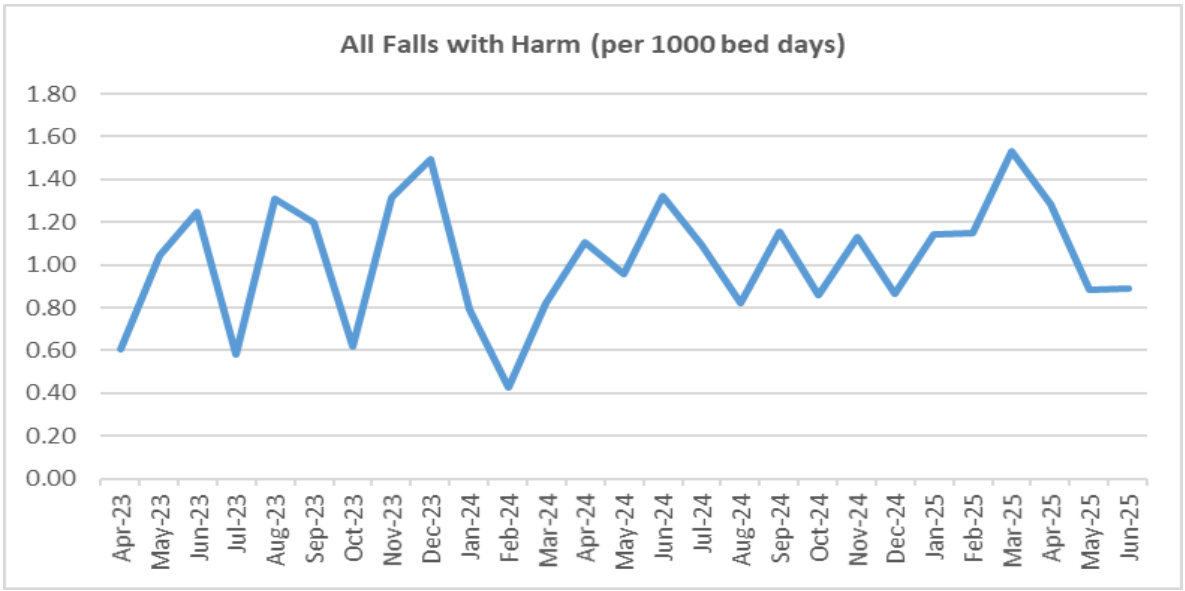
	Total falls in month	Top 3 wards		
Total falls	68	AAU and Kingsmoor - 6	Harold, Lister, OPAL - 5	
Unwitnessed falls	41	Kingsmoor - 5	Harold - 4	AAU, ED. OPAL, Winter - 3
Falls with harm *	10	ED - 2	OPAL - 2	Tye Green - 2

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

The Trust falls reduction strategy and workplan (2024/2025) remains in place and mandatory falls training has increased to 97%.

Falls Rate per 1000 bed days



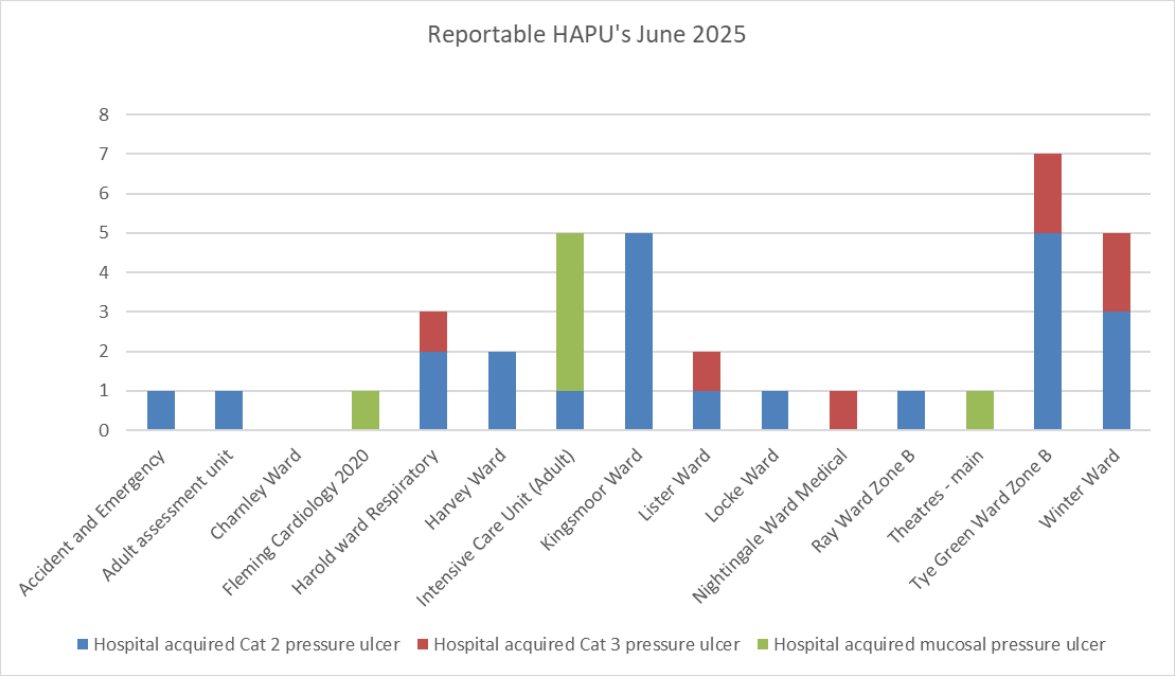


Pressure Ulcers

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

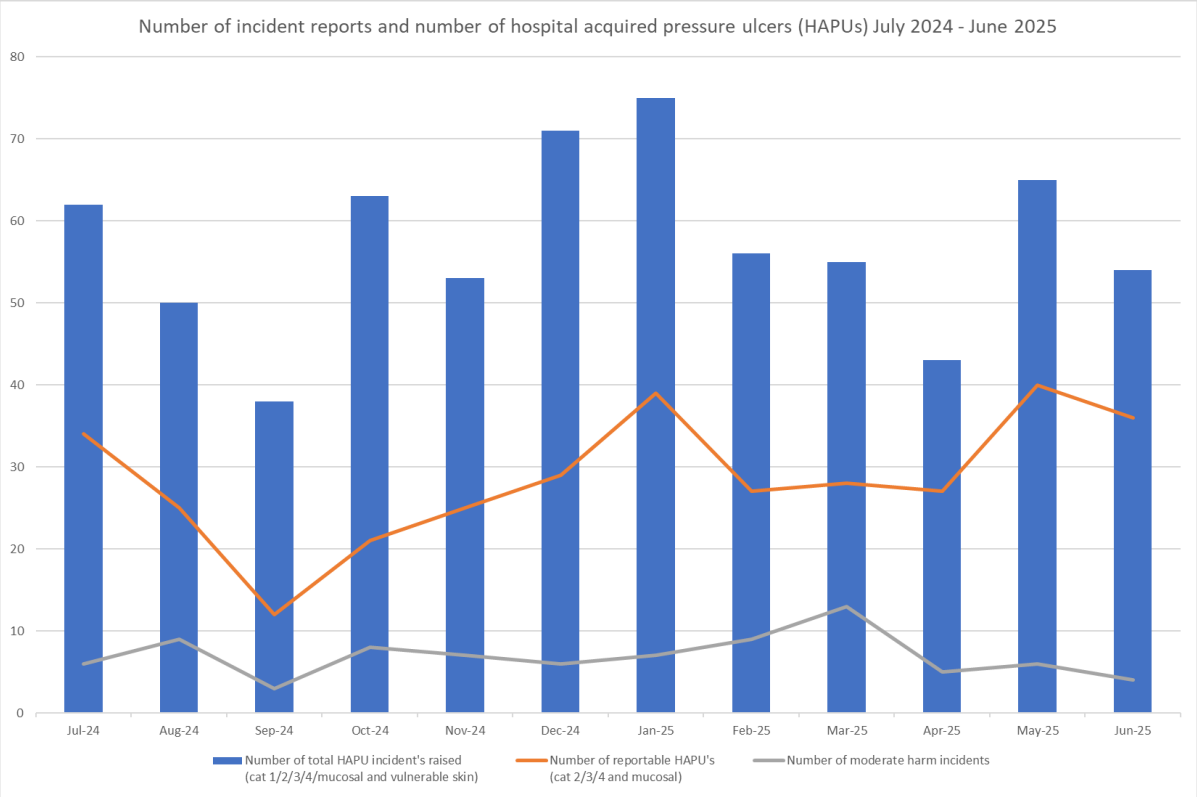
June showed a decrease in reportable HAPUs (36) compared to last month (40), there were 7 category 3 HAPU's, a decrease of 4 and 23 category 2, a decrease of 3 from May's data.

"Pressure Ulcer Prevention Wednesdays" commenced in May and will continue. The focus for a remains prevention of catheter related pressure ulcers with 185 staff members receiving this training.



Total in month	Top 3 wards		
36	Tye Green - 7	Kingsmoor - 5	ITU/HDU - 5

Table 2b. Reported Incidents and Actual Hospital Acquired Pressure Ulcers June 2025



Hospital acquired pressure ulcer data taken from different sources can be inconsistent and not comparable. Due to these variables a more unified approach to data capture and data reporting is underway and therefore the rate per 1000 occupied bed days is currently not being completed. As a consequence the footfall is not reflected in the graph.

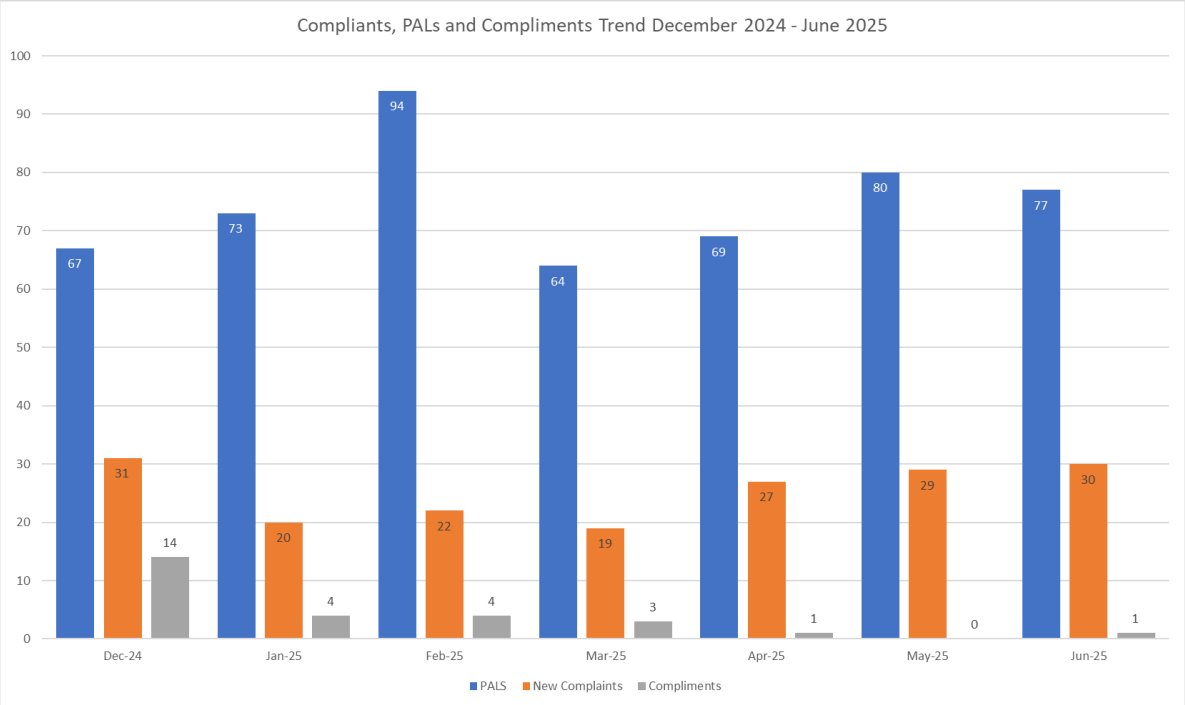
The above chart captures:

- The number of incident forms completed per month relating to total number of skin changes (category 1,2,3,4, mucosal and vulnerable skin/deep tissue injury)
- The actual number of reportable pressure ulcers per month
- The number of moderate harm incidents validated.

The number of reportable HAPU's has reduced again this month, as have the number of validated moderate harm incidents.

It is important to note that the number of incidents reported does not equal the number of HAPUs. Multiple incidents reported in the year will have included more than one HAPU per incident due to the patient's skin being vulnerable.

Complaints, PALS and Compliments Trend Data December 2024 – June 2025



Complaints, PALS and Compliments

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

	Total in month	Top Departments		
New complaints	77	A&E – 7	Paediatric A&E – 6	
PALs	30	A&E – 16	Lister – 6	Locke – 6
Compliments	1	Neo-Natal Unit		

Unfortunately, compliments received in June 2025 have not been logged on Datix this month

The 3 main PALS themes for May were:

- Delay – 34.3%
- Communication – 25.09%
- Cancellations – 10.42%

Complaints themes for May were:

- Medical care – 25%
- Communication – 21.88%
- Delay – 11.46%

The team have advised due to pressures, they prioritise processing complaints and this can cause compliments to be tracked 1 month behind.

The Princess Alexandra Hospital NHS Trust

Trust Board – 2nd October 2025

4.5

Agenda item:	4.5
Presented by:	Andrew Kelso | Chief Medical Officer
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Andrew Kelso | Chief Medical Officer
Date prepared:	22nd September 2025
Subject / title:	Learning from Deaths and Mortality Paper

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

Key issues:	Mortality indices are deteriorating Increased number of SMR mortality outliers Likely due to data quality as a consequence of changes with the Alex Health EHR
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.

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

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

The Princess Alexandra Hospital NHS Trust

4.5

1.0 Purpose

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

2.0 Background

PAHT has a learning from death process that meets the national requirements. The Strategic Learning from Deaths Group (SLfDG) was held on 19th August 2025. The risks associated with this are captured on the learning from death risk register.

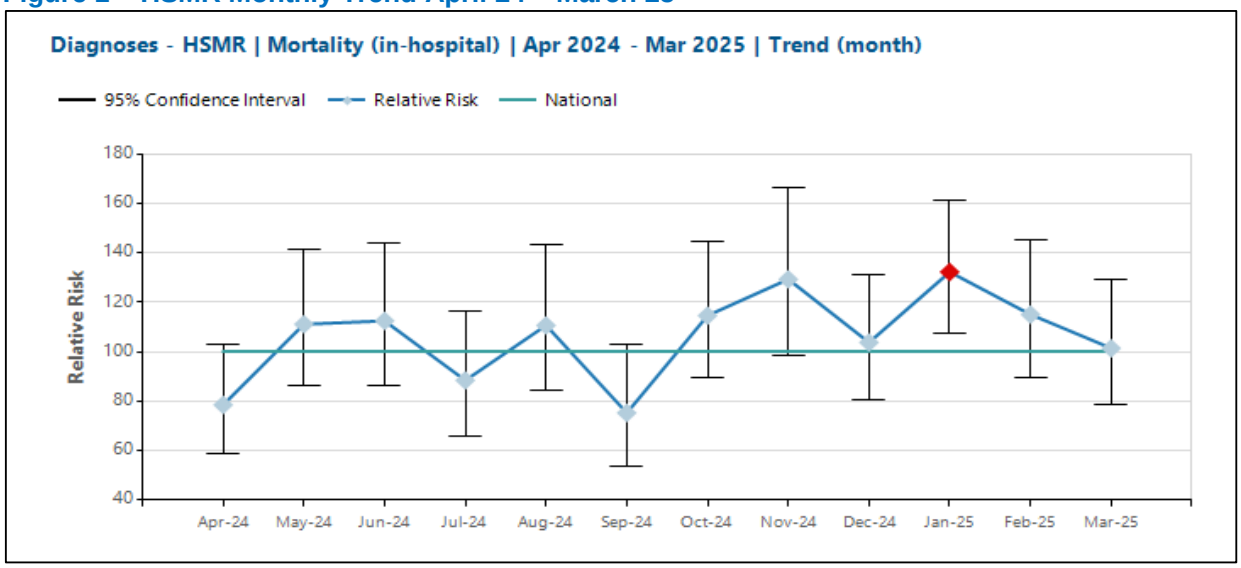
3.0 Current Telstra update on mortality indices for Princess Alexandra Hospital

Telstra provide an in-hospital mortality report for all inpatient admissions. This report covers the 12-month time period April 24 – March 25.

3.1 Analysis

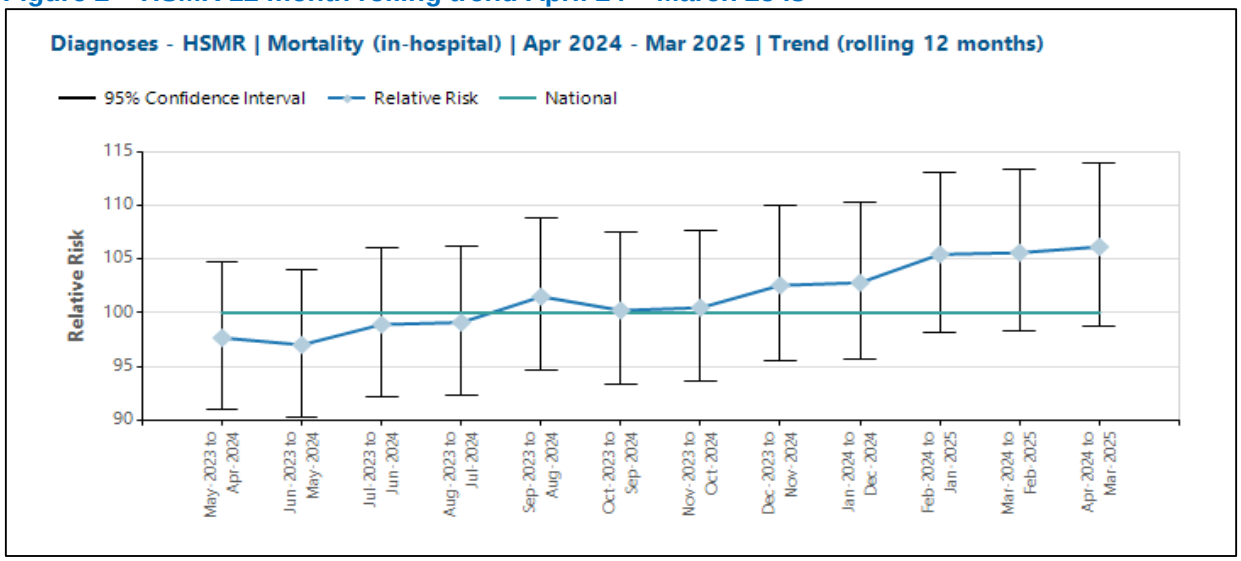
Hospital standardised mortality ratio (HSMR) overview

Figure 1 – HSMR Monthly Trend April 24 – March 25



HSMR+ for Mar-25 is 101.36 and "within expected", based on 1599 superspells and 65 deaths (crude rate 4.07%).

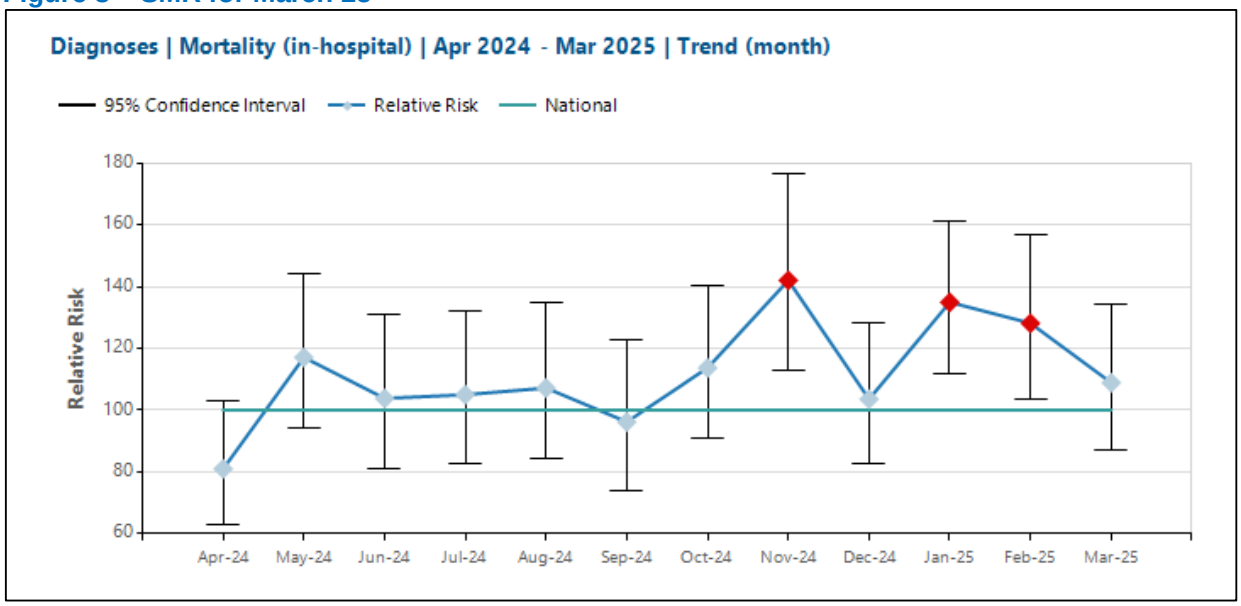
Figure 2 – HSMR 12 month rolling trend April 24 – March 25 is



HSMR+ for the period April-24 to March-25 is 106.14 (within expected)

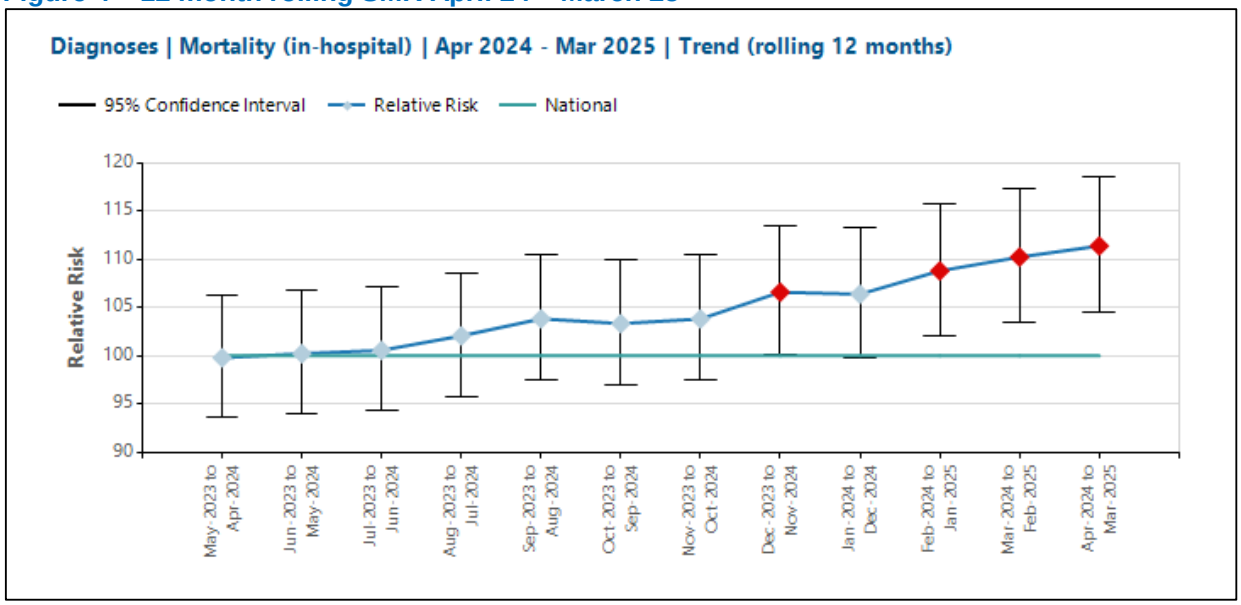
Standardised Mortality Ratio (SMR) overview

Figure 3 – SMR for March 25



SMR for March 25 is 108.8 'within expected' based on 5794 superspells and 86 deaths (crude rate 1.5%).

Figure 4 – 12 month rolling SMR April 24 – March 25



SMR for the period Apr-24 to Mar-25 (FY24/25) is 111.39 and "higher-than-expected", based on 66,944 superspells and 985 deaths (crude rate 1.47%).

3.2 Relative Risk and CUSUM Alerts Apr 2024 - Mar 2025

There are four CUSUM alerts flagging for the month of Mar-24; and across these there are 8 deaths, all of which have multiple episodes of care:

- fluid and electrolyte disorders
- Other circulatory disease
- Other endocrine disorders
- Other psychoses

These will undergo a clinical coding review.

3.3 Summary

HSMR+ for the period Apr-24 to Mar-25 (FY24/25) is 106.14 and "within expected", based on 19,967 superspells and 764 deaths (crude rate 3.83%).

SMR for the period Apr-24 to Mar-25 (FY24/25) is 111.39 and "higher-than-expected", based on 66,944 superspells and 985 deaths (crude rate 1.47%).

SHMI for the period Mar-24 to Feb-25 reports as 109.88 and "within expected".

As reported previously, the Trust have seen a noted rise in the number of episodes per spell since going live with EPR in Nov-24. This appears to be having a knock-on effect on understanding the Trust's deteriorating model outcomes. For instance, there has been a rise in the percentage of patients admitting with a non-HSMR+ primary diagnosis group (i.e. "low-risk") and dying with a HSMR+ group (i.e. "high-risk"). This is a result of imprecise terminology in the medical record on admission, rather than a change in clinical condition of the patient.

Subsequently, the Trust are reporting an increase of lower-risk activity. From a HSMR+ perspective, this plays out whereby there ultimately are fewer patients surviving with a HSMR+ diagnosis, resulting in fewer expected deaths while observed deaths is less impacted. Therefore, the HSMR+ is deteriorating.

From an SMR perspective, it can be determined that there is an increase in patient deaths with a "lower-risk" primary diagnosis and hence, more observed mortality and less expected mortality. This results in a deteriorating SMR.

With regards to SHMI, this is not as straightforward to investigate as the SHMI only is presented from a rolling-12-month perspective; and there is a minor methodological difference with how the primary diagnosis is assigned; but it can also be seen that SHMI is deteriorating post-October 2024.

For Mar-25 there are four CUSUM alerts; three among new diagnosis groups to alert ('fluid and electrolyte disorders'; 'other circulatory disease' and; 'other endocrine disorders'); and one among an existing alerting group ('other psychoses'). Across all of these alerts, there are a total of 8 patient deaths, all of which have multiple episodes of care in their final spells in-hospital. Following clinical review, it is likely that these alerts have occurred as a result of a change in how the data is now structured following the implementation of Alexhealth. All CUSUM alerts will undergo a clinical coding review.

3.4 Conclusion

There are a number of issues in relation to mortality data, which are all likely to be data quality associated with the way episodes of care are now recorded by Alexhealth. These issues are being addressed by a dedicated working group.

4.0 Mortality Programme Updates

4.1 Mortality Narrative

- There were 77 deaths in July 2025.
- 10 cases referred for SJRs

4.2 Deaths Investigated Under the Patient Safety Incident Response Framework

- 1 death is currently under investigation

4.3 Cases awaiting the second review panel

- There is 1 death currently awaiting the second review panel, of which the divisions investigation found to be no harm

4.4 Themes and Issues Identified from Reviews and Investigation

- Missed opportunity to involve SPCT
- End of Life care, however still being actively treated
- Good initial assessment, investigation and treatment
- Prompt referral to appropriate specialist
- Good involvement of next of family
- Appropriate switch from active treatment to End of life care
- Lack of SPCT involvement
- MDT approach to care
- Good documentation and nursing care
- Family involved in decision making
- Timely referral and review from specialist clinical teams
- Ineffective pain management

4.5 Actions Taken in Response to Avoidable Deaths

- Nil required until investigations referred to above are complete

5.0 Medical Examiner (ME) Headlines

5.1 Scrutiny Update

- 100% were scrutinised by 7 Medical Examiners.
- 18 cases were referred to the Coroner.

<u>MCCDs issued within 72 hours (National Target)</u>

- 89.3% of MCCDs being issued within 72 hours in July 2025.

6.0 Ongoing Work

- The Alexhealth team has established a working group to identify and resolve the issues with increased episodes of care. The SLfDG collectively agreed that a risk assessment in relation to these issues would be drafted and presented at the September 2025 meeting.
- SMART training continues to be provided for new junior doctors across many specialities.
- MCCD improvement project has commenced with the MEO team and Quality First.
- Themes from learning from deaths now captured via a new artificial intelligence (AI) section on SMART.
- The Learning from Deaths Policy has been revised and approved at the August 2025 SLfDG.

7.0 Risks

There are no changes to the risk register.

8.0 Recommendation

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

9. Appendices

Appendix A - Mortality Data Explained

Telstra Health UK is a healthcare intelligence company that provides the Hospital Standardised Mortality Ratio (HSMR) and a newer model called HSMR+ to analyse mortality data in hospitals. These tools help hospitals benchmark their performance against national averages and identify areas for improvement in patient care.
Benchmarking includes comparing hospitals performance against regional and national averages to other hospitals.
Telstra will identify areas for improvement in patient care and safety and can make informed decisions about resource allocation and service delivery; and by doing so, they assist hospitals to be accountable and committed to improving patient outcomes.

SMR: Standardised Mortality Ratio
SMR is a health measure that compares the actual number of deaths in a specific population (e.g., a hospital or group with a specific condition) to the number of deaths expected in a reference population with the same demographic characteristics. It is calculated as the ratio of observed deaths to expected deaths, multiplied by 100, to show whether a population has a higher or lower mortality rate than a standard population.
It helps to evaluate the clinical performance of a hospital or health service by showing if the number of deaths is higher or lower than expected given the patient population.
SMRs are used to compare disease risks and mortality in specific cohorts, such as patients with a chronic disease or a particular occupational exposure, to the risks in the general population.

HSMR: Hospital Standardised Mortality Ratio HSMR
HSMR is a specific measure used to assess the mortality of patients within a particular hospital or trust, according to NHS. It provides an indication of how performance for the current incomplete year compares to the national average.
It calculates the ratio of observed deaths to expected deaths, but it specifically focuses on hospital admissions. This is estimated for each of the 41 diagnoses by dividing the trust's SMR (using the existing benchmark) by the national SMR and multiplying by 100.
The primary focus is to assess the performance of individual hospitals or trusts in terms of mortality.
There are limitations with this model due to being unable to fully reflect the complexity of patient cases and not including every diagnosis group.

SHMI: Summary Hospital-level Mortality Indicator
SHMI is a more refined measure developed by the NHS to address the limitations of HSMR.
This mortality indicator also calculates the ratio of observed to expected deaths, but it incorporates a wider range of factors, including patient characteristics and the type of admission (emergency or elective).

It provides a more nuanced picture of hospital mortality, considering factors that may influence patient outcomes.
Key Differences of this measure includes deaths occurring up to 30 days after hospital discharge, whereas HSMR focuses on in-hospital deaths. It does not make an adjustment for palliative care but considers more variables, including co-morbidities and the emergency/elective split of admissions.

CUSUM: A cumulative sum
A CUSUM is a type of control chart used to monitor small shifts in the process mean. It uses the cumulative sum of deviations from a target. The CUSUM chart plots the cumulative sum of deviations from the target for individual measurements or subgroup means.
A cumulative sum statistical process control chart plots patients' actual outcome against their expected outcomes sequentially over time.
The charts help identify patterns and deviations from expected mortality, allowing for timely interventions to improve patient outcomes.
The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered.

BOARD OF DIRECTORS: Trust Board - Public 02 October 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: 29 September 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Annual Medical Revalidation Report	Yes	No	No	The Committee recommended the report to Board for approval, with a further review in six months agreed. The report is on the Board agenda.
2.2 GMC Survey	Yes	Yes	No	The response rate of 72% for the GMC survey was noted, with overall improvement in the Trust's results. Areas for improvement include clinical supervision and team work. Targeted support is in place for medicine, emergency medicine, anaesthetics, and paediatrics.
2.3 Improving Resident Doctors Lives	Yes	Yes	No	Following the receipt of a letter from NHS England a gap analysis against NHS England's 10-point plan had been completed; focusing on unique challenges for resident doctors, such as frequent rotations and regional travel. Key improvement areas include workplace well-being (parking, catering), timely rota/leave notifications, and reducing payroll errors, with some progress already made. The Committee endorsed the governance around the improvement plan and agreed to review progress in six months and took assurance that efforts are ongoing.
2.4 People Report	Yes	Yes	No	Highlights included; progress in inclusive recruitment, a new applicant tracking system, and efforts to reduce bank usage and improve rostering.
2.5 Organisational Change Updates:	Yes	Yes	No	The MARS process had concluded with 35 applications accepted, 29 leavers, and a small net cost (£177.4k) this

BOARD OF DIRECTORS: Trust Board - Public 02 October 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: 29 September 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
• MARS Outcomes • Consultation				financial year. The consultation on restructuring the clinical divisions has completed and the final structure will be confirmed mid-October. The Committee took assurance from these updates
2.6 Leadership and Development Programme & Cultural Baseline Proposal	Yes	Yes	No	The OD proposal for leadership and cultural development was discussed. Concerns were noted regarding the lack of visible EDI and lived experience among the consultants. The Committee was re-assured that internal diverse teams would be involved and EDI would be prioritised.
2.7 Staff Survey	Yes	Yes	No	The plan for to increase response rates to at least 60%, with new engagement strategies such as walkarounds, videos from leadership, and visible promotion (e.g. T-shirts) was discussed.
2.8 Learning and OD Update	Yes	Yes	No	The Trust had been recognised as an exemplar by NHS England for its CPD (Continuing Professional Development) spending and processes, following a recent review. Appraisal rates remain a concern, especially in Surgery and CHaWS, with ongoing support offered to these areas. The Committee agreed that while overall performance is strong, a detailed action plan is needed to address appraisal compliance in underperforming areas.
2.9 EDI Annual Report	Yes	Yes	No	The EDI Annual Report 2024 -2025 provides assurance that the Trust is meeting its statutory duties under the Equality Act 2010. The report outlines the progress made towards delivering the Trust's annual equality objectives.

BOARD OF DIRECTORS: Trust Board - Public 02 October 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: 29 September 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				The Committee recommended the report to Board for approval. The report is on the Board agenda.
2.10 Workforce Quality Standards Report (WRES)	Yes	Yes	No	The improvements in BME staff recruitment (now at 46%) and more proportionate disciplinary processes for BME staff were highlighted. There is underrepresentation of BME staff at senior bands (8C to VSM) and in clinical bands 5–6, with ongoing work to understand and address these gaps. Bullying and harassment rates for both white staff and BME are above the national average, and BME staff report higher discrimination; actions are planned to address these issues. The Committee discussed the impact of international recruitment on senior band diversity and the need for focused succession planning and further action on discrimination. A progress report will be provided in 6 months. The Committee recommended the report to Board for approval. The report is on the Board agenda.
2.11 Workforce Quality Standards Report (WDES)	Yes	Yes	No	The Committee noted the low disability declaration rates, higher bullying/harassment for disabled staff, and fewer reasonable adjustments than the national average. Actions include focusing on improving reasonable adjustments, policy review, and disability awareness training. The Committee agreed to receive an update on the planned actions in six months. The Committee recommended the report to Board for approval. The report is on the Board agenda.

BOARD OF DIRECTORS: Trust Board - Public 02 October 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: 29 September 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.12 Safer Nurse Staffing Report	Yes	No	No	There has been a sustained Registered Nurse fill rate of > 95%. No wards in month achieved < 75% overall fill rate. The increase in overall fill rates is multifaceted with a combination of enhanced care needs and supernumerary time driving this. The Birthrate Plus review for maternity is in progress. The report is on the Board agenda.
2.13 Staff Health & Wellbeing • Annual Report • Strategy - Update on Progress	Yes	Yes	No	The report detailed health and wellbeing activities throughout the year and progress against the strategy. A new wellbeing trolley initiative was noted, funded by the Rainbow Service charity, to support staff morale. The Committee took assurance from the report and ongoing wellbeing initiatives.
2.14 Sexual Safety Charter Implementation	Yes	Yes	No	An update on progress since the Sexual Safety Charter launch was received. Updates included, a dedicated group reviewing incidents, e-learning is now part of the essential training toolkit, and a reporting inbox has been established. A campaign is planned for the Charter's 12-month anniversary, and the team is exploring sexual safety bodies, inspired by successful programmes at other trusts.
2.15 BAF Risk 2.1 Staff Engagement and Morale	Yes	Yes	No	The score was reviewed and remained at 12.
2.16 Horizon Scanning	Yes	No	No	Highlights included: • Potential upcoming strikes and further disruptions • Divisional restructure • ICB and ICS changes

BOARD OF DIRECTORS: Trust Board - Public 02 October 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: 29 September 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.17 Communications Update	Yes	Yes	No	An update on internal communications was received, reporting that a recent staff survey showed strong support for proposed ideas and provided valuable feedback. There is a planned communications away day to develop a tactical implementation plan based on these results, aiming to improve internal communications.

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 October 2025

5.2

Agenda item:	5.2
Presented by:	Andrew Kelso, CMO
Prepared by:	Jane Bryan, Medical Professional Standards Manager
Date prepared:	23/09/25
Subject / title:	Professional Standards Assurance

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	The responsible officer in each designated body has a duty under the regulations to assure and improve their professional standards function for doctors with whom they hold a prescribed connection. The report gives a summary of Appraisal & Revalidation metrics and processes relating to 1st April 2024- 31st March 2025 for quality assurance
Recommendation:	This paper is presented for approval

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

Previously considered by:	N/A
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	In accordance with national guidance and GMC regulations, promoting good practice
Appendices:	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

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

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

Section 1 Qualitative/narrative

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

1A – General

The board/executive management team of **The Princess Alexandra NHS Hospital Trust** can confirm that:

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

Action from last year:	N/A
Comments:	An appropriately trained licensed medical practitioner is in post as the Responsible Officer. This changed on 1st July 2025, this is now Dr Fiona Hikmet, Deputy Medical Director
Action for next year:	N/A

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

Yes / No:	Yes
Action from last year:	N/A
Comments:	None
Action for next year:	N/A

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

Action from last year:	N/A
Comments:	The medical professional standards team continue to monitor and maintain accurate records of all practitioners with a prescribed connection, as part of our appraisal and revalidation processes. Monthly Reports are received from the People Information team listing all starters and leavers and are actioned appropriately on GMC connect.
Action for next year:	N/A

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

Action from last year:	To review the Medical appraisal and revalidation policy
Comments:	All policies are monitored and reviewed on a 3 yearly basis
Action for next year:	N/A

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

Action from last year:	To hold a peer review meeting with West Herts Hospital Trust
Comments:	The peer review meeting was held in October 2024. Positive feedback was received in the peer review report which highlighted the following- Great monitoring of upcoming Revalidations, this includes a weekly meeting between the Deputy RO/Medical Professional standards manager to discuss doctors under notice/issues. A *Doctors under notice list / progress sheet* is sent weekly by Medical Professional standards manager to RO/Deputy RO, we also have a 5-year revalidation plan for each Doctor. Good communication between the team and the Doctors approaching revalidation. *Action from peer review*- To utilise support tool for Quality Assurance to support PAHT with reintroducing a Quality Assurance exercise for appraisers, which is complete. Employee relations manager to meet with the CEO and the relevant NED monthly to update on MHPS cases. They share details required to board for oversight. This has been actioned
Action for next year:	N/A

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

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

1B – Appraisal

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

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

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

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

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

Action from last year:	To review policy in line with updated Good Medical Practice Guidance
Comments:	This was reviewed and agreed by the JLNC however minor queries were raised by trust policy group which are under review and will be returned to the next JLNC
Action for next year:	Review and resend policy to JLNC prior to next meeting

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

Action from last year:	N/A
Comments:	Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners with a prescribed connection We continue to monitor the number of required appraisees to ensure that there are sufficient numbers and equal distribution of appraisals, amongst appraisers, usually an average of 10-12 per annum, spread throughout the year. We have mitigated this risk as one of the lead appraisers if required will complete additional appraisals.
Action for next year:	N/A

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

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

Action from last year:	N/A
Comments:	Medical Appraisers attend annual refresher training, internal bi- monthly appraisal forums, where they are updated on changes, developments, and changes to guidance. This forum gives an opportunity to raise queries and have open discussions. Appraisers also attend network events, and development events. This is supported by access to regular Medsu webinars as appropriate. The next appraisers' annual refresher training is scheduled for 2nd October 2025.
Action for next year:	As above

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

Action from last year:	To review the approach to quality assurance of the appraisals carried out by individual appraisers in order to support high quality appraisals
Comments:	We have a quality assurance process in place, this has been reviewed and detailed in our policy and will report to the People Committee There is a quality assurance process in place for appraisal and revalidation recommendations. The deputy RO completes a quality assurance form prior to due date to confirm recommendation to the GMC following review of evidence. The Deputy RO quality assures the last five appraisals of all doctors undergoing revalidation each year (approximately 20%) of the appraisees. Any themes are raised with appraisers at meetings. The Clarity system ensures that the minimum standard of quality assurance is met as the appraisals cannot be 'completed' otherwise. Anonymous feedback forms are completed by appraisee as part of the Trust process for individual appraisers and the processes carried out within the organisation. This is discussed at the Appraisers forums and reviewed where necessary.
Action for next year:	N/A

1C – Recommendations to the GMC

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

Action from last year:	N/A
Comments:	Records for doctors under notice are maintained, reviewed and discussed on a regular basis, with progress continually monitored by the Medical Professional Standards manager and the Deputy RO. There is a quality assurance process in place for appraisal and revalidation recommendations. The deputy RO completes a quality assurance form on review of evidence prior to the recommendation date, to confirm the timely recommendation to the GMC.
Action for next year:	N/A

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

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

1D – Medical governance

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

Action from last year:	The clinical audit process has been audited by PAH internal auditors (September 2024). The Trust will be implementing recommendations once agreed by Audit Committee within 12 months of the final report.
Comments:	The audit was complete, the recommendations were highlighted in the report, and are listed in the actions below The clinical audit policy has been reviewed with plans to submit to CE Group for approval in November Clinical governance processes are in place in line with policies and national guidance There is a clinical effectiveness meeting bi –monthly that is chaired by the medical director and follows an annual work plan. A half day each month is designated protected time for audit/clinical effectiveness/learning and are led by the Associate medical director for risk and quality Clinical effectiveness policies are in place relating to audit, the implementation of NICE guidance and new interventional procedures. These are available on the intranet. There is a quality governance structure in place, Trust wide audit meetings are held quarterly. There is a divisional patient safety and quality board meeting that is held within each division and led by the divisional patient safety and quality lead
Action for next year	For divisions to: • Update participation status of national quality account audit for 2025/2026 • Review national report recommendations to identify learning/actions required to improve compliance • Review and update NICE guidance , focussing on those that are outside of their review period • Review the finding of the internal audit

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

Action from last year:	N/A
Comments:	Effective systems are in place in line with national guidance and policies A grievance policy is in place, as well as a disciplinary policy. An MHPS policy is in place with a framework for dealing with conduct and concerns A complaints policy is in place A quarterly meeting is held with the GMC Employment Liaison advisor to monitor and discuss concerns, cases and outcomes
Action for next year:	N/A

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

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

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

Action from last year:	N/A
Comments:	Responding to concerns policy and processes are in place, in line with the national framework guidelines - NHS England. The Trust has an MHPS policy which is used in these circumstances. Since the last report the trust has appointed a dedicated senior employee relations manager who supports with fitness to practice concerns.

Action for next year:	The trust MHPS policy and associated paper work is being reviewed and updated

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

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

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

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

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

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

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

Action from last year:	Plans to hosts patient safety learning events to ensure all teams learn from incidents, inquests, complaints and claims
Comments:	Trust compliance with national reviews, reports and enquiries is reported at the clinical compliance and clinical effectiveness committees. These are chaired by the Chief Medical Officer and all divisional leads in attendance. This committee reports to the Trust Quality and Safety committee. Since the implementation of PSIRF – we have held some patient safety and governance training session with resident doctors, at all new doctors inductions and at the new consultant inductions, we also present at Grand Round and MAC to ensure all teams learn from incidents, inquests, complaints and claims
Action for next year:	N/A

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

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

1E – Employment Checks

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

Action from last year:	N/A
Comments:	On-boarding of fixed term locums and substantively employed doctors follow all recruitment processes and doctors are unable to start until all checks are cleared. This includes obtaining references and police checks from previous host organisations and countries. Agency locums obtained via an agency as temporary staff can only be booked/appointed if their CV has been reviewed by a clinician and must include references, statutory training, DBS and qualification history
Action for next year:	N/A

1F – Organisational Culture

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

Action from last year:	N/A
Comments:	Leadership and Management competence is included in the appraisal for all people managers and a rating required. Executive team members must have an objective related to EDI in their annual appraisal The NHS Staff Survey results feed into an annual 'Feedback to Action' plan to address the People Promise elements which include EDI data. All new

	starters attend a forum to meet the Executives and Non-Executive Directors where culture is discussed and promoted as well as avenues for feedback such as Freedom to Speak up Guardians, raising risks, people team and support through Here for You. New consultants attend a Consultant development programme
Action for next year:	N/A

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

Action from last year:	To implement our EDI strategy, we have developed our EDI Delivery Plan 2024 to 2026. This provides the details of the projects and activity we aim to achieve in our EDI strategy, the Equality Act 2010 and the NHS Standard contract
Comments:	Our starting point is that everyone has the right to be treated fairly and equitability. This is true whether they are members of PAHT staff, those from partner organisations that we work with, community groups we seek to engage, or the patients, carers and families who our work is ultimately for. • We aim to maintain and promote a zero-tolerance approach to discrimination in any form, and we are committed to planned and consistent action to reduce and eliminate all practices that allow the continuation of discriminatory behaviours, policies or practices. • We value both visible and non-visible difference as a key part of a healthy organisation. We will strive to harness people's differences to create an environment in which people feel valued, staff talents are fully utilised, and we deliver against our strategy. • We know that celebrating individual difference, and bringing diverse teams together with disparate styles and talent, will foster innovation and continuous improvement for patients, service users, their families, carers and our people. • We recognise that equality and diversity are most effective and sustainable if we are inclusive, and all of our people are welcome, valued and able to contribute. • We want to build a reputation of being a values-based organisation that focuses on ensuring that all care delivered to patients by our people has a truly person-centred focus. • We are in no doubt that equality, diversity and inclusion is a collective responsibility, and the Trust Board has a duty to ensure this work is at the heart of our business. • We are asking all our people to adopt and embrace this strategy within their individual roles and workplaces. Our core goals and objectives are: 1. To Put EDI at the heart of our organisation

	2. Recruit, retain develop and support a diverse workforce. 3. Improve patient experience and outcomes for people with protected characteristics and other communities who experience marginalisation. 4. Engage our diverse communities across our services and pathways.
Action for next year:	N/A

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

Action from last year:	N/A
Comments:	All staff are encouraged to speak up, this has been particularly encouraged with our medical staff over the past year. The Trust has freedom to speak up guardians, one of whom is a doctor, alongside this there are some resident doctors who are FTSU ambassadors. Listening events have been held for doctors. Issues are listened to at both JLNC and RDC and acted upon and shared in order to improve processes.
Action for next year:	N/A

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

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

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

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

1G – Calibration and networking

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

Action from last year:	To hold a peer review meeting in partnership with West Herts Trust
Comments:	• Participating in peer reviews with partnering organisation -West Herts • Engaging with higher level responsible officer reviews with NHSE • Attending RO Training network meetings • GMC updates • Accessing Responsible Officer hub –GMC website • Attending appraisal and revalidation network groups
Action for next year:	N/A

Section 2 – metrics

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

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

2A General

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

Total number of doctors with a prescribed connection on 31 March	**353**

2B – Appraisal

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

Total number of appraisals completed	**351**
Total number of appraisals approved missed	**0**
Total number of unapproved missed	**2**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	101
Total number of late recommendations	0
Total number of positive recommendations	100
Total number of deferrals made	12
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	12
Total number of trained case managers	12
Total number of new concerns registered	4
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March	14 months

Median duration of concerns processes closed	6 months
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

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

Total number of new doctors joining the organisation	84
Number of new employment checks completed before commencement of employment	84

2F Organisational culture

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

Section 3 – Summary and overall commentary

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

General review of actions since last Board report
Key Actions from last year To hold a peer review meeting with partnering organisation West Herts. This has taken place receiving positive feedback in the report To review the Quality assurance process for Appraisers and reintroduce this. This has now been successfully implemented To implement our EDI strategy, in relation to development the Trust EDI Delivery Plan 2024 to 2026. This is complete Employee relations manager to meet with the CEO and the relevant NED monthly to update on MHPS case, and share details required to board for oversight. This action is complete Plans to hosts patient safety learning events to ensure all teams learn from incidents, inquests, complaints and claims. This has been actioned

Actions still outstanding
Medical appraisal policy needs minor amendment and to be returned to JLNC MHPS policy to be reviewed by Employee relations manager
Current issues
N/A
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To review how details of complaints and datix incidents are shared with the doctors to detail in their appraisals To review any policies as necessary and seek ratification The Trust will be implementing recommendations following the PAHT clinical audit, internal audit (September 2024) For divisions to: • Update participation status of national quality account audit for 2025/2026 • Review national report recommendations to identify learning/actions required to improve compliance • Review and update NICE guidance , focussing on those that are outside of their review period Review the findings of the internal audit
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Positive feedback received from Peer review report Appraisal completion rates increased to 95 % The consultants development programme take place annually The Revalidation deferral rate has decreased from 19 to12 this year with a plan to further decrease this by next year by strengthening the Trust 5 year revalidation plan

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

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

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

Name:	Thom Lafferty
Role:	Chief Executive
Signed:	Thom Lafferty
Date:	

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 October 2025

5.3

Agenda item:	5.3
Presented by:	Arleen Brown – Head of Equality, Diversity & Inclusion
Prepared by:	Arleen Brown – Head of Equality, Diversity & Inclusion
Date prepared:	5 September 2025
Subject:	Workforce Race Equality Standard (WRES) 2024

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	• Improvement in the overall recruitment of BME staff into PAH. • Underrepresentation of BME staff at Bands 8c to VSM, and Clinical BME staff from Band 5 to 6. • There has been an improvement in Staff entering into the formal disciplinary process as it shows a proportionate ratio of BME to White Staff • Both BME and white staff continue to experience bullying and harassment higher than the national average. • BME staff disproportionately experience discrimination. • There has been a significant improvement in BME NEDs Board membership.
Recommendation:	That the Key Issues are noted and discussed and the WRES Action Plan agreed.

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

Previously considered by:	PC.29.09.25
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	The Trust has a number of statutory duties arising from the Equality Act 2010 and the NHS Standard Contract.
Appendices:	None

1.0 Introduction

1.1 The Workforce Race Equality Standard (WRES) was introduced in 2015 as part of the NHS standard contract to enable employees from black and minority ethnic (BME) backgrounds to receive fair treatment in the workplace. The WRES is a data collection framework which measures elements of race equality in NHS organisations. Implementing the WRES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

1.2 The WRES is designed around nine indicators, or measures, which compare BME colleagues and their white counterparts.

Five indicators of the WRES are populated with workforce data from our Electronic Staff Record (ESR), the recruitment system (TRAC), Employee relations (Conformity) and NHS National Staff Survey which shows comparative data for BME and White staff.

Indicator 1: the distribution of staff in each pay band (ESR)

Indicator 2: likelihood of being appointed following shortlisting (TRAC)

Indicator 3: likelihood of entering a formal disciplinary process (Conformity)

Indicator 4: access to training and development (Staff records)

Indicator 5 & 6: Bullying and Harassment (Staff Survey)

Indicator 7: Equal opportunities (Staff Survey)

Indicator 8: Experiencing discrimination from manager or other colleagues (Staff Survey)

Indicator 9: BME Board Membership (ESR)

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

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

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

The Princess Alexandra Hospital NHS Trust

5.3

2.0 Context

2.1 The data in this report is mainly comparing 2023 - 2024 and 2024 - 2025.

When reviewing the information, it is useful to understand the overall numbers of BME and white staff in the workforce. As at 31 March 2025 the ethnic profile of staff represents 46% for BME staff (43% previous year), and 51% classed as white British (54% previous year). Staff who have not stated their ethnicity represents 3%, which remains the same as last year.

2.2 Whilst there has been an increase in the BME workforce profile from 43% in 2024 to 46% in 2025, this is not proportionate across the senior posts when our leaders under Medical and Dental terms and conditions are removed from the data. However, they are an integral part of our leadership and as such should not be discounted.

Ethnicity	Headcount as at 31 March 2025	%
BME	1896	46
Not Stated	119	3
White	2131	51
Grand Total	4146	

3.0 WRES Indicators

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

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

Non Clinical	Apr23 - Mar24						Apr24 - Mar25					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
Band 1	10	71%	2	14%	2	14%	10	71%	2	14%	2	14%
Band 2	340	72%	109	23%	21	4%	331	70%	127	27%	18	4%
Band 3	153	85%	21	12%	6	3%	146	82%	28	16%	5	3%
Band 4	174	88%	20	10%	4	2%	172	87%	22	11%	3	2%
Band 5	63	81%	11	14%	4	5%	61	77%	14	18%	4	5%
Band 6	57	72%	20	25%	2	3%	65	70%	26	28%	2	2%
Band 7	73	78%	18	19%	2	2%	61	74%	18	22%	3	4%
Band 8a	40	80%	10	20%	0	0%	34	83%	7	17%	0	0%
Band 8b	23	72%	8	25%	1	3%	27	71%	11	29%	0	0%
Band 8c	9	82%	2	18%	0	0%	9	82%	2	18%	0	0%
Band 8d	8	80%	2	20%	0	0%	10	77%	2	15%	1	8%
Band 9	7	88%	1	13%	0	0%	10	83%	2	17%	0	0%
VSM	7	88%	1	13%	0	0%	7	88%	1	13%	0	0%
NEDS	5	63%	3	38%	0	0	5	50%	4	40%	1	10%

3.3 BME staff in Band 6 are underrepresented in the last 2 years showing 20 staff (25%) and 26 staff (28%) respectively. There has been a decrease in white staff in Band 7 from 73 (78%) to 61 (74%).

3.3 In 2023/2024 we made progression in Band 8a for BME staff to 20%. However, this year the number has fallen to 17%. This may be reflected in the increase in the number of BME staff in Bands 8b which has increased 25% last year to 29% this year, potentially showing a promotion. There is an underrepresentation of BME staff at band 8A when compared to white staff.

3.4 At the most senior levels of the Trust non- clinical BME staff continue to be underrepresented over the last three years. For this statistic we consider the collectively numbers in Bands 8c, 8d, 9, and VSM). For 2024 to 2025 BME staff held 7 posts compared to White who held 36,1 unknown, BME staff representing 16%, against the total of 46%. To address this underrepresentation of BME staff in senior posts, this year we will be introducing a Talent management and succession Planning Strategy. We will also take a review of our starts and leavers data.

3.5 We have however increased the number of BME NEDS on the Board from 3 to 4 members which now represents 40%, which is a positive outcome for Board BME representation.

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

Clinical	Apr23 - Mar24						Apr24 - Mar25					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
Band 2	247	61%	150	37%	9	2%	35	41%	51	59%	0	0%
Band 3	102	78%	26	20%	3	2%	257	60%	161	38%	9	2%
Band 4	66	57%	48	42%	1	1%	54	69%	17	22%	7	9%
Band 5	136	20%	532	78%	14	2%	138	19%	561	79%	13	2%
Band 6	244	51%	220	46%	17	4%	237	50%	229	48%	10	2%
Band 7	197	62%	108	34%	12	4%	195	63%	110	36%	4	1%
Band 8a	90	63%	47	33%	5	4%	90	65%	48	35%	0	0%
Band 8b	17	63%	7	26%	3	11%	17	59%	9	31%	3	10%
Band 8c	9	69%	3	23%	1	8%	7	70%	2	20%	1	10%
Band 8d	7	88%	1	13%	0	0%	7	88%	1	13%	0	0%
Band 9	0	0%	1	100%	0	0%	1	50%	1	50%	0	0%
Medical & Dental	152	25%	422	71%	24	4%	151	24%	447	71%	34	6%

3.7 The majority of BME staff are at Band 5 representing 78% staff, a similar position to the 2023/2024 data at 79%. White staff in Band 5 represented 20% in 2023/2024, and 19% in 2024/2025. The data shows an overrepresentation of BME staff in Band 5 compared to the Trust profile at 46%.

3.8 In Band 7 and Band 8a the staff profile for BME and White staff has largely remained the same showing a slight variance over the two years for both groups.

3.9 At the most senior levels of the Trust clinical staff under Agenda for Change terms and conditions, BME staff continue to be underrepresented over the last two years, collectively in Bands 8c, 8d, 9. In 2023/2024 BME staff represented 23% while on the year 2024/2025 BME staff representation declined to 20%. We will well with our medical recruitment team to better understand the underrepresentation.

3.10 In our staff under the Medical and Dental terms and conditions the data remained the same, which shows significant overrepresentation of BME staff compared to White staff.

The disparity however is not represented by total numbers in the same way for other groups. For this staff group, differences can include clinical awards, academic posts, and fitness to practice referrals.

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

Indicators	2023/24						2024/25					
Relative likelihood of white staff being appointed from Shortlisting compared to BME staff across all posts	2.14						1.63					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	690	42%	529	32%	412	25%	350	41%	485	56%	28	3%

The relative likelihood of white staff being appointed compared to BME staff in 2023/24 was 2.14. This is an improvement compared to last year which was 1.63. We will be reviewing applications for training to understand the decline and address the outcome for next year.

Last year we implemented the NHS debias recruitment programme to assist us in improving this outcome. We will continue with more robust monitoring with our new recruitment system, to examine the stages from applications, shortlisting, through to appointments, for BME and White staff. Ideally the WRES outcomes aim for our recruitment data to be at 1:1.

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

Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to white staff (two years rolling average)	2023/24						2024/25					
	0.54						1.01					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	23	70%	10	30%	0	0%	10	53%	9	47%	0	0%

This is a positive outcome as a score less than one is a positive outcome for BME Staff.

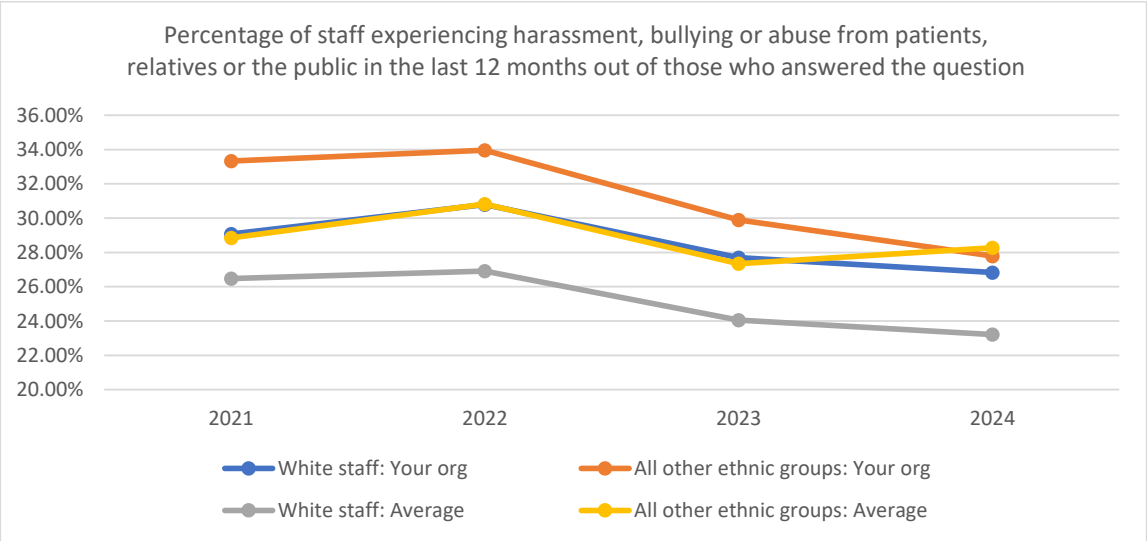
3.13 - Indicator 4**:** Relative likelihood of White staff **accessing non-mandatory training and CPD** compared to BME staff**:**

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	2023/24						2024/25					
	0.87						0.78					
	White		BME		Unknown		White		BME		Unknown	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	321	53%	296	44%	19	3%	353	52%	309	45%	18	3%

The likelihood of White staff accessing non-mandatory training and has slightly dropped from last year. A value of “1.0” for the likelihood ratio means that white and BME staff are equally likely to access non-mandatory training or CPD.

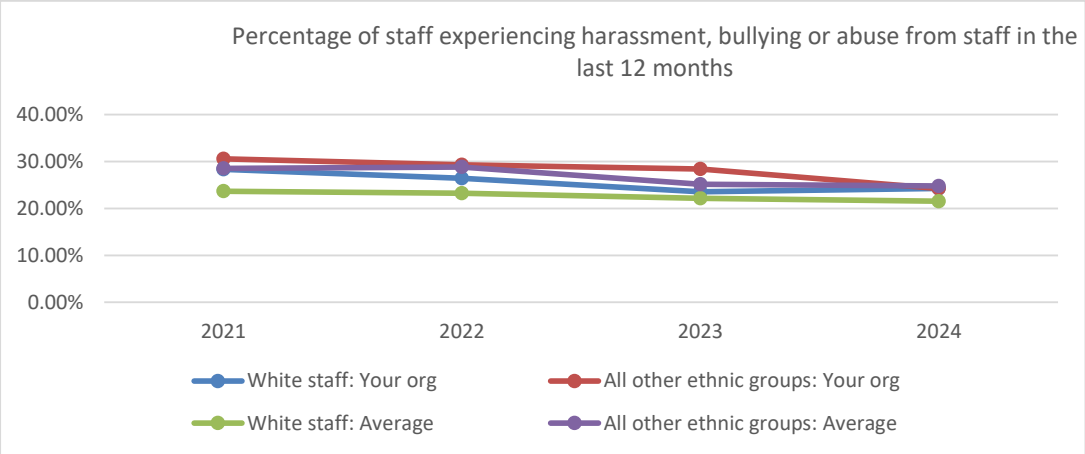
During the initial stages of the annual process, the OD & L team liaised with internal communications to promote the CPD across the organisation (for all staff) whilst also liaising directly with divisional leaders to communicate, encourage and promote continuous learning. A number of open workshops were promoted and held for all staff regarding any questions they had on the process, applicability and benefits of CPD. Posters were distributed in different areas on sites to encourage staff to enquire about CPD, whilst OD & L staff visited wards to encourage and educate staff.

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



The table above indicates that bullying and harassment within the Trust has reduced from last year. However, it is still higher than the national average for both BME and white staff and, BME staff still experience bullying and harassment at higher ratios than white staff. The People Business partnering Team will be creating a plan to address bullying and harassment cases by January 2026.

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



The table above indicates that bullying and harassment or abuse within the trust is higher than the national average for both BME and white staff. The data also shows that both BME and White staff experience bullying and harassment in our organisation.

3.16 In December 2024 we launched a new zero-tolerance campaign, titled '*no excuse for abuse*,' aimed at combating the risk of violence and aggressive behaviour towards our people and encouraging patients and visitors to reflect on their actions.

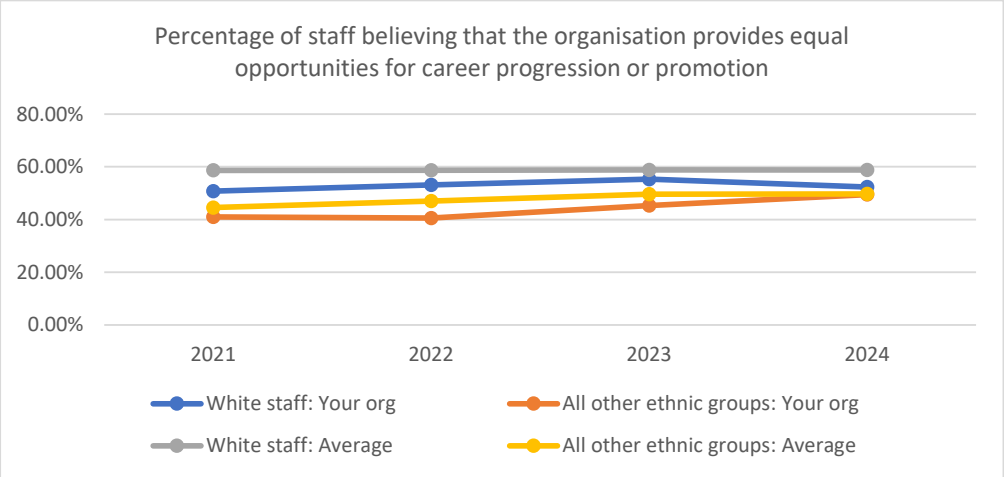
The campaign aims to embed a culture of support, safety, and respect at all times and to create an environment that is free from abuse of all kinds, including verbal, physical, and racist taunts.

The visual assets for the campaign are promoted across the hospital, off-site offices, and community sites through vinyl graphics and posters on entrance doors and lifts, including our off-site locations, as well as through digital messaging display screens and social media channels.

3.17 In order to further reflect our commitment to creating a workplace that prioritises your safety and wellbeing, the campaign is underpinned by:

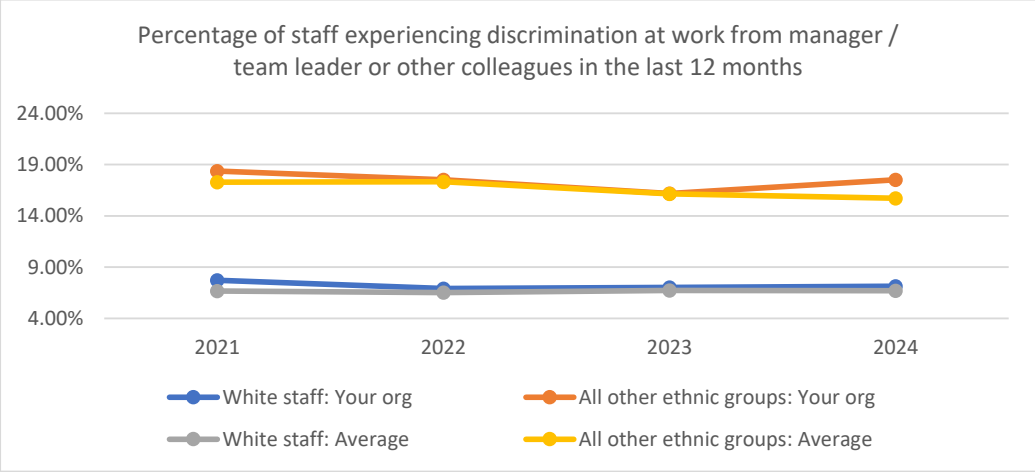
- The encouragement of reporting all incidents relating to violence and aggressive behaviour through Datix.
- Enhancing policies and protocols in place to manage challenging behaviours and to guide appropriate action to be taken.
- Introducing a straightforward process to exclude patients from the hospital and community sites, when it is clinically safe to do so, if they have acted violently or aggressively towards our people.
- Providing adequate safety and de-escalation training for colleagues in 'high-risk' environments.
- Developing a violence prevention and reduction strategy.

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



The table above indicated BME staff respondents, consistently do not believe the Trust provides equal opportunity for career progression. However, there has been an increase in the number of BME staff who believe the Trust provides equal opportunities for career development from last year. This now shows an improvement which is in line with the national average for BME staff, and almost at the same percentage as White staff within the Trust.

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



The previous table above indicates that there is a significant difference in experience of discrimination amongst BME staff (18%) and White staff (7%) in our Trust. The data also indicates there has been a slight increase on this indicative for BME staff from 2023 to 2024. This indicator signal that although we are sitting close to the national average we still have work to do to foster a climate of tolerance and civility within our people.

Part of the work we have already started is implementing appropriate actions from the East of England Anti-racism Strategy, which we have identified as a continued action in the WRES and PAHT EDI Delivery Plan 2025 to 2026.

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

Total Board Members by ethnicity	2023/24				2024/25			
	White		BME		White		BME	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%
	13	72%	4	22%	13	65%	6	30%

BME representation at board level is 30% when compared to 22% last year. This shows a significant steady increase and improvement from 2023 which was at 16%. This significant increase demonstrates the commitment of Princess Alexandra Trust to equality and diversity to enable us to serve our population and community to the best of our abilities.

4.0 Actions for 2025 to 2026

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

Reference	Indicator	Actions	Lead	Timescale
1	2, 9	Debiased recruitment NHS programme to be implemented in line with the NHS EDI High impact actions – attraction, recruitment and retention.	Head of People -Recruitment and Retention	**On going**
2	2, 9	Review the role of recruitment inclusion specialist. To ensure they are effectively able to challenge and report on bias recruitment processes.	Head of People -Recruitment and Retention & Head of EDI	**November 2025**
4	3	Review disciplinary cases, policy and processes. To ensure investigations are fair, transparent and adopt the 'just culture' principles.	Head of Employee relations and Head of EDI	**On going**
5	5 & 6	Within our culture change programme and initiatives, set standards of behaviour to tackle bullying and harassment.	Head of People Business Partners & Head of EDI & Head of ODL	**January 2026**
6	5 & 6	Develop an action plan to review all data and complaints to address bullying and harassment.	People Business Partnering Team	**January 2026**
7	5 & 6	Consider bystander training - Select existing EDI champions, Freedom to Speak up Guardians, and Inclusion Specialist for the Active Bystander Train-the-Trainer programme - to roll out across the Trust.	Head of EDI	**February 2026**
8	7 & 8	Review the EOE Anti- racism Strategy and Action plan – to ensure we appropriately challenge racism within PAHT.	Head of EDI	**February 2026**
9	1 & 9	Implement a Talent Management and Succession Planning Strategy.	Head of OD&L	**March 2026**
10	1	Review our starters and leavers data to understand if we can introduce incentives for the attraction and retention of BME staff above AFC band 8c.	People Information Team	**December 2025**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 October 2025

5.4

Agenda item:	5.4
Presented by:	Arleen Brown Head of EDI
Prepared by:	Arleen Brown Head of EDI
Date prepared:	5 September 2025
Subject:	Workforce Disability Equality Standard (WDES) 2024

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	• The percentage of 'unknown' on disability status of staff in ESR, in particular when triangulated with our Staff Survey results. • Disabled staff are less likely to be employed than non-disabled staff. • Increase in total number of staff, entering the formal capability process, • All four indicators for bullying and harassment are higher than national averages over the last two years. • Disabled staff receiving reasonable adjustments are much lower than the national average. • WDES Action Plan for approval to be signed off by the Trust Board • Note Appendix 1 – Summary of Metrics • Note Appendix 2 - Definitions of disability based on the Equality Act 2010, and the Social Model of disability, driver to developing the WDES.
Recommendation:	That this report is discussed and the WDES Action Plan agreed.

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

Previously considered by:	PC.29.09.25
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	The WDES was introduced in April 2019 and it is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
Appendices:	Appendix 1 – Summary of WDES Metrics Appendix 2 – Definition of disability and monitoring questions

1.0 Introduction

1.1 The NHS Workforce Disability Equality Standard (WDES) is an essential tool in supporting the NHS to be an inclusive and fair workplace. It helps evaluate progress and identify areas where further improvement is needed. Implementing the WDES is a requirement for NHS commissioners and NHS healthcare providers through the NHS Standard Contract.

The WDES was introduced in 2019 and is built around 10 evidence-based measures (metrics) which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

1.2 Last year we had concerns with the lack of information on ESR where staff had not completed their disability status ('unknown'). We still have some work to do this year to encourage staff who have not declared their status to complete their profile on ESR. It is clear from the staff survey that staff are comfortable declaring their disability status (when anonymous) considering the difference is 19% of staff who completed the survey, compared to 4% who have their disability recorded on ESR.

We could deduce that anonymity encourages declaration of disabilities whilst ESR, being open for appropriate staff and managers to view, may harbour feelings of potential discrimination. Staff feel safer declaring their status for the Staff Survey as they know that it is anonymous.

1.3 In addition, we recognise the consistent feedback from staff with a disability or long-term condition who; are less likely to be recruited; experience bullying and harassment; feel pressured to come to work despite not feeling well. We are also hoping to increase our reporting and monitoring of reasonable adjustments, which should reduce the gap and bring us in line or above the national average.

1.4 A campaign is underway to encourage staff to complete their equality profiles on ESR which we will be starting towards the end of September. It is important that we explain the medical definition of disability and encourage staff to also complete their records if they have a long-term condition. It is not mandatory for staff to complete their profiles, we need to ensure that the language we use is sensitivity to encourage and support staff in coming forward. We can also learn from the campaign done at Sussex PHFT Improving disability declaration rates at Sussex Partnership NHS Foundation Trust | NHS Employers

In addition, completion of the data in ESR will also help us to provide a more accurate reflection for the purposes of Disability Pay Gap which is due this year. If we can improve the data we should have a reduction in the 'unknown' fields and a more accurate picture for 2025 to 2026.

1.5 Essentially this means that we have to do more in the organisation to show staff the work we are doing in changing the culture and behaviours across the Trust to be more inclusive and disability friendly. This will be assisted through the work we are embarking on to complete the Business Disability Forum self-assessment across PAHT.

1.6 All of the actions in our WDES Action Plan are monitored through our EDI Strategy Delivery Plan 2025 to 2026

2.0 Context

2.1 At PAH our aim is to create a workplace in which disabled staff are visible and feel supported which will engender greater awareness throughout the workforce. Making disability integral to mainstream policies from the point of application, through induction and continuing development and training, recognises that disability can affect us all and that promoting inclusion is everyone's business.

2.2 The data is for the reporting year 2025. For the Staff Survey metrics there are comparisons from 2021 to 2024. When reviewing the data, it is useful to understand the overall numbers of disabled staff and non-disabled staff in the workforce. As at 31 March 2025 disability profile of staff: disabled staff 4% (3% - 2024); non-disabled staff 75% (71% - 2024); not declared 20% (10.6% - 2024); prefer not to answer 1% (0.4% - 2024); and unspecified (15% - 2024).

2.3 The Staff Survey response to the disability question indicated of the 1987 staff who completed the survey 23% identified with having a disability or long-term condition, against a national average of 24%. This is almost 20% difference than the information we have on ESR.

Disability	Headcount – 31 March 2024	Headcount March 2025
Yes	130	156
No	2959	3129
Not declared	427	838
Prefer not to answer	18	23
Unspecified	632	(within not declared)
Grand Total	4166	4146

3.0 Our WDES outcomes

3.1 Metric 1: Percentage of staff in AFC (agenda for change) pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce. This data is provided in clusters by grouping Bands, due to the small numbers of staff declaring a disability.

Table 1 shows headcount and percentage of disabled and non-disabled **non-clinical** staff by bands

Non- clinical staff	Bands 1-4		Bands 5-7		Bands 8a-8b		Bands 8c-9 &VSM		Non-Executives	
Disabled	43	5%	11	4%	9	11%	2	5%	1	10%
Non-Disabled	602	70%	179	70%	52	66%	38	86%	9	90%
Unknown	221	26%	64	25%	18	23%	4	9%	0	0%

Bands 1 to 7 and Bands 8C-9 show comparable representation with our data on ESR. Bands 8a-8b and Non- executives show an over-representation of disabled staff in comparison to our 4% overall data. However, the percentages of unknown are high across Bands 1 to 8b. This indicates that we do not have a true picture of the number of disabled staff, across the non-clinical workforce. Since last year disabled staff from band 8a to VSM has increased by 5 staff.

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

Clinical staff	Bands 1-4		Bands 5-7		Bands 8a-8b		Bands 8c-9 &VSM	
Disabled	23	4%	49	3%	7	4%	1	5%
Non-Disabled	472	81%	1162	77%	118	69%	16	80%
Unknown	89	15%	289	19%	46	27%	3	15%

All bands have a proportionate representation of disabled staff except for Bands 5 to 7. However, the percentages of unknown in across all clinical bands are high, which means we may not have a true picture of the number across the clinical workforce. This data reflects the same outcome as last year.

3.3 - Table 3 identifies the headcount and percentage of **medical staff** who are disabled and non-disabled

Medical staff	M&D consultants		M&D career grade		M&D trainee grade	
Disabled	4	2%	7	7%	0	0%
Non-Disabled	140	63%	71	72%	279	89%
Unknown	77	35%	21	21%	34	11%

The data on medical staff indicates that there is underrepresentation in M&D consultants and M &D trainee grades. M & D career grades show a slight over representation.

However, since last year the number of M &D consultants declaring has increased by 2, and Career grade have increased by 7, and Trainee grade has reduced from 8 staff.

3.4 As with the previous analysis of the workforce in Table 1 & 2 & 3 the percentages of unknown are high. To show a true picture of the number of disabled staffs in the workforce, we need to focus on encouraging staff to complete their equality profiles in ESR by updating their personal data.

3.5 - Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from Shortlisting across all posts. This refers to both external and internal posts.

Indicator	Disabled	non-Disabled	Unknown
Relative likelihood of non-disabled staff compared to disabled staff being appointed from Shortlisting across all posts. This refers to both external and internal posts.	43	788	32

Relative likelihood is 1.27 compared to last year's figure of 1.18. A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting. This indicator shows that disabled staff are less likely to be appointed from shortlisting compared to non-disabled staff.

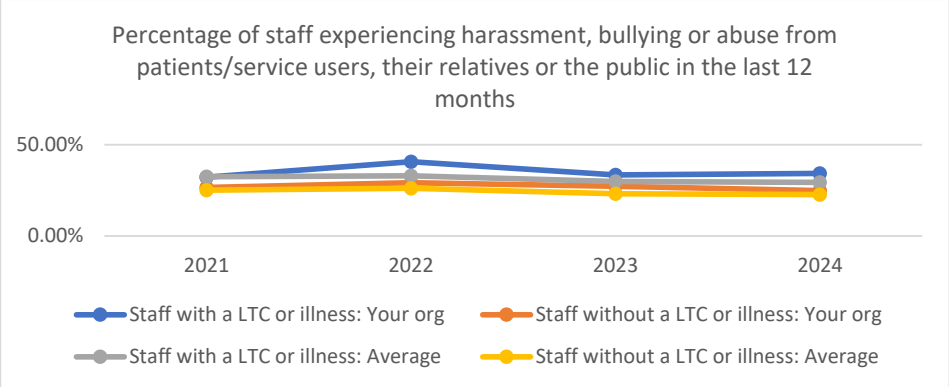
3.6 - Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Indicator	Disabled	non-Disabled	Unknown
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	5	16	11
Data from 2023 to 2024	**2**	**3**	**4**

As the figures for this indicator are so low the auto calculation field has not generated a ratio which is meaningful. We have therefore calculated this outcome by a percentage of those entering the capability process.

Out of the total 32 staff who have entered the formal capability process, disabled staff represent 16% and non-disabled staff represent 50%.

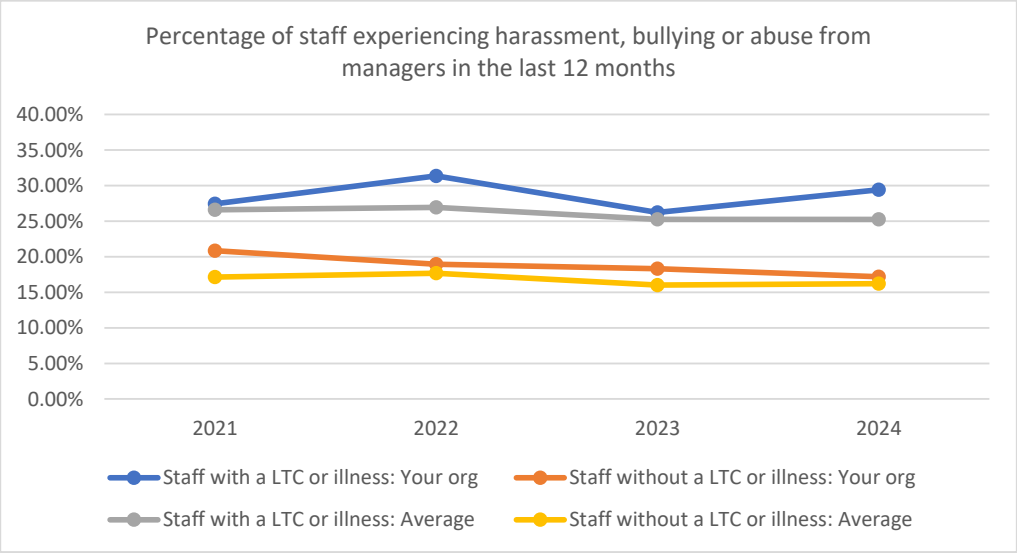
3.7 - Metric 4 (1): Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months



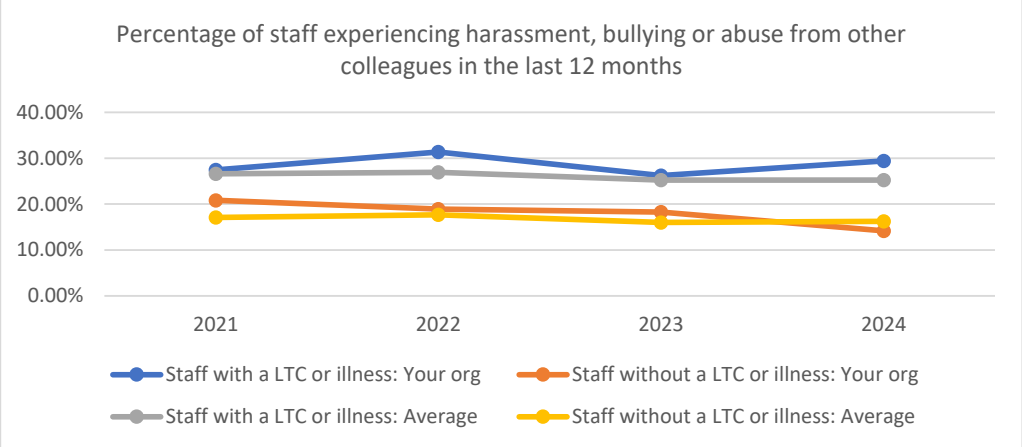
The percentage of staff declaring a long-term condition (LTC) is the highest marker. It has slightly risen from 2023 from 29.83 to 2024 at 34.22. We have implemented a 'Zero tolerance' approach, reviewed our policy, along with posters on walls to support staff.

There is still much more that we can do in regards to reviewing Datix reports and investigations to ensure appropriate action is taken and fed back to staff. This piece of work is planned to start by January 2026

3.8 - Metric 4 (2): Percentage of staff **experiencing harassment, bullying or abuse from managers** in the last 12 months.



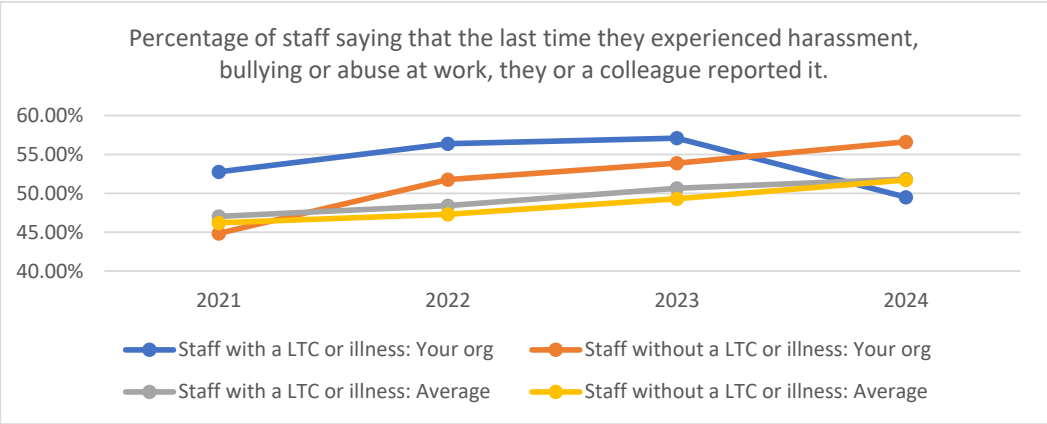
3.9 - Metric 4 (3): Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.



Both Metrics 4(2) & 4(3) show staff with a long-term condition (LTC) or illness compared to those without, disproportionately experience harassment, bullying or abuse from managers and colleagues in the Trust. This trend is consistently high over the 3 years, and we have been consistently higher than the national averages. We have also seen an increase from 2023 to 2024.

We are planning aa robust campaign to address bullying and harassment weaved into our Culture Change Programme planned to start by January 2026

3.10 - Metric 4 (4): Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

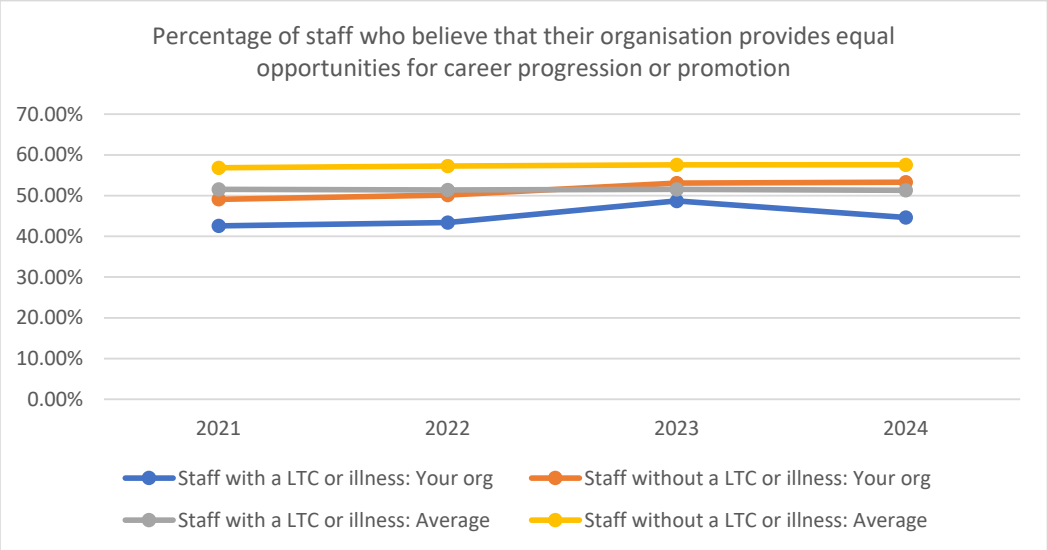


Although the gap between the two groups within our Trust have reduced in 2022 and 2023, the overall data for our Trust remains higher than national averages for both groups. In 2024 The reporting of those with a long-term condition or illness has reduced and for the first time in four years is below the national average.

Staff Reporting incidents	2021	2022	2023	2024
Staff who have a LTC or illness	53% (163)	56% (204)	57% (167)	49% (200)
Staff without a LTC or illness	45% (466)	52% (512)	54% (426)	56% (461)

Further analysis above of Staff Survey data shows the staff numbers who have reported incidents. As the volume of incidents do not equate to the numbers in our employee relation case work. we have decided to review theses how these cases have been investigated and fed back to staff, as part of our bullying and harassment project.,

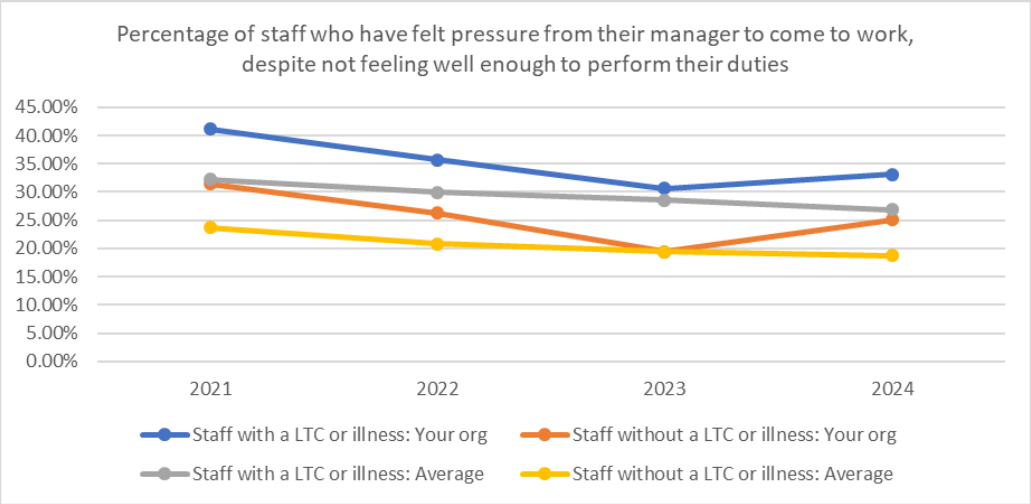
3.11 - Metric 5**:** Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.



In 2022 -2023 there was an increase in staff with a long-term condition. However, this has dipped slightly from 51% to 45% in 2023 to 2024. In addition, we continue to fall below the national trends for both groups of staff.

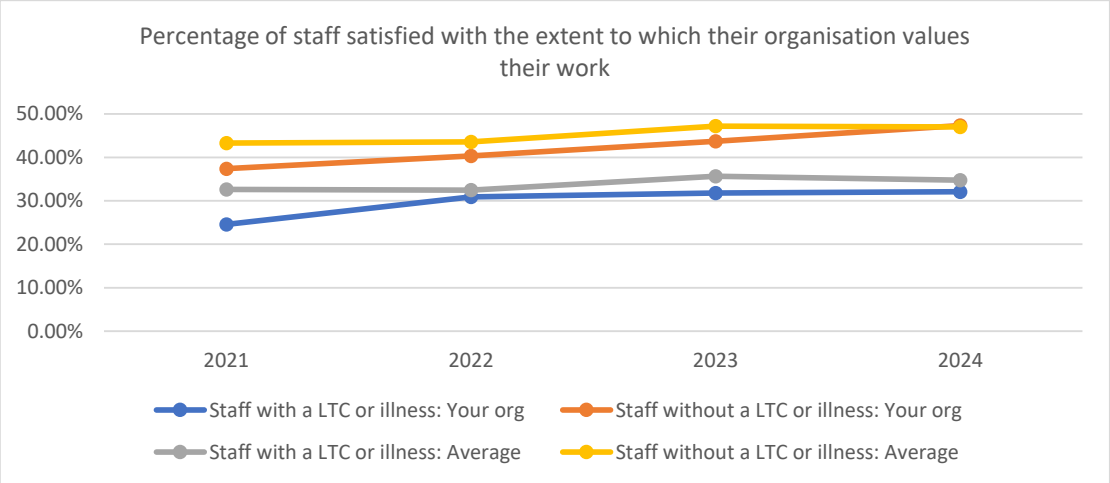
During the initial stages of the annual process, the OD & L team liaised with internal communications to promote the CPD across the organisation (for all staff) whilst also liaising directly with divisional leaders to communicate, encourage and promote continuous learning. A number of open workshops were promoted and held for all staff regarding any questions they had on the process, applicability and benefits of CPD. Posters were distributed in different areas on sites to encourage staff to enquire about CPD, whilst OD & L staff visited wards to encourage and educate staff.

3.12 - Metric 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



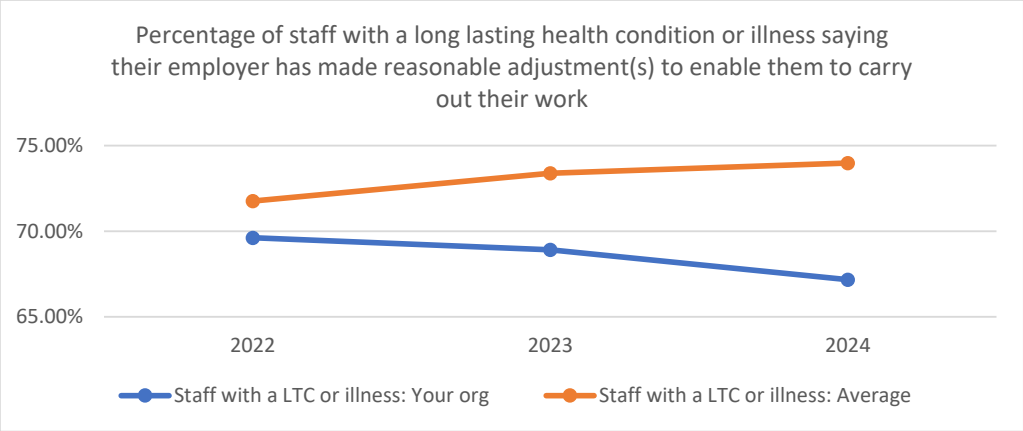
Since 2021 we were on a downwards trend for this indicative. In 2024, however, the data shows that in both groups there has been an increase in staff who feel pressured to come back to work when they are not well.

3.13: Metric 7: Percentage of staff satisfied with the extent to which their organisation values their work



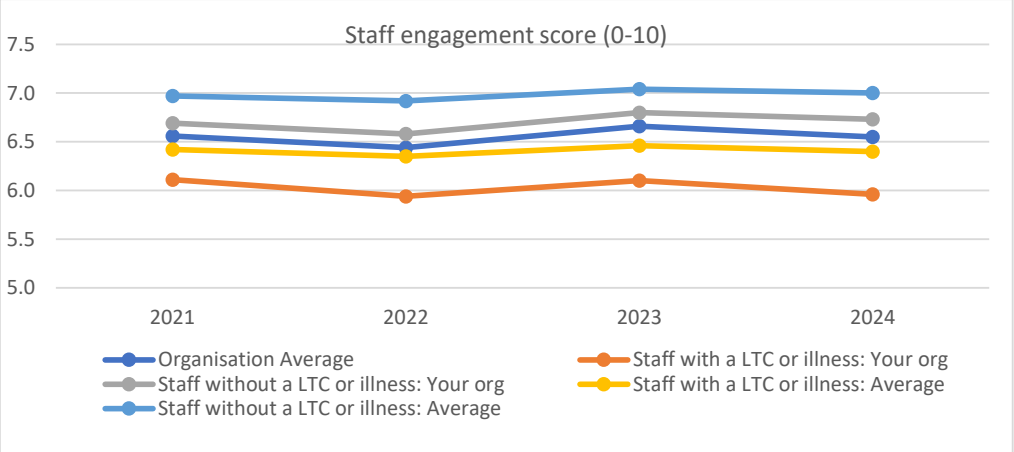
Whilst there is a slight increase in satisfaction for both groups, for those staff with a long-term condition or illness the level is still slightly under the national average.

3.14 - Metric 8: Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work



We have seen a great decrease on this indicative which is a major concern for us. To mitigate we are in the process of developing a Reasonable Adjustment Policy to be delivered by November and will continue to monitor staff experience.

3.15 - Metric 9: The staff engagement score for Disabled staff, compared to non-disabled staff



The data shows that our engagement score for both groups of staff is below the national average. Our People Strategy highlights the work we will be undertaking to improve staff engagement in everything we do, from recruitment, to day-to-day up to the point of exit.

We will be carrying out a disability audit to understand more about engagement, communication and carrying out recommendations to improve. We will be investing more into our staff network (DAWN) to increase engagement and working with external parties such as the BDF (Business Disability Forum) for strategic advice on best practices. Our ESR Campaign will also encourage staff to update their disability details.

3.16 - Metric 10: Percentage difference between the organisation's board voting membership and its organisation's overall workforce. (ESR)

	By Voting membership of the Board		By Executive membership of the Board	
Disabled	1	10%	1	11%
Non-Disabled	9	90%	8	89%
Unknown	0	0%	0	0%

The data shows that disabled staff are represented at Voting Board Membership and Executive Membership. We will be encouraging all Board members to complete their disability status.

4.0 WDES Action Plan for 2025 - 2026

Ref	Metric	Actions	Lead	Timescale
1	1,2,	Debias recruitment NHS programme to be implemented in line with the NHS EDI High impact actions – attraction, recruitment and retention.	Head of People – Recruitment and Retention	**On going**
2	3,4,5,6 & 9	EDI training covering disability awareness and our responsibilities, including the role out of our new Reasonable Adjustment Policy.	Head of EDI	**January 2026**
3	All metrics	Devise a campaign to encouraging staff to complete their equality profiles in ESR by updating their personal data.	Head of EDI & Communication Team	**October 2025**
3	3,4,5,6 & 9	Review existing measures and strengthen our policies in regards to tackling bullying and harassment.	Head of EDI & Head People - Business Partners	**February 2026**
4	4,5 & 6	Set up a system to monitor all cases and of bullying, harassment and abuse. Identify where cases are being recorded, investigated and where the information is provided on case outcomes.	Head of People – Business Partners & Head of EDI	**February 2026**
5	8	Review the sickness policy to align with the Reasonable Adjustment Policy to ensure it sufficiently supports staff and addresses reasonable adjustments.	Head of People – Business Partners	**December 2024**
6	3,4,5,6 & 9	Through our membership with Business Disability Forum - conduct an audit of policies, practices and processes to measure the impact and make improvements for staff with disabilities in the workplace	Head of EDI	**March 2026**
7	9	Deep dive and spot checks on non-mandatory training and CPD process and policy	Head of ODL	**Ongoing 2025**

The Princess Alexandra Hospital NHS Trust

5.4

Appendix 1 – Summary of WDES Matrix

The information below is used to compare disabled with non-disabled staff:

Metric 1 - Percentage of staff in Agenda for Change (AfC) pay-bands (ESR)

Metric 2 - Appointed from shortlisting across all posts (TRAC)

Metric 3 - Staff entering the formal capability process (ESR)

Metric 4 - Staff experiencing harassment, bullying or abuse from service users' managers and colleagues. (Staff Survey)

Metric 5 - Staff believing that the Trust provides equal opportunities for career progression or promotion. (Staff Survey)

Metric 6 - Staff feeling pressured from their manager to come to work, despite not feeling well enough. (Staff Survey)

Metric 7- Disabled staff who are satisfied with the extent to which their organisation values their work. (Staff Survey)

Metric 8 - Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work. (Staff Survey)

Metric 9a - Staff engagement

Metric 9b – Action taken to facilitate the voices of Disabled staff to be heard (Yes or No)

Metric 10 Percentage difference between the organisation's board voting membership and its organisation's overall workforce. (ESR)

The Princess Alexandra Hospital NHS Trust

5.4

Appendix 2 – Definition of disability and monitoring questions

Equality Act 2010

Legal definition of disability15 A person (P) has a disability if— (a) P has a physical or mental impairment, and (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

Social Model of Disability

Using these metrics, NHS organisations are expected to develop data-driven action plans that support improvement in recruitment, retention, development and workforce experience. The WDES also helps to shape inclusive practices, embed accountability and deliver measurable progress in disability equality.

Principles that have informed the design of WDES are the Social Model of Disability, the ethos of 'Nothing About Us Without Us' and the concept of 'Disability as an Asset', which are advocated by Disabled people and disability rights organisations, underpin the WDES.

What is powerful and liberating about the social model is that it reflects the lived experience of Disabled people. It puts forward a radical and practical approach to ending Disabled people's exclusion and oppression that does not require Disabled people to change who they are in order to be deemed to be entitled to the same rights and opportunities as non-disabled people.

The 'social model of disability' recognises that Disabled people face a range of societal barriers, and these, rather than an individual's impairment or long-term condition, create disability.

These barriers can include:

- Buildings and estates – which may have been poorly designed and are not fully accessible. Older buildings may have also been built at a time before accessibility requirements were legally mandated.
- Limited job and career opportunities – As WDES highlights, disabled people are less likely to be appointed to jobs in the NHS. Disabled staff in the NHS are also underrepresented in middle to senior pay bands.
- Working environment – WDES data also highlights the for employers to provide reasonable adjustments. Reasonable adjustments are intended to remove or reduce any barriers that a Disabled colleague may experience in the workplace.
- Attitudinal – Compared to non-disabled colleagues, we also know that disabled colleagues are more likely to experience harassment, bullying or abuse from patients/the public, managers and colleagues. The social model helps people to recognise the barriers that make life harder for Disabled people.

The Princess Alexandra Hospital NHS Trust

5.4

NHS Staff Survey disability monitoring question Q28a.

Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

If YES, please answer part b below; if NO, go to Question 29 Q28b.

Has your employer made adequate adjustment(s) to enable you to carry out your work?
1 Yes
2 No
3 No adjustment required

NHS Jobs disability monitoring question

The Equality Act 2010 protects Disabled people - including those with long term health conditions, learning disabilities and so called "hidden" disabilities such as dyslexia. If you tell us that you have a disability, we can make reasonable adjustments to ensure that any selection processes - including the interview - are fair and equitable.

Do you consider yourself to have a disability?

• Yes • No • I do not wish to disclose this information.

Please state the type of impairment which applies to you.

People may experience more than one type of impairment, in which case you may indicate more than one.

If none of the categories apply, please mark ‘other’.
- Physical impairment
- Learning Disability/Difficulty
- Sensory impairment
- Long-standing illness
- Mental health condition
- Other

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 October 2025

5.5

Agenda item: 5.5 **Presented by:** Arleen Brown Head of Equality, Diversity & Inclusion **Prepared by:** Arleen Brown Head of Equality, Diversity & Inclusion **Date prepared:** 28 July 2025 **Subject:** PAHT Equality, Diversity & Inclusion Annual Report 2024-2025								
Purpose:	**Approval**	x	**Decision**		**Information**		**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	• The EDI annual Report 2024 -2025 provides assurance that the Trust is meeting its statutory duties under the Equality Act 2010. • The report outlines the progress made towards delivering the Trust's annual equality objectives. • Reports on the progress made against the NHSE High Impact Actions. • To note this is mainly a retrospective report showing annual compliance with the national requirements. • Appendix 1 provides a snapshot of staff diversity data as at 31 March 2025. • Appendix 2 provides information of patient service users from Alex health data, October 2024 to March 2025.							
Recommendation:	The Board is asked to: • Note the contents of this report • Approve for publishing in line with national requirements							
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	x	x	x	x	x			

Previously considered by:	PC.29.09.25
Risk / links with the BAF:	Robust performance in relation to equality, diversity and inclusion helps mitigate against risks of service/policy gaps that put protected groups at a disadvantage.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Equality Act 2010 Public Sector Equality Duty CQC Well Led Framework Equality Delivery System
Appendices:	Appendix 1 - Workforce Information EDI Profiles Appendix 2 - Patient Information

The Princess Alexandra Hospital NHS Trust

1.0 Purpose and background to the report

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

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

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

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

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

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

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

1.3 PAH publishes diversity data annually as statutory requirement and as an enabler to meeting its general and specific duties under the under the Equality Act 2010. Our Equality, Diversity and Inclusion (EDI) Reports for:

- Annual Reporting – Equality Objectives
- Work force race equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Equality Delivery System (EDS)
- Gender Pay Gap Report
- Ethnicity Pay Gap Report

Published on our public website.

Equality, diversity and inclusion - The Princess Alexandra Hospital NHS Trust

2.0 Introduction

2.1 PAH, is a 414-bed acute hospital in Harlow, serving a diverse community that includes areas of significant deprivation.

PAH employs 4000 staff and it is vital that our people reflect the wider society that we serve, bringing diverse experience, attitudes and opinions to our work.

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

2.2 We are committed to ensuring that we meet the requirements of the PSED, by monitoring our EDI objectives and reviewing them every 4 years. We have identified appropriate actions in our EDI Strategy 2023 to 2030, which covers both the workforce and patients. In 2024 we developed our EDI delivery plan to deliver the strategy with a summary of the progress being evidenced through this report.

The Princess Alexandra Hospital NHS Trust

3.0 Delivering our Equality Diversity & Inclusion Strategy 2024 -2025

3.1 Our EDI governance process

3.1.1 Our EDI Strategy Delivery Plan features our governance timetable and our EDI annual projects. It ensures our projects are ratified in line with NHSE deadlines. The EDI Delivery of the Plan is monitored through our EDI steering group.

The group consists of a diverse range of managers from departments across the Trust e.g. Freedom to Speak Up Guardian; Head of services from the People & Organisational Development Team; Staff Network Chairs, Head of Communications; Head of Patient Experience; and a variety of representatives from the Clinical Divisions.

3.1.2 The Group is chaired by the Chief People Officer the main purpose of the group is to monitor the EDI Delivery Plan and projects, and to help shape the organisation's strategies and policies to improve the experience of staff and patients
.
The steering group meets quarterly and reports progress to the People committee, as a sub-committee of the board, to ensure visibility and scrutiny of all interventions.

3.2 External drivers set by NHSE

3.2.1 All of our Equality, Diversity and Inclusion reports are ratified through; our EDI Steering Group; Joint Staff Consultative Committee; Executive Board; People Committee; and then to our Trust Board.

3.2.2 Workforce Race and Disability Equality Standards - The national data submissions for the Workforce Race Equality Standard, and the Workforce Disability Standard have been reviewed and an action plan has been developed in response to the findings.

3.2.3 Gender and Ethnicity Pay Gap reporting - The annual Gender Pay Gap Report 2024 has been audited and published. This is the first year that we have also completed an audit and publication on our Ethnicity Pay Gap Report 2024.

3.2.4 Disability Pay Gap Reporting - This year we will be producing our first Disability Pay Gap Report.

3.2.5 Equality Delivery System (EDS) is designed to help NHS Trusts to improve the services we provide to our local communities and provide better working environments, free from discrimination for our staff. The overall aim of EDS is for us to evidence how we meet the requirements of the Equality Act 2010 - Public Sector Equality Duty.

Since April 2014, EDS has been mandated in the NHS Standard Contract and is cited as a key implementation requirement.

During 2024 to 2025 under EDS we reviewed the following services; Paediatrics Maternity & Outpatients.

Our Reports can be found on our website:

Equality, diversity and inclusion - The Princess Alexandra Hospital NHS Trust

3.3 NHSE High Impact Actions

3.3.1 In June 2023, NHS England released a mandated plan for all trusts with the following high impact actions:

1. Measurable objectives for EDI for chairs chief executives and board members.

2.Overhaul recruitment processes and embed talent management processes.

3.Eliminate total pay gaps with respect to race disability and gender

4.Address health inequalities within their workforce

5.Comprehensive induction and onboarding program for international recruited staff

6.Eliminate conditions and environment in which bullying harassment and physical harassment occurs.

3.3.2 Our progress against the 2024/25 actions is summarised in the table below.

Green	Yellow	RED
Green signifies actions that were fully underway or completed by 31st March 2025.	Yellow are actions that were started and will be underway or completed by 31st March 2026	Actions that have not been started

High Impact Actions	Actions	RAG Rating
1 Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	Every board and executive team member must have EDI (SMART) objectives and be assessed against these as part of their annual appraisal process (by March 2024).	
	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).	
	Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).	
2.. Embed fair and inclusive recruitment processes	Create and implement a recruitment plan to improve the diversity of executive and senior leadership	

and talent management strategies that target under-representation and lack of diversity.	teams **(by June 2024)** and evidence progress of implementation **(by June 2025)**	
	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024).	
3. Develop and implement an improvement plan to eliminate pay gaps.	Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (**by March 2024).**	
	Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. **(March 2024)**	
4. Develop and implement an improvement plan to address health inequalities within the workforce.	Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework. **(by October 2023).**	
	Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. **(by April 2025).**	
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.	Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options **(by March 2024)**.	
	Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, staff survey results and cohort feedback **(by March 2024).**	
	Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety **(by March 2024).**	
	Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams,	

	particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression **(by March 2024).**	
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set **(by March 2024)** and plans implemented to improve staff experience year-on-year.	
	Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this **(by March 2024).**	
	Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it. **(By June 2024)**	
	Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff **(by March 2024).**	
	Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence **(by March 2024).**	

3.4 East of England Anti-racism Strategy

3.4.1 We have been working towards achieving the outcomes in the East of England (EoE) Anti-racism Strategy under the following four pillars:

Pillar 1 - Education & Commitment

Pillar 2 – Civility, Respect and Safety

Pillar 3 – Representation

Pillar 4 - Policies

3.4.2 Delivery of the Strategy is monitored through our PAH EDI Strategy Delivery Plan. We will be working through 2025 to 2026 to continue to deliver the actions of the Strategy through our People Directorate and staff networks.

During 2024 to 2025 we have achieved the following:

- Signed up to Unison Race Charter.
- Engaged in a psychological support contract in place from April 2024. The continuation of the service has been promoted widely.
- Implement debias recruitment NHS Programme in line with NHS EDI High Impact actions Attract, recruit and retain.

4.0 Our EDI Strategy Equality Objectives to comply with the PSED

Within our EDI Delivery Plan to comply with the PSED we have published our equality information.

- **Our objectives** - Our four Goals to demonstrate are additional activity
- **Appendix 1** - Workforce Information EDI Profiles
- **Appendix 2 –** Patient Information

4.1 Goal 1: To put equality, diversity and inclusion at the heart of our organisation

4.1.1 Staff Networks

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

The **REACH** has supported the organisation to move forward on race equality with a focus on its three primary objectives:
1. The promotion of *Psychological Safety*
2. Support for *Continuing Professional Development*
3. Achieving our goals through Allyship with other networks.

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

However, we have noticed a decline in attendance and we are actively trying to understand why this has happened, and see how we can address and improve attendance. We want to support our staff so that their voices are heard, and they are able to contribute to any changes needed within the Trust.

4.1.3 The DAWN has been operating for just over 2 years and formed in response to feedback from staff and review of staff survey findings. The purpose of the network is to be an independent and effective voice for staff with long term health conditions and disabilities. We want to ensure that the organisation recognises and responds to the needs of all its staff, thereby increasing staff morale and improving the patient experience.

4.1.4 The **LGBTQ+** staff network re-established its name to **Alex Pride** in 2024 and is running virtually. The network has invited members of the LGBTQ+ community to meetings to share learning and as an opportunity to inform trust policies and practices. The network is linked in with the East of England LGBTQ+ network.

4.1.5 We are developing our staff networks and are in the process of starting a Religion & Belief Women's and Allies network. Our Staff Networks all have executive leads who work with the Chairs to develop the activity for the networks.

Equality impact assessments

4.1.6 Conducting an Equality Impact Assessments (EIA) is part of our legal duty under the Equality Act 2010. We want to ensure that the impact of our decisions is assessed in a structured and robust way. We need to understand and evaluate the impact on the workforce, patients and services users, from different protected groups.

4.1.7 EIA is a tool and that assists the process and supports the Trusts' responsibility to assess the impact of our policies, processes, practices and strategies. The purpose of an EIA is to predict possible positive or negative impacts, and take appropriate action such as removing or mitigating any negative impacts. Where possible, we maximise and promote any potential for positive impacts.

4.1.8 In order for this tool to support our objectives we have engaged with senior leaders to review the process for 2025. We are in the process of reviewing our EIA Template in line with our Quality Impact Assessments, and are working with the H& WE ICS to produce a template to be used across the region.

4.2 Goal 2: Recruit, Retain, Develop and support a diverse workforce

4.2.1 Our Resourcing team has significantly expanded its outreach and engagement activity over the past year. Working closely with community partners, educational institutions, and employability services, we've strengthened pathways into healthcare careers and ensured our recruitment activity reaches a broad and diverse audience.

4.2.2 To improve our aims on creating inclusive recruitment practices we have:

- Reviewed areas identified for improvement based on the Disabled NHS Directors Network (DNDN) Good Practice Toolkit.
- Outline the actions being taken to enhance the inclusivity of our recruitment processes.
- Introduce the transition to Jobtrain, which will enable us to implement more accessible and flexible recruitment practices.
- Actions to be incorporated into next year's Trust-wide Resourcing Action Plan, which will also include actions from the NHS England De-biasing Recruitment Toolkit.

Learning and development

4.2.3 The Trust has rolled out a variety of training ranging from; corporate induction; EDI awareness as part of; inclusive management training for managers. Below is an update on completion of training from last year.

Training	Number of attendees
Corporate Induction (Equality, Diversity & Inclusion).	574
Inclusive Managers	86
Oliver McGowan – e-Learning	1390
Webinar	300
In-Person	194
EDI e-Learning	1396
System Leadership Development (ADDS, Mary Seacole)	8

4.2.4 Talent management and succession planning - A paper regarding proposal for talent management and succession planning process has been approved by the board, with the intention to begin work during Q3/Q4 2025 (pending any potential organisational changes). The strategy and processes include mechanisms to promote diversity and inclusion. Work has begun on identifying external training providers for development training which will be based on the NHS leadership competency framework.

4.2.5 Staff survey – summary of key findings and organisational priorities - In 2024, the staff survey participation rate was 49%, half of the employees surveyed would recommend PAHT as an employer, an improvement on the previous year. There were improvements in the majority of people promise areas, however a slight regression in the area of 'we are compassionate and inclusive'.

Further to analysis, three key areas were selected by the executive board as organisational themes for improvement.

i) We are compassionate and inclusive
ii) We are a team
iii) We are rewarded

4.2.6 Apprenticeships We had 17 application with 24/25 of which 8 were approved throughout the year. The following tables show a breakdown of successful applications;

4.2.7 For 25/26, we have completed an apprenticeship strategy which has been approved by executive board. The strategy includes identifying roles and vacancies that could be filled by upskilling internal employees through apprenticeship training (before sourcing external options), whilst increasing opportunities for jobs and training for external candidates in more diverse areas such as facilities management, IT, finance, HR and business administration.

CPD

4.2.8 We had 680 applications of which 531 applications were improved. The breakdown is as follows;

<u>Ethnicity Representation</u>

- White ethnic group forms the largest segment, around 38% of applicants. (204)
- Asian/Asian British staff represent about 27%. (141)
- Black/Black British applicants make up roughly 11%. (57)
- Mixed/multiple ethnic groups constitute approximately 14%. (76)
- Other ethnic groups, including those of Middle Eastern and other origins, account for the remaining 10%. (53)

4.2.9 Gender Distribution

Female applicants (431) represent the majority, constituting roughly **81%** of the approved applications.

- Male applicants (98) account for approximately 18%.
- A very small percentage, likely less than **1%**, identify as non-binary or have not disclosed their gender.

4.2.10 Disability Status

- Approximately 2% of applicants (12) identify as having a disability.
- The majority (505), around 95%, report no disability.
- A small fraction (14), less than 3%, chose not to disclose their disability status.

4.2.11 Sexual Orientation

- The majority (480), roughly 90%, identify as heterosexual or straight.
- Those who did not want to disclose their status was approximately 1%.
- A small fraction, less than 1%, were bisexual.
- A minor percentage, around 8% (42), preferred not to disclose their sexual orientation.

4.2.12 Work is underway for an extensive Training Needs Analysis in clinical areas to improve the mapping of skills gaps with training courses, which should be complete by February 2026.

Health & Wellbeing

4.2.13 The staff survey results showed a marginal reduction that our people felt that we are keeping them safe and healthy, however the health and safety climate score has seen an improvement, this sub score includes the question relating to my organisation takes positive action on health and wellbeing increased by 0.76%.

4.2.14 As part of our focus on psychological support in April 2024 the health and wellbeing team were successful in being awarded funding from the Trust to support a psychological staff support service commissioned service with Here for You (HFY) via Essex Partnership University Trust, after central funding ceased via the ICS in January 2024. The HFY Staff support service is a core aspect of the Health and Wellbeing offer and strategic direction for staff at PAHT. While it is a specialist clinical service offering psychological assessment and intervention for staff and teams, the service also provides subject-expert led webinars and resources as well as consultation back into the wider organisation and system.

4.2.15 We will be improving our EDI monitoring of staff who use our well-being services across the protected characteristics, by March 2026 we will be setting up monitoring processes.

Our Zero tolerance abuse campaign

4.2.16 In December 2024 we launched a new zero-tolerance campaign, titled '*no excuse for abuse'*, aimed at combating the risk of violence and aggressive behaviour towards our people and encouraging patients and visitors to reflect on their actions.

The new campaign aims to embed a culture of support, safety, and respect at all times and to create an environment that is free from abuse of all kinds, including verbal, physical, and racist taunts.

The visual assets for the campaign are promoted across the hospital, off-site offices, and community sites through vinyl graphics and posters on entrance doors and lifts, including our off-site locations, as well as through digital messaging display screens and social media channels.

4.2.17 In order to further reflect our commitment to creating a workplace that prioritises your safety and wellbeing, the campaign is underpinned by:

- The encouragement of reporting all incidents relating to violence and aggressive behaviour through Datix.
- Enhancing policies and protocols in place to manage challenging behaviours and to guide appropriate action to be taken.
- Introducing a straightforward process to exclude patients from the hospital and community sites, when it is clinically safe to do so, if they have acted violently or aggressively towards our people.
- Providing adequate safety and de-escalation training for colleagues in 'high-risk' environments.
- Developing a violence prevention and reduction strategy.

Sexual Safety Charter Implementation

4.2.18 A subject matter expert (consultant Breast Surgeon) has been appointed from September 2025 to increase compliance of the sexual safety in the workplace e-learning module. This will now be essential training and compliance will be tracked through divisions. A preferred supplier for bespoke situational training has been selected, and a business case is being written for the funding required.

4.2.19 The national MS form has been adopted to report Sexual safety concerns. This has been branded as Tell Alex and will be launched with a communications campaign in October 2025.

4.2.20 The Trust will adopt the national sexual safety policy; this will go for ratification to policy group in October.

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Employee Relations Data

4.2.21 Last year we implemented a new system to record our Employee Relation (ER) data and activity. The following data analyses the total number of staff entering a formal ER process, from April 2024 to March 2025 broken down by ethnicity, gender, disability and age group.

Case Type	Closed	Open	Total	% of Total Cases
Capability Ill – Health	108	214	322	68.66%
Dignity at Work	7	2	9	1.92%
Disciplinary	22	9	31	6.61%
ET	6	4	10	2.13%
MHPS	11	9	20	4.26%
Grievance	19	13	32	6.82%
Performance Management	14	3	17	3.62%
Probation	24	4	28	5.97%
Grand Total	**211**	**258**	**469**	**100%**

Ethnicity	Closed	Live	Total	% of Total Cases
White	109	154	263	56.08%
BME	94	94	188	40.09%
Not Stated	8	10	18	3.84%
Grand Total	**211**	**258**	**469**	**100%**

Disability	Closed	Live	Total	% of Total Cases
Disabled	14	19	33	7.04%
Not Declared	110	58	168	35.82%
Not Disabled	87	181	268	57.14%
Grand Total	**211**	**258**	**469**	**100%**

Gender	Closed	Live	Total	% of Total Cases
Female	163	191	354	75.48%
Male	44	65	109	23.24%
Not declared	4	2	6	1.28%
Grand Total	**211**	**258**	**469**	**100%**

Age Band	Closed	Live	Total	% of Total Cases
16-20	3	3	6	1.28%
21-25	9	14	23	4.90%
26-30	16	39	55	11.73%
31-35	23	30	53	11.30%
36-40	22	36	58	12.37%
41-45	25	30	55	11.73%
46-50	22	24	46	9.81%
51-55	23	23	46	9.81%
56-60	22	34	56	11.94%
61-65	15	18	33	7.04%
66-70	1	1	2	0.43%
71-75	1	2	3	0.64%
Blanks	29	4	33	0.07
Grand Total	**211**	**258**	**469**	**100%**

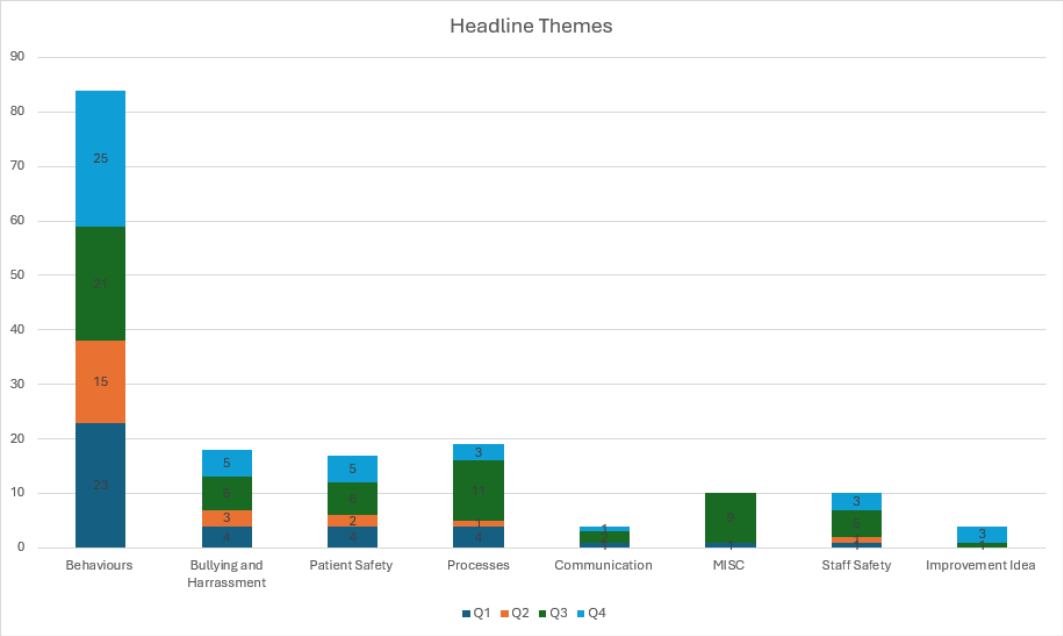
Freedom to Speak Up (FTSU)

4.2.23 The FTSU service has increased the number of ambassadors from a wide range of ethnic and professional backgrounds to help break down barriers to speaking up. We currently have 29 FTSU ambassadors who have a wide range of ethnic and professional backgrounds.

4.2.24 There is a plan to increase the number of guardians to include staff from ethnic backgrounds and the guardians will continue to attend the staff network meetings to raise their profile and to try and understand the barriers to some staff speaking up to identify actions required to address them. The guardians have begun formal training with the Trust EDI lead to raise their awareness as well as the annual refresher module they undertake on EDI.

4.2.25 The data on the protected characteristics was very limited this year so to address this the new feedback forms will include voluntary submission for staff to feed back any PCs.

The following diagram is a summary of the cases (by concern theme) we handled over the last year.



4.3 Goal 3: Improve patient experience and outcomes for people with protected characteristics and other communities who experience marginalisation.

Appendix 2 – Sets out our patient service user demographics.

4.3.1 Over the coming year we will be working on:

- Improving the recording and monitoring of protected characteristic data for patients.
- Use patients and service user experiences to inform and improve the design of our services.
- Ensuring working practices and spaces are accessible for all - (Accessible information Standard - AIS).

4.4 Goal 4: Engage our diverse communities across our services and pathways

4.4.1 Over the coming year we will be working on:

- Reviewing the implementation of Patient & Carer Race Equality Framework (NHS Standard Contract).
- Increasing collaboration and co-design and production with protected groups, particularly in our work on the new hospital and new electronic health record aligned to CORE20PLUS5 and the major conditions.
- Engage all relevant stakeholders in the promotion of the Equality Delivery System (EDS) agenda and achievements ensuring all protected characteristics are addressed

Partnership working

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

Business Disability Forum

4.4.3 Through our new membership with the Business Disability Forum, we will be undertaking a disability self-assessment audit by February 2026, to examine and improve policies and practices across the organisation.

We will work in partnership with other Trusts to improve the experience of staff, patients and service users.

5.0 NHS Confederation Diversity in Health and Care Partners Programme

5.1 In July 2025 we successfully completed the NHS Confederation Diversity in Health and Care Partners Programme.

5.2 The areas below cover the objectives of the programme and will continue to help us in the transformation needed to embed EDI into our culture and foster PAH to carry on being an inclusive organisation.

5.3 Strategic reasons for joining the programme:

Transformation and sustainable change;

- Become more **strategic**
- Effect EDI **Change**
- **Develop** the EDI function following a restructure
- Develop EDI leads in their **career paths**
- **Weave** EDI through everything we do.

Shared and collaborative learning;

- **Network**, sharing. Benchmarking and learning
- **Go outside** our organisational **bubble**
- **Shared approach** to the NHS EDI Improvement Plan
- Be **empowered** and **inspired**
- **Celebrate beliefs** and share life stories

Develop anti-racist strategies:

- **Identify** intervention in line with **Too Hot to Handle** Report
- **Support** Internationally educated colleagues
- **Address** the causes of racial inequality

Inclusive Leadership

- **Improve** leadership behaviours and **accountability**
- Compliance with the **Public Sector Equality Duty**
- **Empower leaders** to align their leadership to the National EDI agenda

5.4 Operational reasons for joining the programme:

Build stronger staff engagement cultures

- Develop **staff networks**
- Develop a **culturally competent** workforce
- **Empower managers** to handle difficult conversations

Improve recruitment, retention, and progression strategies

- Ensure **equitable representation** across all levels
- Develop an enhanced recruitment and **career development** process

Address bullying, harassment and violence in the workplace

- Promote **positive behaviours**
- Develop **clear strategies** to tackle systemic inequalities
- **Support staff** with lived experience
- Support **sexual safety** and prevent sexual harassment
- Increase **psychological safety**

Data competent

- Use and analyse data through an **EDI dashboard**
- **Improve** EDI metrics
- Enhance **equality analysis** (EIA'S) and risk monitoring practices
- Create performance indicators that **hold managers to account**

6.0 Recommendations

6.1 The Board is asked to:

1. Note the content of this report

2. Approve for publishing in line with national requirements

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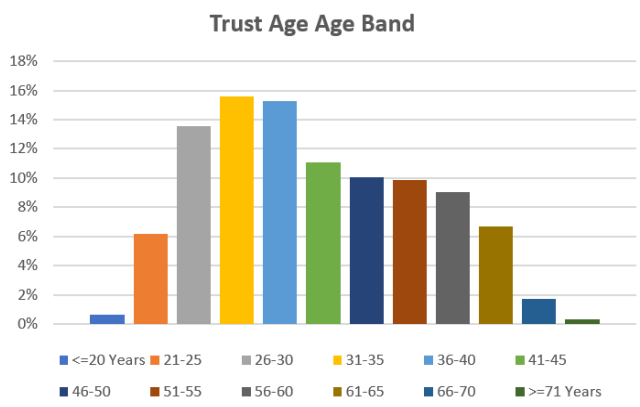
Appendix 1 - PAHT Equality Workforce Profile March 2025



	Trust Total	
Age	**Headcount**	**%**
<=20 Years	27	1%
21-25	256	6%
26-30	561	14%
31-35	647	16%
36-40	632	15%
41-45	460	11%
46-50	416	10%
51-55	410	10%
56-60	376	9%
61-65	276	7%
66-70	71	2%
>=71 Years	14	0%
Grand Total	**4146**	**100%**

	Trust Total	
Disability	**Headcount**	**%**
No	3129	75%
Not Declared	838	20%
Prefer Not To Answer	23	1%
Yes	156	4%
Grand Total	**4146**	**100%**

	Trust Total	
Ethnicity Group	**Headcount**	**%**
BME	1896	46%
Not Stated	119	3%
White	2131	51%
Grand Total	**4146**	**100%**

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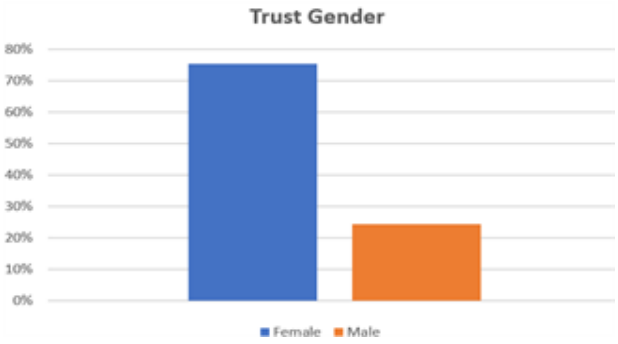
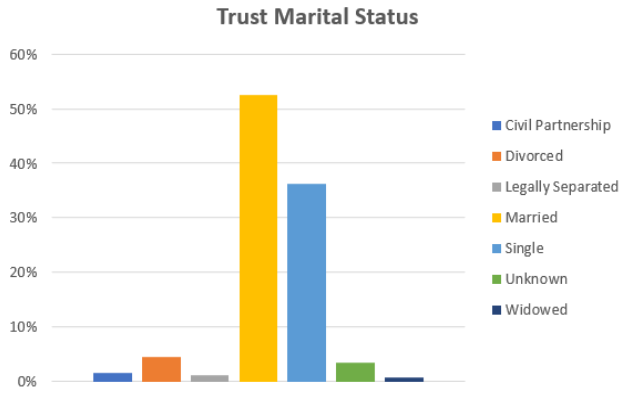
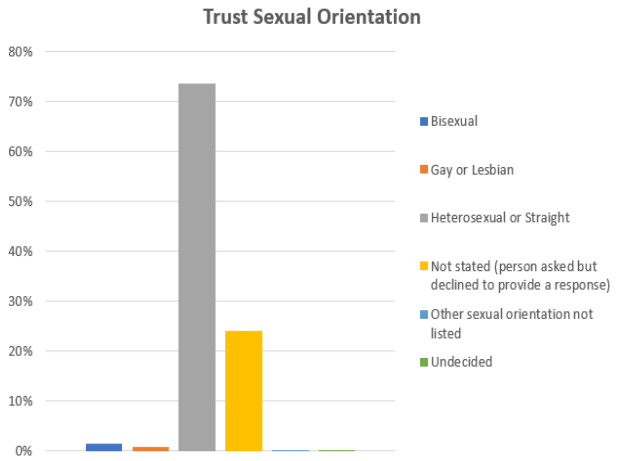


	Trust Total	
Gender	**Headcount**	**%**
Female	3132	76%
Male	1014	24%
Grand Total	**4146**	**100%**



	Trust Total	
Marital Status	**Headcount**	**%**
Civil Partnership	64	2%
Divorced	190	5%
Legally Separated	46	1%
Married	2174	52%
Single	1501	36%
Unknown	139	3%
Widowed	32	1%
Grand Total	**4146**	**100%**



	Trust Total	
Sexual Orientation	**Headcount**	**%**
Bisexual	55	1%
Gay or Lesbian	32	1%
Heterosexual or Straight	3050	74%
Not stated (person asked but declined to provide a response)	997	24%
Other sexual orientation not listed	6	0%
Undecided	6	0%
Grand Total	**4146**	**100%**

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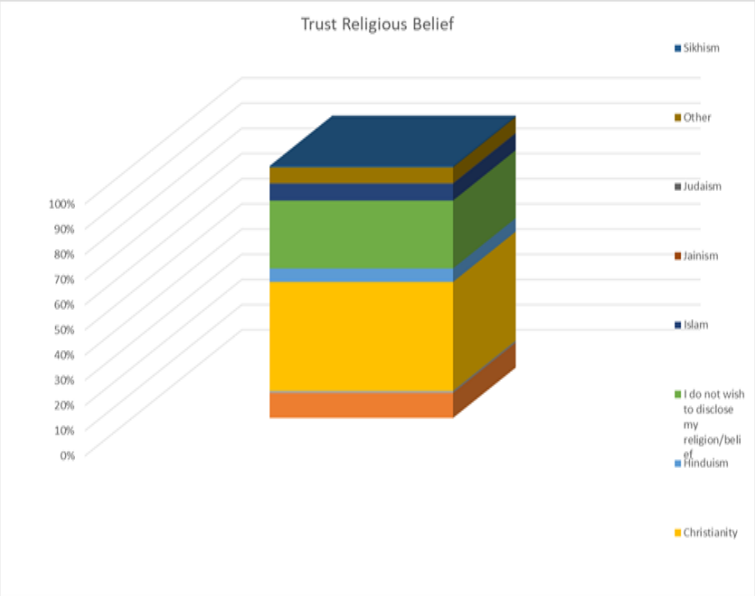

	Trust Total	
Religious Belief	**Headcount**	**%**
Atheism	410	10%
Buddhism	36	1%
Christianity	1791	43%
Hinduism	222	5%
I do not wish to disclose my religion/belief	1117	27%
Islam	275	7%
Jainism	1	0%
Judaism	13	0%
Other	258	6%
Sikhism	23	1%
Grand Total	**4146**	**100%**

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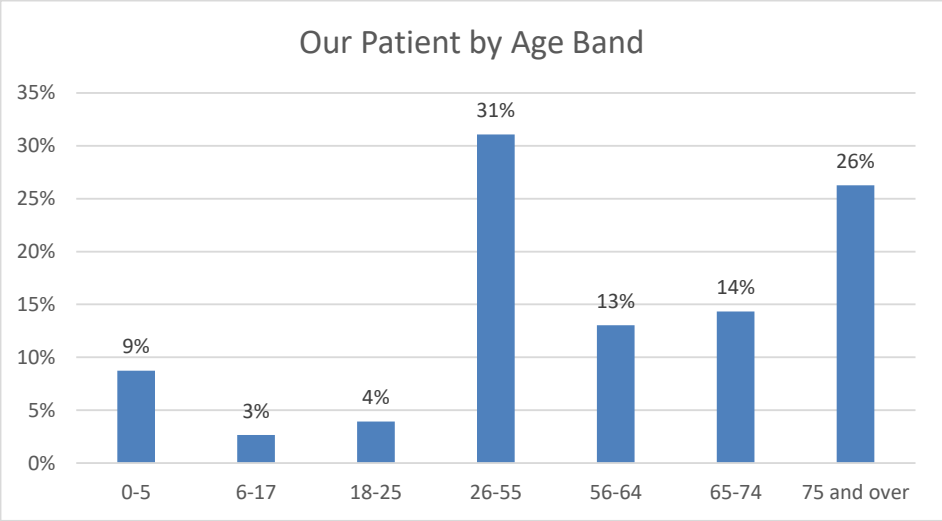
Appendix 2 – Informatics Patient Demographics

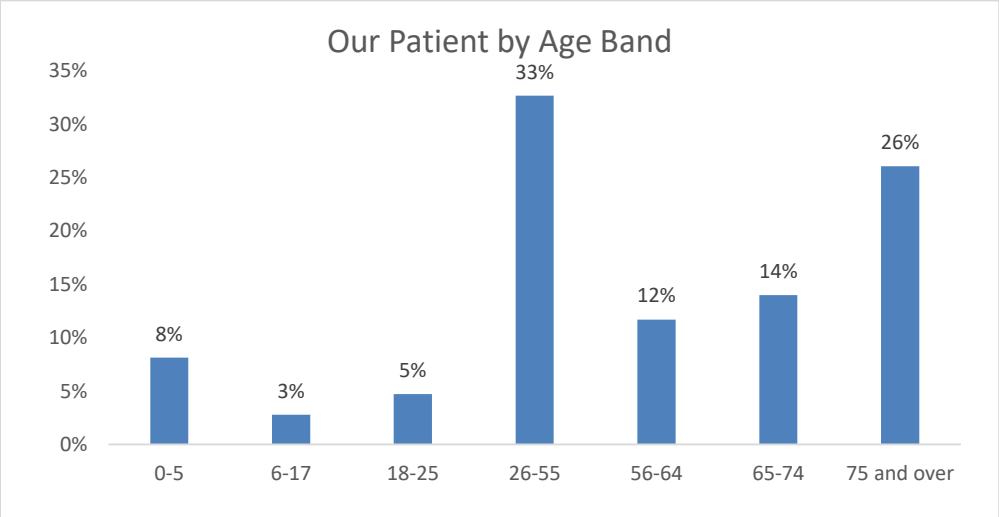
Notes

- Data is between period of October 2024 - April 2025
- Cosmic data – April 2024 - October 2024
- Alex Health data – 4th November – 31 April 2025

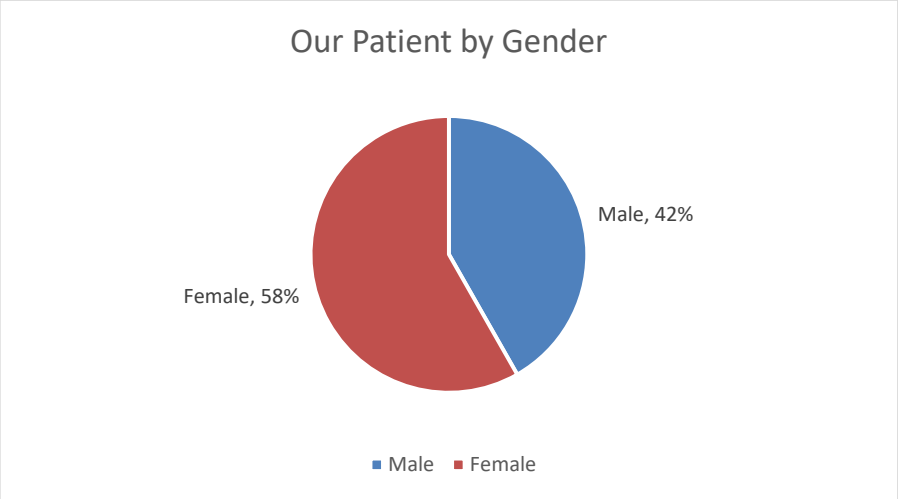
Our Patient by Age March 2024



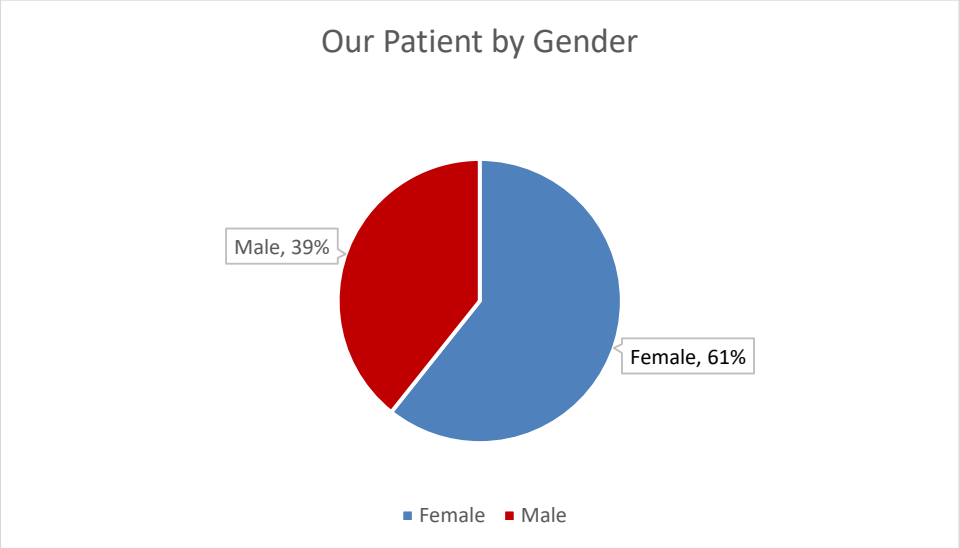
Our Patient by Age Band 2025



Our Patient by Gender March 2024

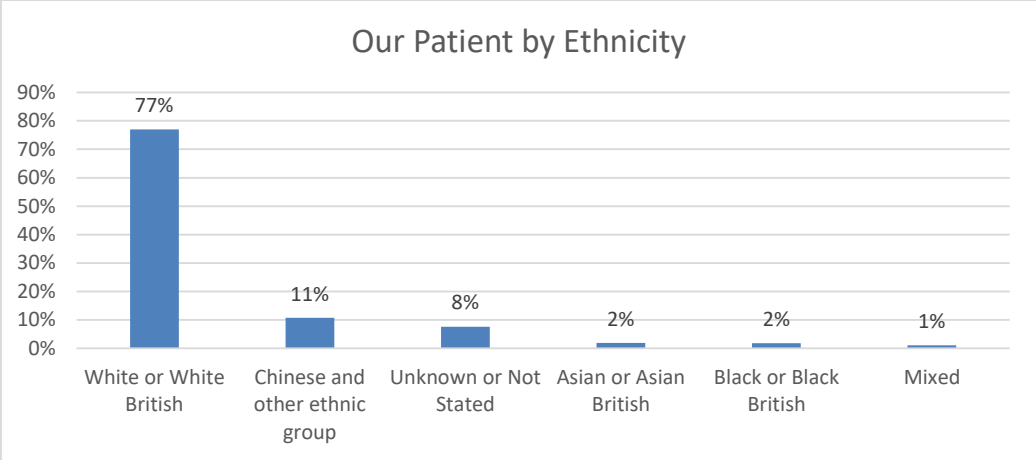


Our Patient by Gender March 2025

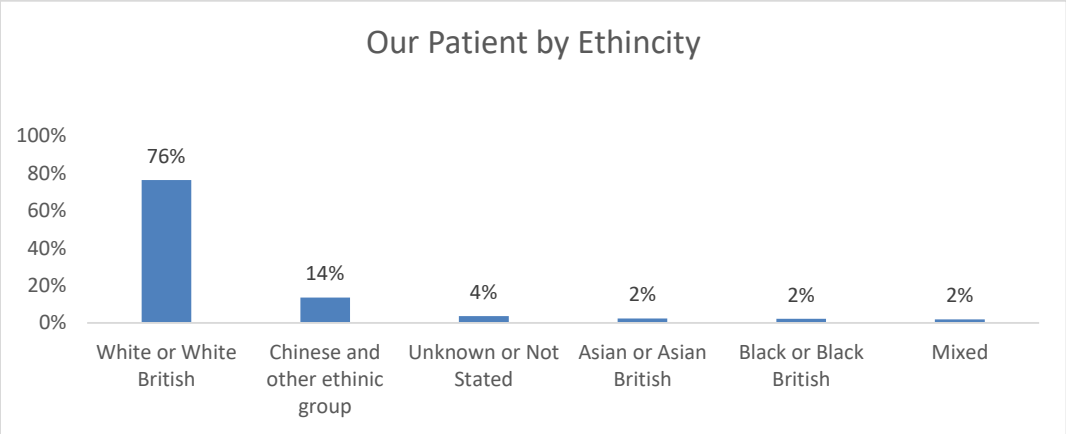


The Princess Alexandra Hospital NHS Trust

Our Patients by Ethnicity March 2024



Our Patients by Ethnicity March 2025



The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31.07.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 M5 Integrated Finance Report	Y	Y	N	The Trust declared a deficit of £0.5m in M5 of 25/26 against a planned deficit of £0.6m. The Trust is on plan year to date. Agency expenditure in-month was higher than it had been in the last 3 months and bank costs remained high and were not reducing in line with the target set by NHSE. Capital was on plan with expenditure to date of £8.6m against a full year plan of £31.4m. Cash at the end of August was £19.4m. There was agreement to start presenting an analysis of non-pay costs going forward.
2.2 25/26 Forecast including Underlying Position	Y	Y	N	The 2025/26 forecast position at M5 was a deficit of £6.7m against a break-even plan. Potential mitigations had been identified which could close the gap, but further review and analysis was required. NHSE had requested all organisations complete an underlying position for 2025/26 to support with future planning. The PAHT underlying position was a £29.1m deficit.

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DATE OF COMMITTEE MEETING:	**31.07.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.3 Capital & Capital Projects Update	Y	Y	N	The presentation provided an update on the Community Diagnostic Centre (St. Margaret's Hospital), Pathology mobilisation, the potential move of Phlebotomy services to the Harvey Centre, the Surgical Hub (St. Albans), Alex Health and the IMS project. Given the usual urgency with which capital needed to be spent and the urgency to approve associated business cases, PAF agreed to a 'start of the financial year' Trust Board discussion around priorities for the year ahead in the current strategic landscape. Bi-monthly updates on the larger strategic capital developments will be presented to PAF with business-as-usual capital updates continuing in line with the workplan. It had been identified that with the urgency of spending capital, delegation may be sought from Board for a number of capital business cases to ensure delivery within the current financial year.
2.4 PQP Update	Y	Y	N	The Trust had a PQP target of £2.0m in M5 which had been fully delivered. The PQP plan was therefore on track at £9.2m YTD.

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REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31.07.25**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Quarterly Procurement Update	Y	Y	N	This report was noted.
2.6 Paeds ED and UEC Developments	Y	Y	N	Included under item 2.3 above.
2.7 Business Case: Emergency Medicine Additional Consultants				The business case was endorsed following approval at Executive Board The case sought to increase the Emergency Medicine consultant establishment by 2.0 WTE, from 13.0 to 15.0 WTE. This would help meet national workforce standards, improve patient safety, enhance operational performance, and reduce reliance on bank spend. The Trust's performance against the 4-hour standard remained significantly challenged, with the current trajectory falling short of the 78% target by March 2026.
2.8 BAF Risk 5.1 (Finance: Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16. PAF agreed however to consider some additional narrative to reflect cashflows following ICB boundary changes.

3.1 M5 Integrated Performance Report	Y	Y	N	Key headlines were: **UEC Performance:** The Trust achieved 75% for the 4 hour standard against a trajectory of 71% following the re-designation of Furthers. **12 hour ED Waits:** % of patients in ED over 12 hours had significantly risen and was above trajectory at 12% for August against a trajectory of 7.4%. **Ambulance Handover:** Handover times had deteriorated to 34.22 minutes against a trajectory of 35 minutes. **Diagnostics:** Diagnostics performed within 6 weeks of referral had slightly decreased for July to 65.49% from 66.26% in June. **Cancer:** For 28-day faster diagnosis standard performance was 73.4% in July, with August's unvalidated position currently at 66.6% against a trajectory of 77%, validations were on-going. The greatest risk to Trust performance sat with Urology, Upper GI, and Lower GI. Diagnostic capacity was the key risk for the 28-day performance. For the 62-day standard finalised performance for July was 57.7%, a marked improvement on the June performance of 41.8% - 16% improvement (and August's unvalidated position was 55.0%). **RTT Elective Standards**: The Trust had 27 live 65+ week wait breaches at month end in July 2025, an increase on the 12 breaches in June. The increase was directly linked to ASI drop-offs and pop-ins onto the PTL. For 52-week breaches, the Trust ended July 2025 on a total of 2402 breaches (5.1% of total PTL size) and June on 2265 breaches (4.7% of total PTL size). July performance was behind plan of 2066. This increase was directly linked to ASI drop-offs/pop-ins onto the PTL. The Trust's 18 RTT week performance had drastically improved in recent months from 41.8% for December 2024, up to 52% in July 2025.
3.2 Oversight Framework	Y	Y	N	PAHT was in Segment 4 of this framework and ranked 120 out of 134 trusts. The dashboard within the report provided a high-level review of PAHT performance against each segment of the

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 6.1**
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DATE OF COMMITTEE MEETING:	**31.07.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				framework along with the actions being taken to address the areas of underperformance.
3.3 Cancer Update/Strategy	Y	Y	N	There had been excellent engagement at the recent Cancer Summit, following two external cancer reviews undertaken by NHSE and BHRUT. A number of recommendations had now been made including the strengthening of leadership and the role of senior nurses. 30, 60 and 90 day frameworks would now be developed with continuing oversight at the Cancer Board. A detailed report will be presented to PAF in October.
3.4 Quarterly Digital Update	Y	Y	N	This paper provided an update on the Trust's Digital Programme. Key issues included a number of challenges with 'first of type' implementations particularly for VitalsLink and the depth and complexity of the Digital programme with multiple projects running in parallel.
3.5 BAF Risk 1.3 (Operating Plan)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15. It was agreed the narrative would be updated to include current ASI issues prior to presentation at Board.

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DATE OF COMMITTEE MEETING:	**31.07.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
3.6 BAF Risk 1.4 (EHR)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
3.7 BAF Risk 1.5 (Cyber)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 6.1**
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REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31.07.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 Estates Strategy	Y	Y	N	Following the deferment of the PAHT New Hospital to Wave 2 of the New Hospital Programme (earliest build 2034), the Trust had initiated a short-term Estates Strategy to ensure safe operation of the acute site to 2034. The report provided an update on current findings and options to date from the draft Estates Strategy. The draft strategy identified high and significant priority works to address immediate critical infrastructure risks and patient safety issues. A focus on decant space, phased refurbishment of inpatient and acute treatment areas (including Theatres and Maternity), and progressive PLACE initiatives to deliver more care in the community, consistent with the NHS Long Term Plan. It also summarised findings from the NHS Facet Survey, outlined investment requirements (£120m incl. on-costs) and set out priority areas for early investment.

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REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31.07.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.2 Estates & Facilities Quarterly Update	Y	Y	N	In 2024/25, PAHT invested over £8m in estates and facilities to enhance patient care, staff wellbeing, and infrastructure resilience. Key achievements 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 were 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.
4.3 Deep Dive on Special Interest Topic: SMH Redevelopment	Y	Y	N	It was agreed to defer this item to the next meeting.

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REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31.07.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
4.4 Green Plan	Y	Y	N	The Princess Alexandra Hospital NHS Trust was committed to delivering on the NHS Net Zero agenda and aligning fully with NHSE Green Plan guidance. Given the submission to be made to NHSE by the end of October, it was agreed to present the Plan to Trust Board on 02.10.25 with a request for delegated authority back to PAF to sign-off the final plan/submission.
4.5 Summary Report from Health & Safety Committee	Y	Y	N	The key risk related to fire compliance and this had been discussed in detail earlier in the meeting.
4.6 Strategic Portfolio Update	Y	Y	N	This update was noted.
4.7 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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REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**31.07.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.8 BAF Risk 3.5 (New Hospital)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

Trust Board – Thursday 2 October 2025

Agenda item:	6.2								
Presented by:	Tom Burton, Chief Finance and Infrastructure Officer								
Prepared by:	Beth Potton, Deputy Director of Finance								
Date prepared:	22 September 2025								
Subject / title:	Month 5 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 declared a deficit of £0.5m in month 5 of 25/26 against a planned deficit of £0.6m. The Trust is on plan year to date. Agency expenditure in month was higher than it has been in the last 3 months and bank costs remain high and are not reducing in line with the target set by NHSE. The Trust had a PQP target of £2.0m in month 5 which was fully delivered, the PQP plan is therefore on plan at £9.2m YTD. Capital is on plan with expenditure to date of £8.6m against a full year plan of £31.4m. Cash at the end of August was £19.4m.								
Recommendation:	The Board is asked to note the month 5 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:	
Risk / links with the BAF:	BAF risk 5.1 (Finance: Revenue)
Legislation, regulatory, equality, diversity, and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

September - Month 5

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a deficit of £0.5m in month 5 of 25/26 against a planned deficit of £0.6m, this is a positive continuation of achievement of the plan from the start of the financial year, with PQP delivering in month and YTD.

- Agency expenditure in month was higher than it has been in the last three months (£0.5m in month versus £0.2m in recent months). Whilst this is still significantly reduced on 24/25 spending, the sudden increase in month is concerning. Medicine and CSS are the areas with the highest increases which will be picked up in the monthly PQP meetings. Agency costs were 2.2% of total pay in month.

- Bank costs 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, whilst there was a small reduction in M5 this has not been achieved so far, this financial year.

- The Trust had a PQP target of £2.0m in month 5 which was fully delivered, the PQP plan is therefore delivering YTD. 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. There is a large proportion of YTD delivery that is non recurrent, we will need divisions to work to convert these into recurrent PQPs to put PAHT in the best position next financial year.

Summary financial results

The Princess Alexandra Hospital NHS Trust

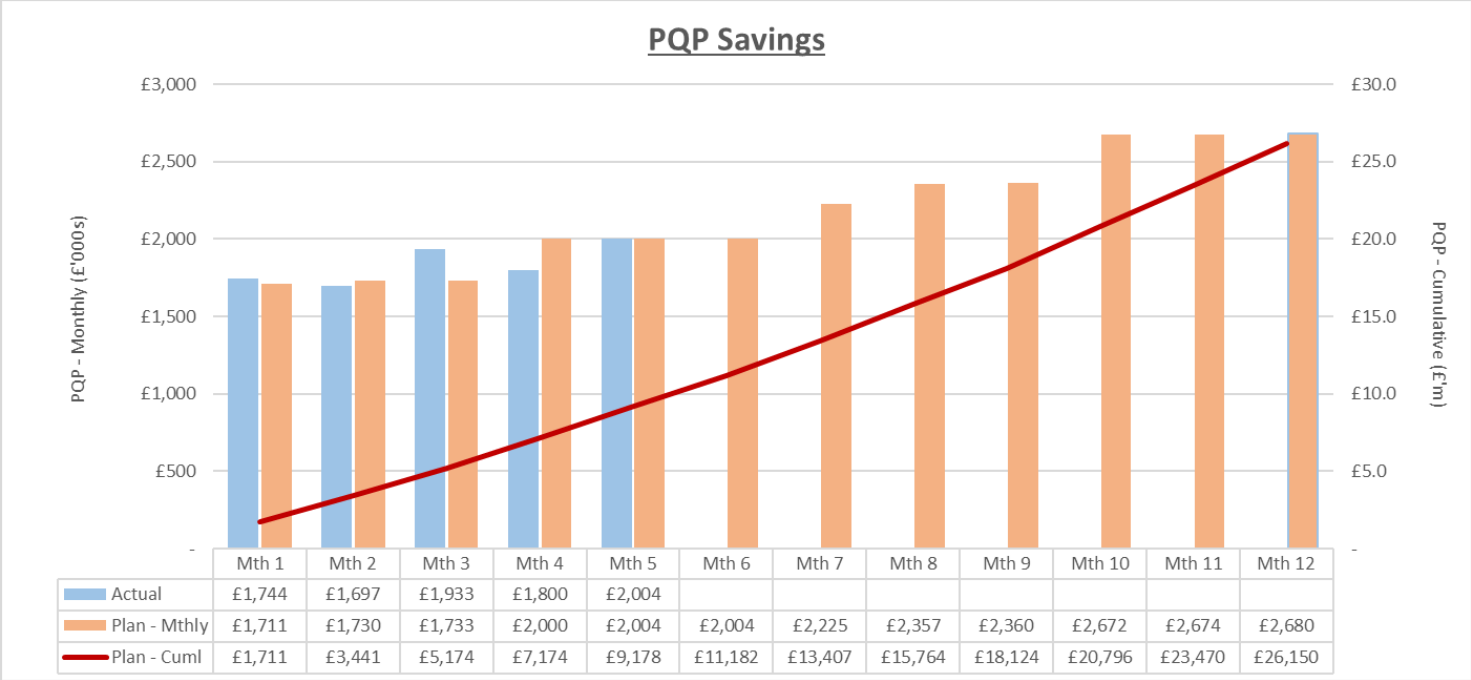
	FY Budget £'m	Aug-25 Budget £'m	Aug-25 Actual £'m	Aug-25 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	411.1	33.7	34.1	0.4	170.0	170.9	0.9
Pass through Income	20.3	1.7	1.6	(0.1)	8.5	8.2	(0.3)
Income Total	**431.4**	**35.4**	**35.6**	**0.3**	**178.5**	**179.0**	**0.6**
Pay							
Substantive	(276.2)	(22.8)	(20.6)	2.1	(115.4)	(103.9)	11.4
Bank	(7.1)	(0.9)	(2.4)	(1.5)	(3.0)	(12.4)	(9.4)
Agency	(3.1)	(0.3)	(0.5)	(0.2)	(1.3)	(1.7)	(0.4)
Pay Total	**(286.4)**	**(23.9)**	**(23.6)**	**0.3**	**(119.6)**	**(117.9)**	**1.7**
Non-Pay							
Drugs & Medical Gases	(11.5)	(0.9)	(0.9)	0.0	(4.6)	(4.2)	0.4
Pass through expenditure	(20.7)	(1.7)	(1.7)	0.0	(8.6)	(8.3)	0.3
Supplies & Services - Clinical	(14.6)	(1.2)	(1.6)	(0.4)	(6.0)	(7.7)	(1.7)
Supplies & Services - General	(6.3)	(0.5)	(0.5)	0.0	(2.6)	(2.1)	0.4
All other non pay costs	(68.9)	(5.8)	(6.0)	(0.2)	(30.1)	(32.1)	(2.0)
Non-Pay Total	**(122.0)**	**(10.2)**	**(10.7)**	**(0.5)**	**(51.9)**	**(54.4)**	**(2.5)**
Financing & Depn							
Depreciation	(17.8)	(1.5)	(1.5)	0.0	(7.4)	(7.4)	(0.0)
PDC & Interest	(5.5)	(0.5)	(0.4)	0.1	(2.3)	(2.0)	0.3
Financing & Depn Total	**(23.3)**	**(1.9)**	**(1.9)**	**0.1**	**(9.7)**	**(9.4)**	**0.3**
Total	**(0.3)**	**(0.7)**	**(0.5)**	**0.2**	**(2.7)**	**(2.7)**	**(0.0)**
Technical Adjustment	0.3	0.0	0.0	0.0	0.1	0.1	0.0
Grand Total	**0.0**	**(0.6)**	**(0.5)**	**0.2**	**(2.6)**	**(2.6)**	**(0.0)**

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 5, the Trust delivered £2.0m PQP against a plan of £2.0m, therefore meeting plan YTD. 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	£1,697	£1,933	£1,800	£2,004							
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	Jul-25	Aug-25	Movement In Month	Movement YTD
	£'m	£'m	£'m	£'m	£'m
Non-current assets					
Property, plant & equipment	189.1	191.4	192.5	1.1	3.4
Right of use assets	43.1	42.1	41.9	(0.2)	(1.2)
Intangible assets	32.1	31.6	31.0	(0.6)	(1.1)
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**265.4**	**266.2**	**266.5**	**0.3**	**1.1**
Current assets					
Inventories	4.2	4.2	4.2	-	-
Trade & other receivables	10.5	19.2	18.7	(0.5)	8.2
Cash & cash equivalents	28.6	18.8	19.4	0.6	(9.3)
Current assets	**43.3**	**42.2**	**42.2**	**0.0**	**(1.1)**
Total assets	**308.7**	**308.4**	**308.7**	**0.3**	**0.0**
Current liabilities					
Trade & other payables	(46.1)	(49.3)	(49.8)	(0.5)	(3.7)
Provisions	(1.2)	(1.2)	(1.2)	-	-
Borrowings	(2.7)	(2.7)	(3.2)	-	-
Current liabilities	**(50.0)**	**(53.2)**	**(54.2)**	**(0.5)**	**(3.7)**
Net current assets/ (liabilities)	**(6.6)**	**(11.0)**	**(12.0)**	**(0.5)**	**(4.8)**
Total assets less current liabilities	**258.7**	**255.2**	**254.5**	**(0.2)**	**(3.7)**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.0)	(1.0)	(1.0)	0	-
Borrowings	(40.2)	(39.3)	(39.1)	0.2	1.1
Total non-current liabilities	**(41.2)**	**(40.3)**	**(40.1)**	**0.2**	**1.1**
Total assets employed	**217.5**	**214.9**	**214.4**	**0.0**	**(2.7)**
Financed by:					
Public dividend capital	384.6	384.2	384.2	- 0	- 0
Income and expenditure reserve	(172.6)	(183.1)	(183.6)	-	(11.0)
Other reserves	(8.3)	0.0	0.0	0.0	8.3
Revaluation reserve	13.8	13.8	13.8	-	-
Total taxpayers' equity	**217.5**	**214.9**	**214.4**	**(0.0)**	**(3.1)**

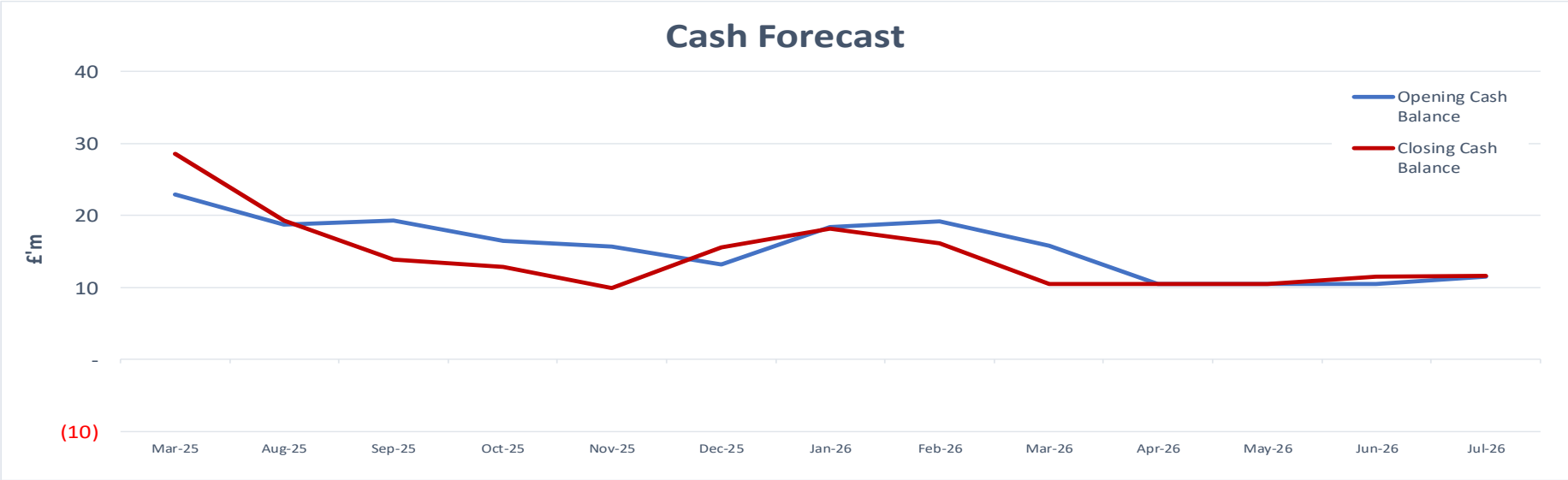
- Non-Current Assets: PPE has increased by £1.1m and is due to Non-Residential & Plant & Machinery AUC additions. A decrease of £0.2m in ROU assets is mainly due to ROU depreciation charge during the year. A decrease of £0.6m in intangible assets relates to amortisation and GRNI credit.
- Trade and Other Receivables have decreased by £0.5m with HSL LLP and EPUT's early settlement of their invoices largely contributing to this.
- Cash balance has increase by £0.6m is mainly due to higher volume of receipts from HSL of £1.6m, EPUT of £0.3m and alongside various other receipts of £0.2m. These inflows were partially offset by payments amounting to £1m to Cambridge University Hospital and £0.5m to ENHT.
- Trade and other payables has increased by £0.5m due to receipt of new unpaid supplier's invoices.
- Borrowings decrease represent payment of ROU lease repayment & Interest charge.

AUC – Assets Under Construction
ROU – Right of Use
PPE – Property, plant and equipment
GRNI – Goods receipted not invoiced

Cashflow

The Princess Alexandra Hospital NHS Trust

	<----Actual---->		<----------Forecast---------->										
	Mar-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26 *
Opening Cash Balance	22,934	18,785	19,358	16,473	15,715	13,153	18,439	19,216	15,774	10,464	10,532	10,498	11,498
Closing Cash Balance	28,628	19,358	13,911	12,849	9,920	15,617	18,172	16,175	10,464	10,532	10,498	11,498	11,572



Cash balance has increased by £0.6m mainly due to higher volume of receipts from HSL of £1.6m, EPUT of £0.3m and alongside various other receipts of £0.2m. These inflows were partially offset by payments amounting to £1m to Cambridge University Hospital and £0.5m to ENHT.

Capital Analysis 25/26

NHS
The Princess Alexandra Hospital

	Month 5			YTD			Forecast		
	In-Month Plan £'m	In-month Actual £'m	Variance £'m	Plan £'m	Actual £'m	Variance £'m	Plan & profile £'m	FY FoT	Variance £'m
Internally Funded Schemes									
Estates									
Estates: Domestic Water Risks	42	42	0	154	154	0	500	500	-
Estates: Electrical-Distribution-BAU	12	12	0	128	128	(0)	400	400	-
Estates: Electrical-BAU-Theatre Lighting 5, 6 and 7	-	-	-	-	-	-	120	120	-
Estates: Fire-BAU-Fire door	-	-	-	0	0	-	250	250	-
Estates: Critical AHU Plant Serving Wards-BAU	-	-	-	-	-	-	172	172	-
Estates: Steam Heating-BAU	23	23	(0)	128	128	(0)	128	128	-
Estates: Fire-CIR- Compartmentation & Fire Doors Match funding	29	29	0	318	318	(0)	1,017	1,017	-
Estates: Main Tower block-BAY-upgrade of main lifts (3N0)	73	73	(0)	170	170	0	200	200	-
Estates: Flooring-BAU-Site Wide flooring repairs - slips, trips and falls	-	-	-	-	-	-	100	100	-
Estates: Sitewide boundary fencing upgrade for security-BAU	-	-	-	-	-	-	60	60	-
Estates: Edge protection systems-BAU	-	-	-	-	-	-	50	50	-
Estates Dishwasher	27	27	0	27	27	0	-	27	(27)
HDU Works	-	-	-	-	-	-	-	200	(200)
Phlebotomy refurb	-	-	-	-	-	-	-	200	(200)
CDC									
CDC	1,793	1,793	(0)	5,778	5,779	(0)	11,029	11,029	-
EHR, ICT & Info									
ICT & Information Schemes	14	13	1	364	363	1	-	564	(564)
EHR	(233)	(233)	(0)	671	671	0	770	1,867	(1,097)
	-								
Corporate									
Corporate schemes	-	-	-	-	-	-	3,300	3,300	-
Medical									
Medical Equipment (Surgery)	-	-	-	-	-	-	-	26	(26)
Medical Software (Medicine)	-	-	-	-	-	-	21	66	(45)
Refurbishment (UTC Works Phase 1)	-	-	-	77	77	-	-	77	(77)
Medical Equipment (CHAWS)	-	-	-	-	-	-	-	66	(66)
CRL to be allocated to plan	-	-	-	-	-	-	-	-	-
YTD Total	1,779	1,778	1	7,817	7,816	1	18,117	20,419	(2,302)
Externally Funded Schemes									
Fire-CIR- Compartmentation & Fire Doors	-	-	-	-	-	-	1,500	1,500	-
Electrical CIR IPS/UPS and Distribution	4	4	0	91	91	(0)	1,083	1,083	-
Childrens ED	-	-	-	-	-	-	1,750	1,750	-
Phase 2 UTC Corridor Refurbishment	104	104	0	466	466	(0)	2,000	2,000	-
CDC	-	-	-	-	-	-	3,000	3,000	-
CDC Equipment (Pathways funding)	-	-	-	-	-	-	163	163	-
NHP	50	50	(0)	168	168	0	2,470	2,470	-
Gamma Probe - Surgery	-	-	-	36	36	(0)	36	36	-
Image Intensifier - Surgery	-	-	-	65	65	(0)	65	65	-
Olympus Keymed CF-Q260DL ADU Endoscopy	-	-	-	-	-	-	920	920	-
Flexible Nasal Endoscopy	-	-	-	-	-	-	86	86	-
Redirooms, canopies and Provide HPV systems	-	-	-	-	-	-	211	211	-
	-	-	-	-	-	-	-	-	-
YTD spend on External Schemes	158	157	0	826	827	(1)	13,284	13,284	-
Total - Internal and External	1,936	1,936	2	8,642	8,642	(0)	31,401	33,703	(2,302)

Plan
Total capital funding approved by the ICS is £31.4m. Included within this is £13.3m of external funding.

Actual and Forecast
Total Capital expenditure for the year to date is £8.6m, which is as planned.

Key Messages:
1. Overspend - The EHR forecast shows a £1.1m budget variance. This is under close review to ensure mitigation actions prevent any further financial deviation.

2. £651k YTD invoices reclassified from capital to revenue due to subscriptions, licenses, warranties, and prepayments.

3. Capital team are finalising 2025/26 forecast with leads.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 October 2025

Agenda item:	6.3							
Presented by:	Camelia Melody – Acting Chief Operating Officer							
Prepared by:	Informatics Team							
Date prepared:	24th August 2025							
Subject / title:	M5 Integrated Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	
Key issues:	**Patients Summary** • **Pressure Ulcers (PU):** The data page for PU isn't included within the pack pending a review of the data set. A briefing paper is planned to be tabled at QSC (Sept) with the PU data set. Of note, as reported in the previous month, there has been an increase in the number of PUs across the organisation which is under the strong focus of the nursing teams with quality surveillance in place across two wards and a nursing quality summit scheduled in September. • **Patient experience:** The number of complaints received by the organisation continues to be higher than Q3 2024/25. Thematically, the concerns raised remain unchanged and are aligned to the feedback received through our adult inpatient survey. A paper detailing our inpatient survey is included within the QSC and Board papers. FFT is also included within the IPR, with July reporting the highest recommender score this year (88.2%). **People Summary** • **Statutory & Mandatory training:** 90% Target for Statutory and Mandatory Training compliance has been achieved. • **Appraisals - non-medical:** Non-medical Appraisal is still below the Trust target for 90% with a reduction in compliance by 0.9% • **Sickness Absence:** Continues to sit under the Trust target. • **Agency Staffing Spend:** Doctors: agency increased slightly in August mainly driven by gaps within medical rotas; active recruitment taking place as part of the resident doctor review. • **Bank Staffing Spend:** Medical - increase in July was linked to resident Doctors industrial action. Nursing and Midwifery - increased usage due to nursing and midwifery vacancies however newly qualified nurses and midwives are in the recruitment pipeline. Ancillary - demand has increased within facilities due to vacancies and sickness **Performance Summary** • **Urgent and Emergency Care Standards:** 4 Hour Standard - The Trust achieved 75% against a trajectory of 71% following the re-designation of Furthers. % of patients over 12 hrs in ED - The % of patients who are in ED over 12 hours has significantly risen and is above trajectory at 12% for August against a trajectory of 7.4%. This due to reduced flow through the department. September month to							

6.3

	date remains 12%. Average Hand over times - Handover times have deteriorated to 34.22 minutes, against a trajectory of 35 minutes. • **Diagnostics:** Diagnostics performed within 6 weeks of referral – performance has slightly decreased for July to 65.49% from 66.26% in June. Echo performance has improved considerably and is now meeting national target however MRI performance has declined over the last couple of months but has improved since July and currently sits at 86.74% because of additional mobile provision being secured for Q3 to further recover the position and address the ongoing spike in demand. • **Cancer standards:** 28-day faster diagnosis standard - performance was 73.4% in July, with August's unvalidated position currently at 66.6% against a trajectory of 77%, validations are on-going. The greatest risk to Trust performance sits in urology, Upper GI, and Lower GI and the services are being managed closely against their improvement plans. Diagnostic capacity is the key risk for the 28-day performance. 62-day standard - finalised performance for July was 57.7%, a marked improvement on the June performance of 41.8% - 16% improvement (and August's unvalidated position is 55.0%). 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 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. • **RTT Elective Standards**: For RTT performance, the Trust had 27 live 65+ week wait breaches at month end in July 2025, this was an increase on the 12 breaches in June. The increase is directly linked to ASI Drop offs and Popins onto the PTL. For 52-week breaches, the Trust ended July 2025 on a total of 2402 breaches (5.1% of total PTL size) and June on 2265 breaches (4.7% of total PTL size). July performance was behind plan of 2066. This increase is directly linked to ASI Drop Offs and Popins onto the PTL. The Trust's 18 RTT week performance has drastically improved in recent months from 41.8% for December 2024, up to 52% in July 2025.
Recommendation:	The Board is asked to discuss/note the report.

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.25.09.25 and OSC.26.09.25
Risk / links with the BAF:	Links to all BAF Risks
Legislation, regulatory, equality, diversity and dignity	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity.
Appendices:	M5 Integrated Performance Report

6.3

Integrated Performance Report:

August 2025

As at 24/09/2025

Section summaries: Patients

Board Sub Committee: Quality and Safety Committee			
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Pressure Ulcers (PU)	The data page for PU isn't included within the pack pending a review of the data set. A briefing paper is planned to be tabled at QSC (Sept) with the PU data set. Of note, as reported in the previous month, there has been an increase in the number of PUs across the organisation which is under the strong focus of the nursing teams with quality surveillance in place across two wards and a nursing quality summit scheduled in September.	For increased visibility and awareness	
Patient experience	The number of complaints received by the organisation continues to be higher than Q3 2024/25. Thematically, the concerns raised remain unchanged and are aligned to the feedback received through our adult inpatient survey. A paper detailing our inpatient survey is included within the QSC and Board papers. FFT is also included within the IPR, with July reporting the highest recommender score this year (88.2%).	For increased visibility and awareness	

Section summaries: People

Board Sub Committee: People Committee			
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Statutory & Mandatory training	90% Target for Statutory and Mandatory Training compliance has been achieved	For recognition	
Appraisals - non-medical	Non-medical Appraisal is still below the Trust target for 90% with a reduction in compliance by 0.9%	For escalation	
Sickness Absence	Continues to sit under the Trust target	For information	
Agency Staffing Spend	Doctors: agency increased slightly in August mainly driven by gaps within medical rotas; active recruitment taking place as part of the resident doctor review	For information	
Bank Staffing Spend	Medical - increase in July was linked to resident Doctors industrial action. Nursing and Midwifery - increased usage due to nursing and midwifery vacancies however newly qualified nurses and midwives are in the recruitment pipeline. Ancillary - demand has increased within facilities due to vacancies and sickness	For information	

Section summaries: Performance 1 of 2

Board Sub Committee: Workforce Committee			
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Urgent & Emergency Care Standards	The Trust achieved 75% against a trajectory of 71% following the re-designation of Furthers. The percentage of patients who are in ED over 12 hours has significantly risen and is above trajectory at 12% for August against a trajectory of 7.4%. This due to reduced flow through the department. September month to date is remains 12%. Handover times have deteriorated to 34.22 minutes, against a trajectory of 35 minutes.	For Information	
Diagnostics	Performance has slightly decreased for July to 65.49% from 66.26% in June. Echo performance has improved considerably and is now meeting national target however MRI performance has declined over the last couple of months but has improved since July and currently sits at 86.74% as a result of additional mobile provision being secured for Q3 to further recover the position and address the ongoing spike in demand. Performance and backlog trajectories for 25/26 to be finalised post reporting fix to support improving performance. Review of validation efforts to ensure accurate submission reporting. PTL monitoring - regular performance meeting established. A re-write of the DM01 process is in progress - testing has identified data issues which we are currently investigating with our data warehouse provider to understand and rectify. OPCS/procedure codes description issue with Alex Health has been escalated and a workstream lead being assigned to work through that is currently affecting Endoscopy and other areas.		

Section summaries: Performance 2 of 2

Board Sub Committee: Workforce Committee

Focus Area	Description and action	Reason for Inclusion	Target Date for Resolution if applicable
Cancer Standards	Performance for **28-day faster diagnosis standard** was 73.4% in July, with August's unvalidated position currently at 66.6% against a trajectory of 77%, validations are on-going. The greatest risk to Trust performance sits in urology, Upper GI, and Lower GI and the services are being managed closely against their improvement plans. Diagnostic capacity is the key risk for the 28-day performance. Finalised performance for 62-day standard in July was 57.7%, a marked improvement on the June performance of 41.8% - 16% improvement (and August's unvalidated position is 55.0%). 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 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 had 27 live 65+ week wait breaches at month end in July 2025, this was an increase on the 12 breaches in June. The increase is directly linked to ASI Drop offs and Popins onto the PTL. For **52-week breaches**, the Trust ended July 2025 on a total of 2402 breaches (5.1% of total PTL size) and June on 2265 breaches (4.7% of total PTL size). July performance was behind plan of 2066. This increase is directly linked to ASI Drop Offs and Popins onto the PTL. The Trust's **18 RTT week performance has drastically improved** in recent months from 41.8% for December 2024, up to 52% in July 2025. Of note, the Trust's PTL size has reduced by 7,480 patients since March 2025.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, the Validation Sprint programme, the re-launch of the Envoy digital patient survey and the commencement of an AI targeted validation tool. Regular PTLs continue and 'super' PTLs are in place for the larger specialties in order for the improvements in the RTT standards to continue. Whilst July's performance delivered the forecast, the emerging risk involving ASI drop off patients poses a challenge to August's performance. The issue has been escalated at Trust and Board level.		

Introduction

About this pack

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

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

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

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

Contents

Key Performance Indicators

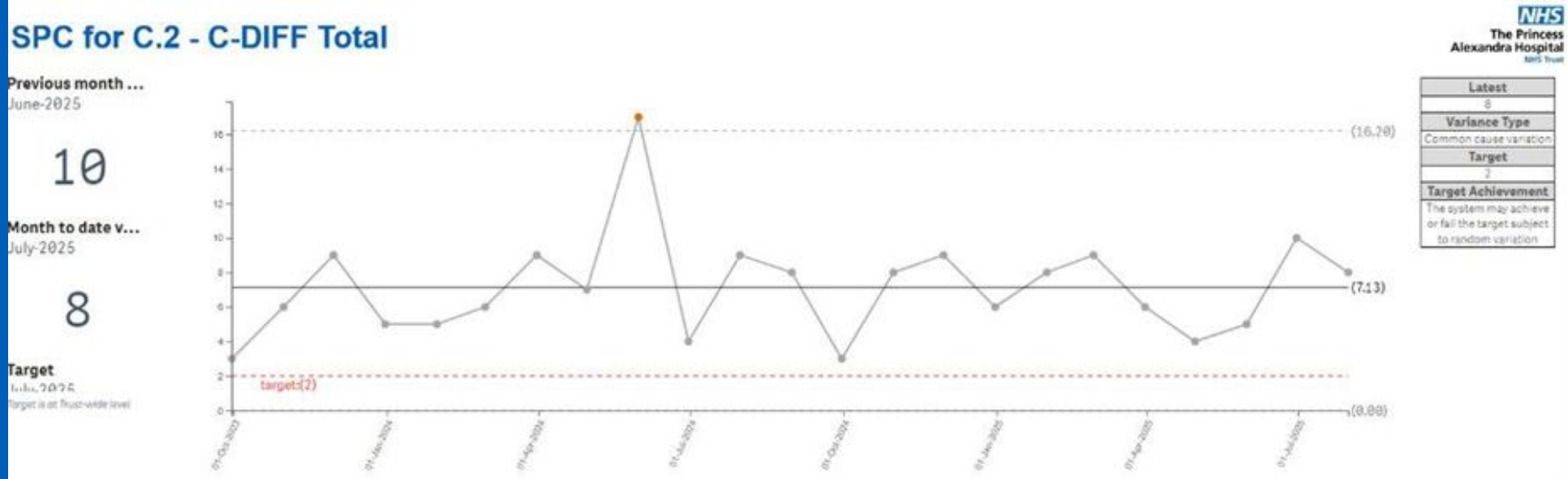
The Princess Alexandra Hospital NHS Trust

5P Section	KPI	SPC Status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	C-DIFF Total		8	1.1	16	12
	C-DIFF Hospital onset Healthcare Associated		4	1.1	16	12
	Complaints - New	H	63	1.1	16	12
	PALS		483	1.1	16	12
	Falls - total of Minor, Moderate & Severe		10	1.1	16	12
	FFT Patient Satisfaction		88.2%	1.1	16	12
People	Appraisals - non medical		75.2%	2.3	16	8
	Statutory & Mandatory training	H	90.3%	2.3	16	8
	Agency Staffing Spend	L	2.2%	2.3	16	8
	Bank Staffing Spend	L	10.3%	2.3	16	8
Performance	Proportion of Patient treated within 4 hours in ED		55%	4.2	20	12
	Propotion of Ambulance Handovers less than 15 minutes	H	28.70%	1.3	16	12
	Propotion of Ambulance Handoversbetween 15 & 30 minutes		35.40%	1.3	16	12
	RTT Incomplete Performance	L	52%	1.3	16	12
	Diagnostic times - Patients seen within 6 weeks		65.50%	4.2	20	12
	Cancer two week waits		50.50%	4.2	20	12
	Cancer 28 Day Faster Diagnosis		73.40%	4.2	20	12
	Cancer 62 Day - Shared treatment allocation rules		57.70%	4.2	20	12
	RTT over 65 week waiters		127.00%	1.3	16	12

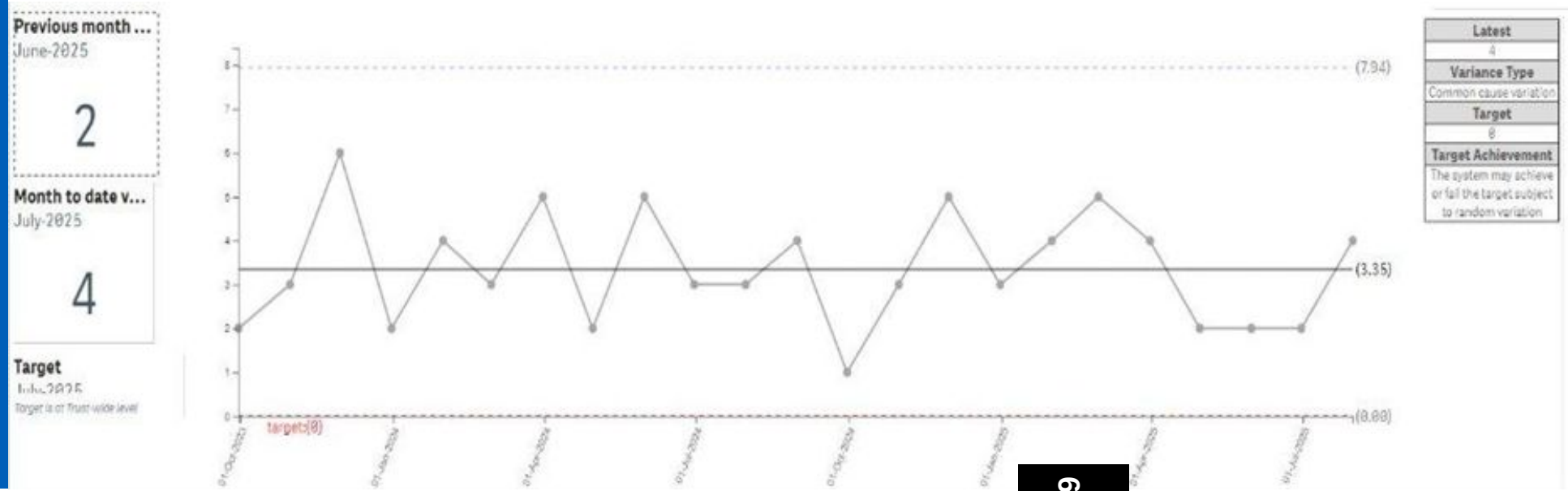
Patients section measures

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for C.2 - C-DIFF Total



SPC for C.3 – C-DIFF Hospital onset Healthcare Associated



Patients section measures

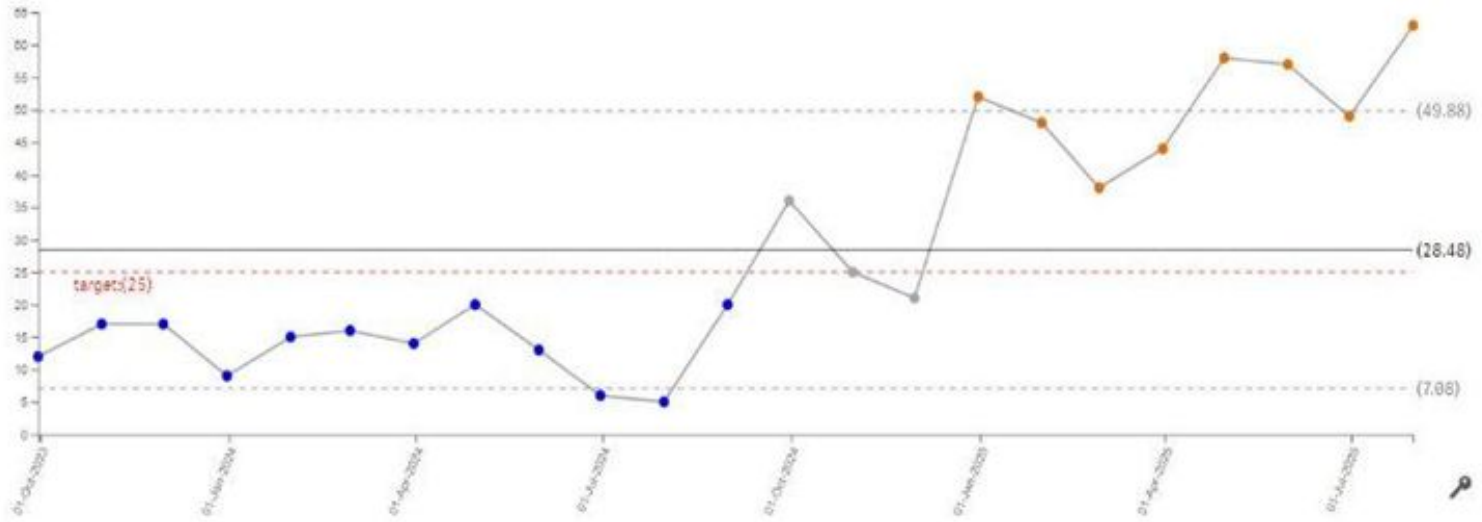
The Princess Alexandra Hospital NHS Trust

SPC for D.11 - Complaints - New

Previous month ...
June-2025
49

Month to date v...
July-2025
63

Target
July-2025
Target is at Trust-wide level



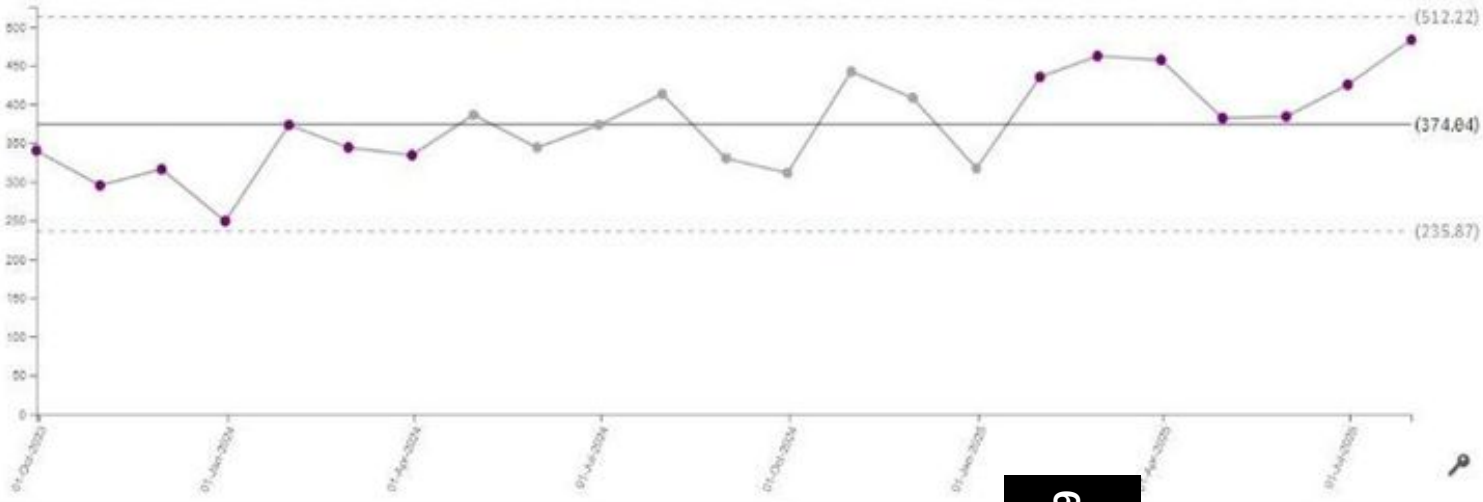
Latest
63
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
25
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.13 - PALS

Previous month ...
June-2025
425

Month to date v...
July-2025
483

Target
July-2025
Target is at Trust-wide level



Latest
483
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

6.3

Patients section measures

The Princess Alexandra Hospital NHS Trust

SPC for D.2 - Falls - total of Minor, Moderate & Severe

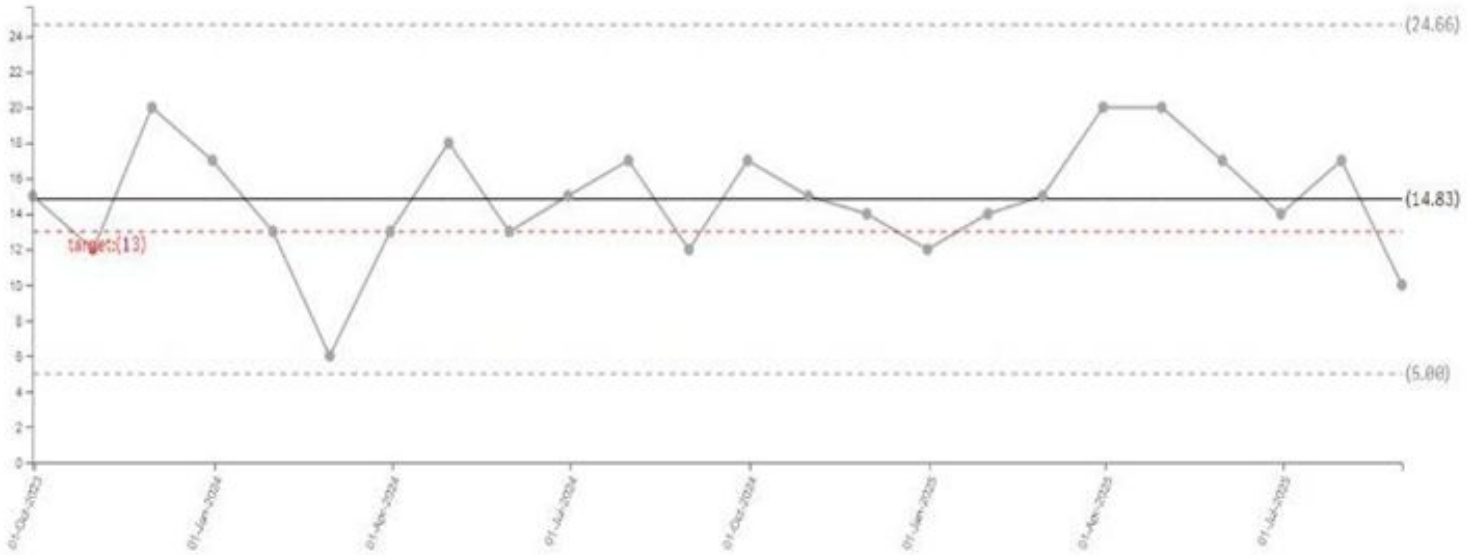
Previous month ...
August-2025

10

Month to date v...
September-2025

6

Target
August-2025
Target is at Trust-wide level



Latest
10
Variance Type
Common cause variation
Target
13
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.54 - FFT Patient Satisfaction

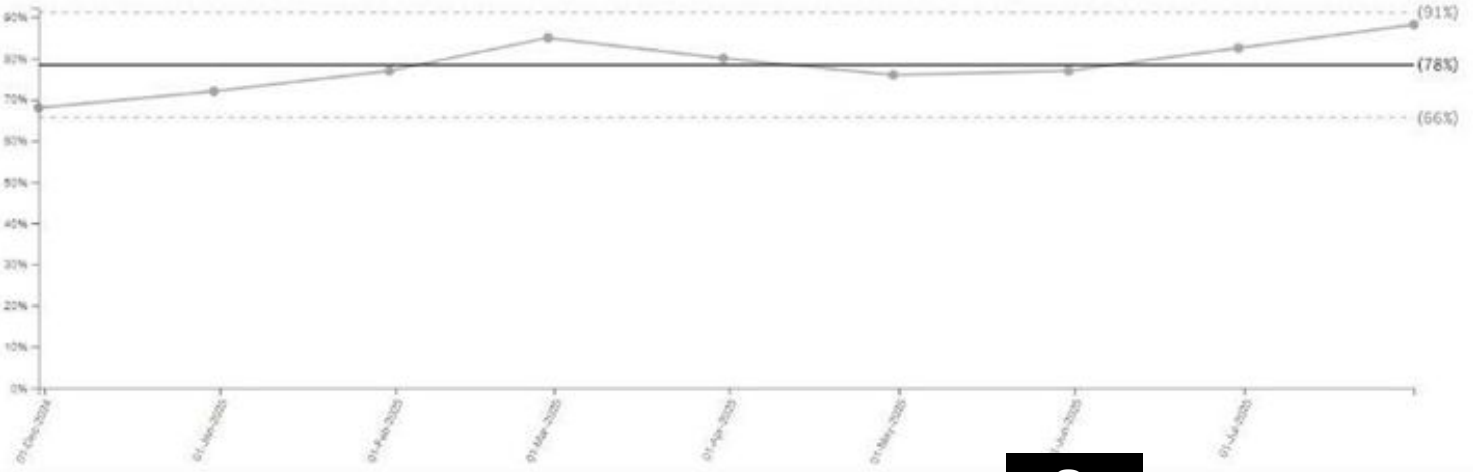
Previous month ...
June-2025

82.5%

Month to date v...
July-2025

88.2%

Target
July-2025
Target is at Trust-wide level



Latest
88.2%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

People section measures

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for D.28 - Appraisals - non medical

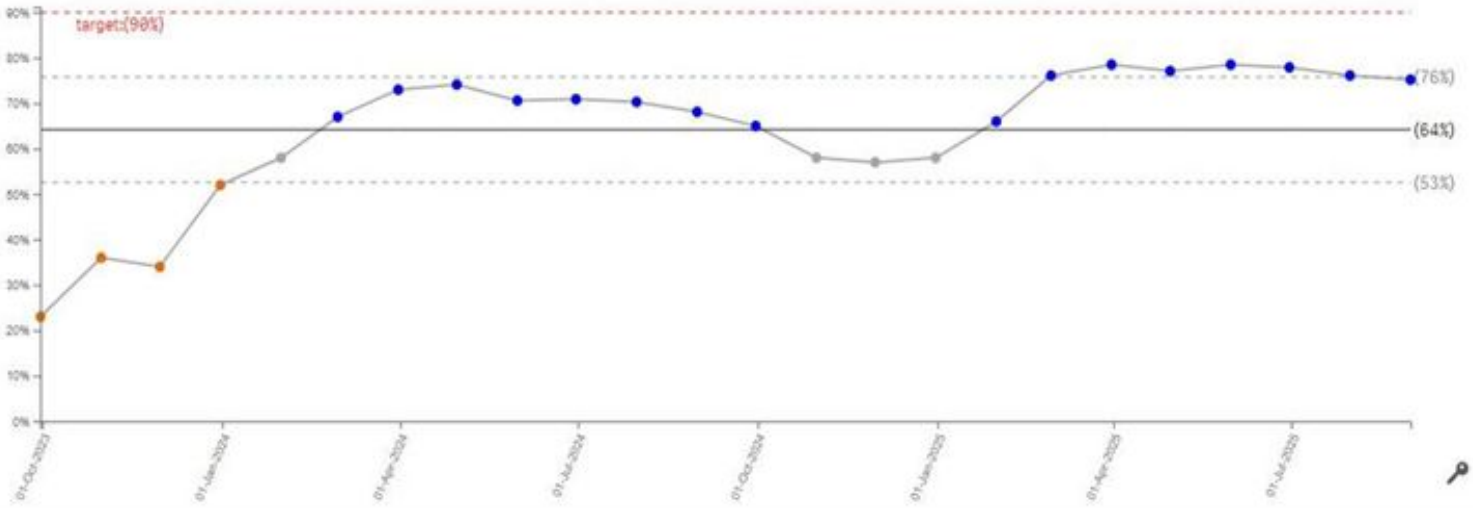
Previous month ...
July-2025

76.1%

Month to date v...
August-2025

75.2%

Target
August-2025
Target is at Trust-wide level



Latest
75.2%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
90%
Target Achievement
The system is expected to consistently fail the target

SPC for D.29 - Statutory & Mandatory training

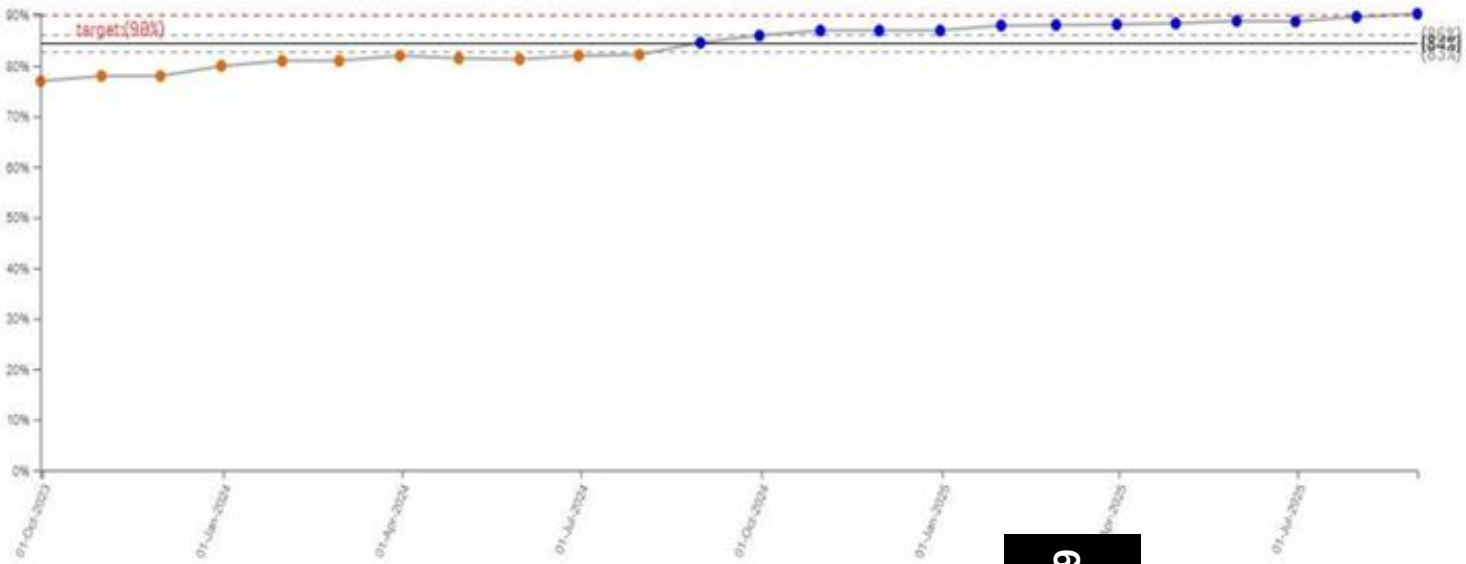
Previous month ...
July-2025

89.7%

Month to date v...
August-2025

90.3%

Target
August-2025
Target is at Trust-wide level



Latest
90.3%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
90%
Target Achievement
The system is expected to consistently fail the target

People section measures

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for D.25 - Agency Staffing Spend

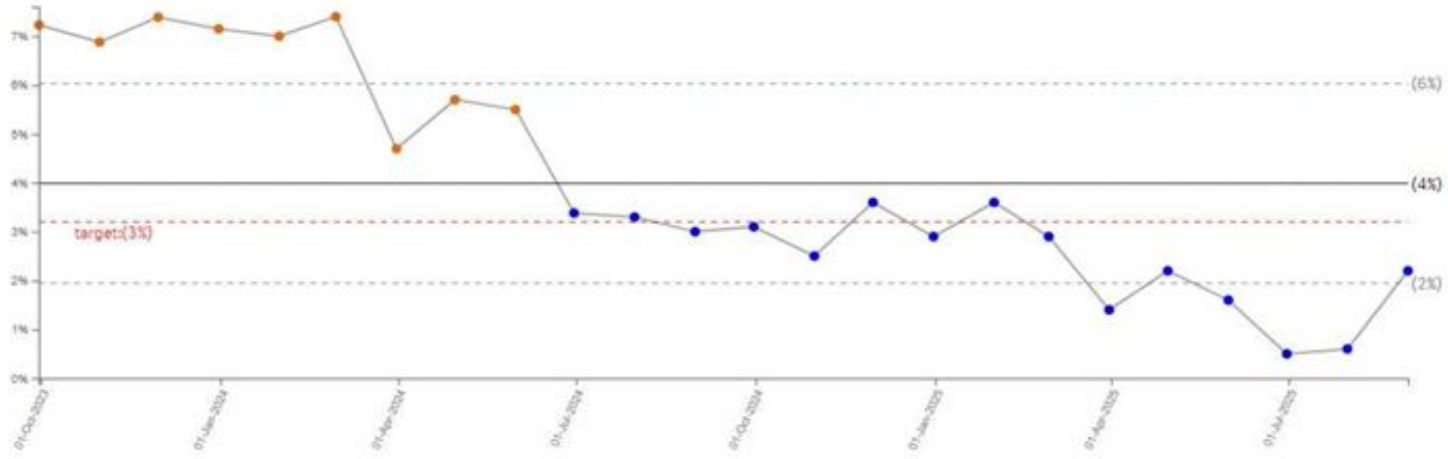
Previous month ...
July-2025

0.6%

Month to date v...
August-2025

2.2%

Target
August-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

Latest
2.2%
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
3%
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.26 - Bank Staffing Spend

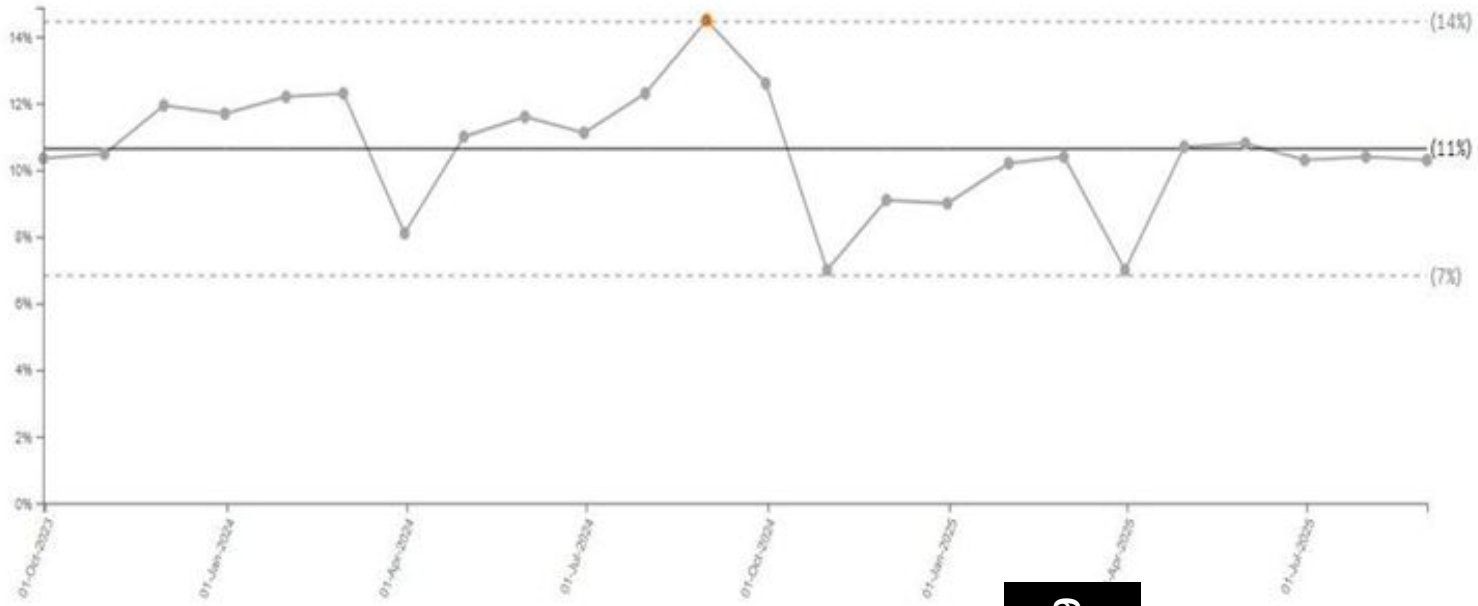
Previous month ...
July-2025

10.4%

Month to date v...
August-2025

10.3%

Target
August-2025
Target is at Trust-wide level

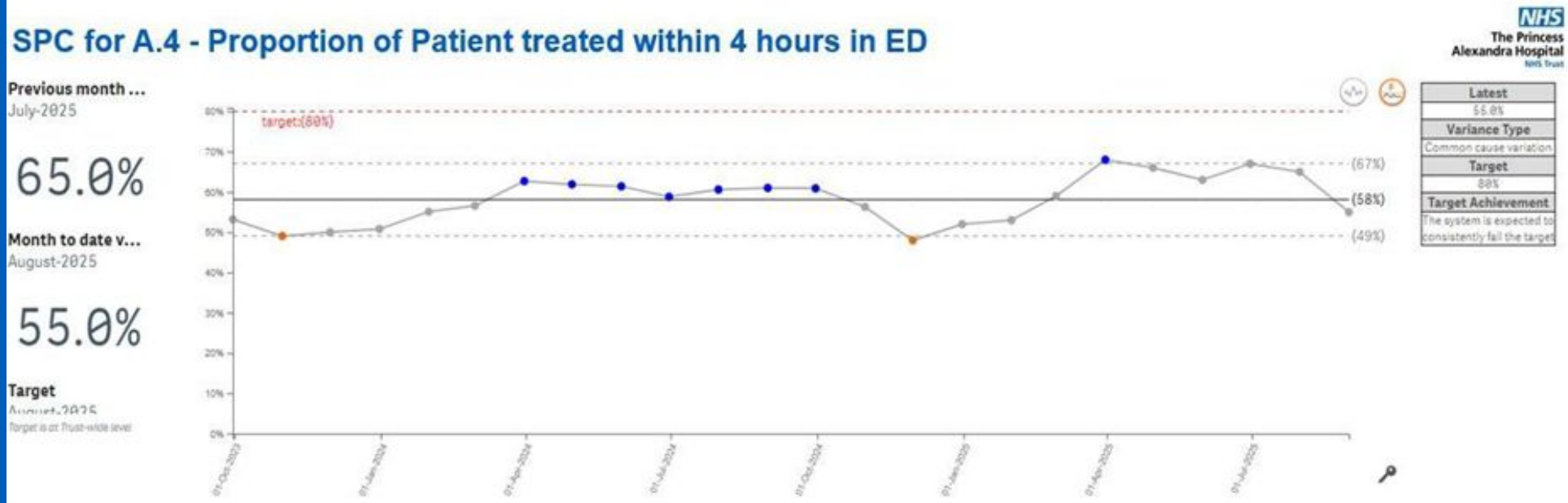


Latest
10.3%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

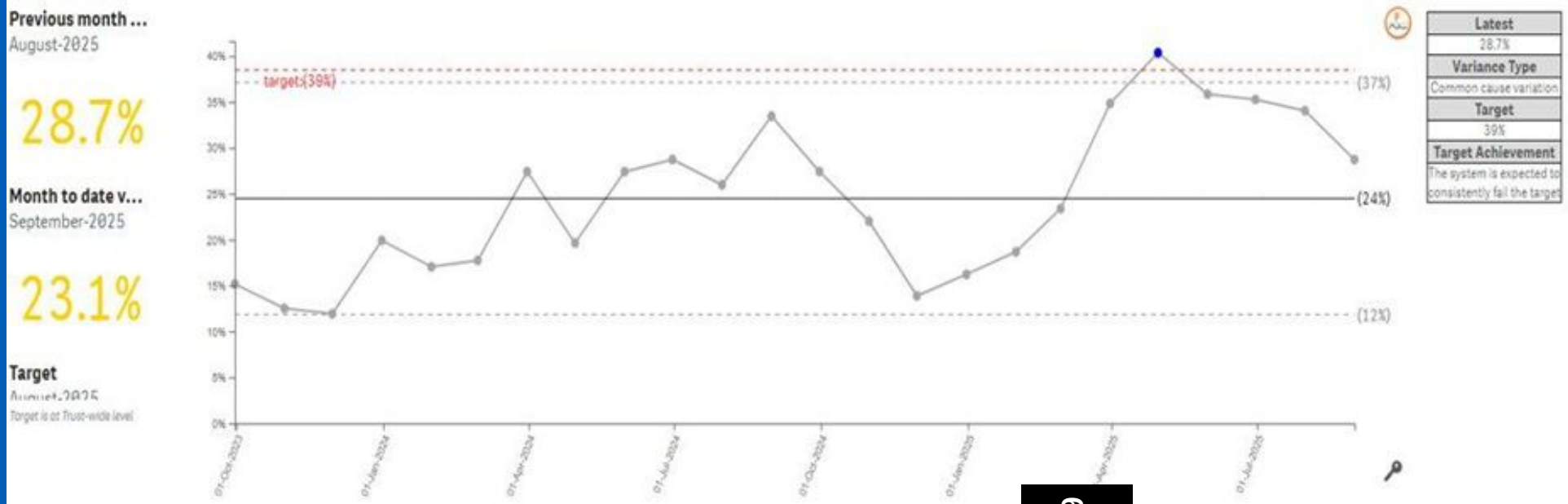
Performance section measures

The Princess Alexandra Hospital NHS Trust

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



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



6.3

Performance section measures

The Princess Alexandra Hospital NHS Trust

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

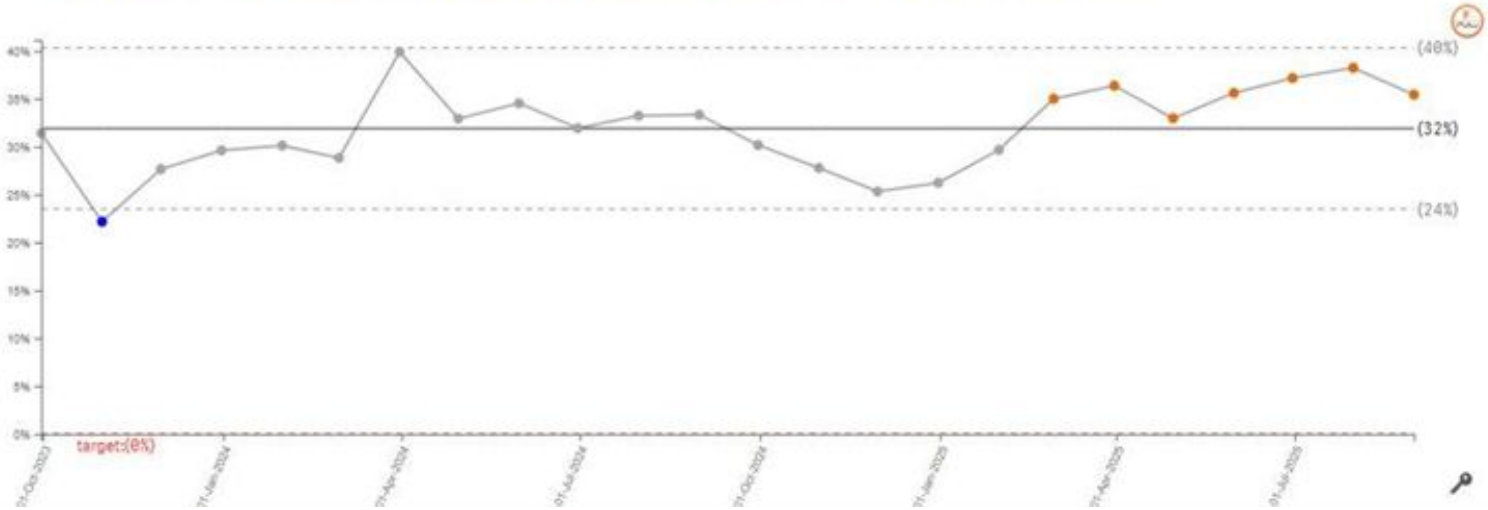
Previous month ...
August-2025

35.4%

Month to date v...
September-2025

27.7%

Target
Target is on Trust-wide level



Latest
35.4%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
8%
Target Achievement
The system is expected to consistently fail the target

SPC for E.46 - RTT Incomplete Performance

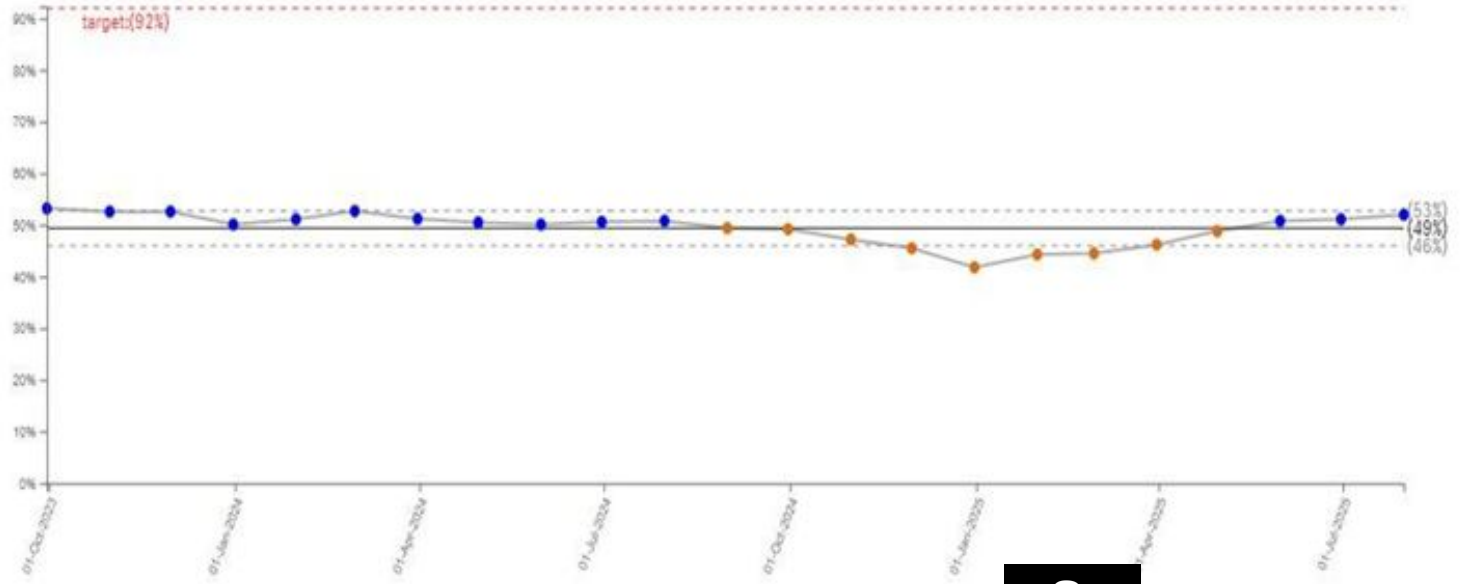
Previous month ...
June-2025

51.1%

Month to date v...
July-2025

52.0%

Target
Target is on Trust-wide level

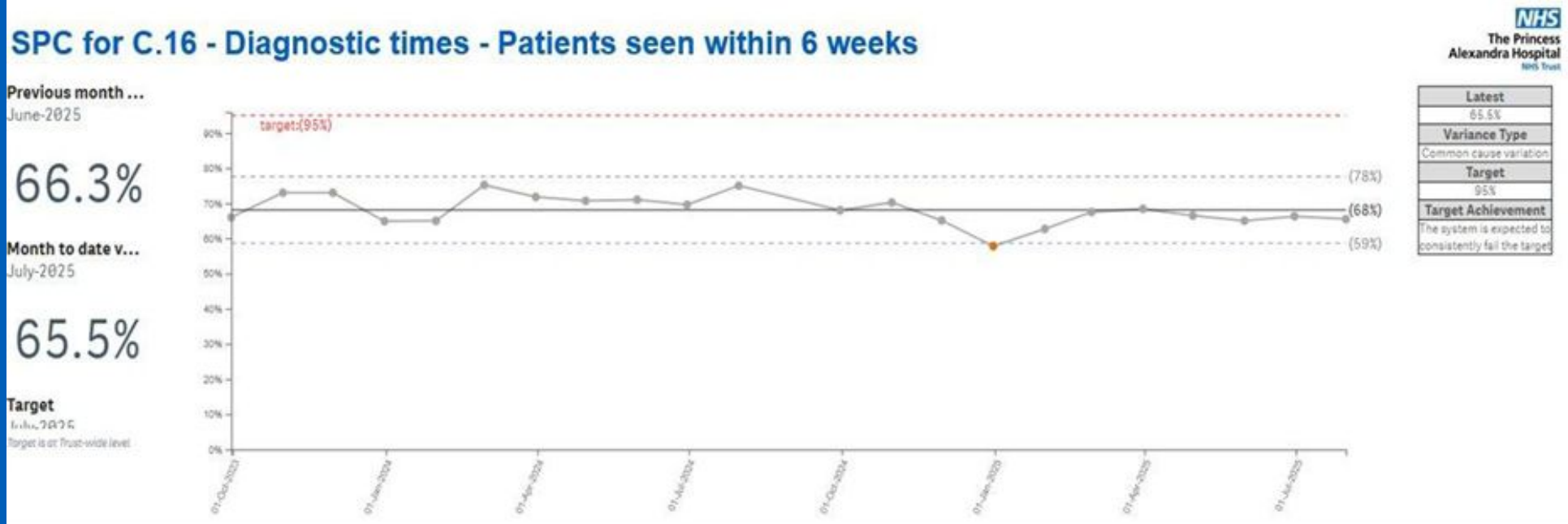


Latest
52.0%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
92%
Target Achievement
The system is expected to consistently fail the target

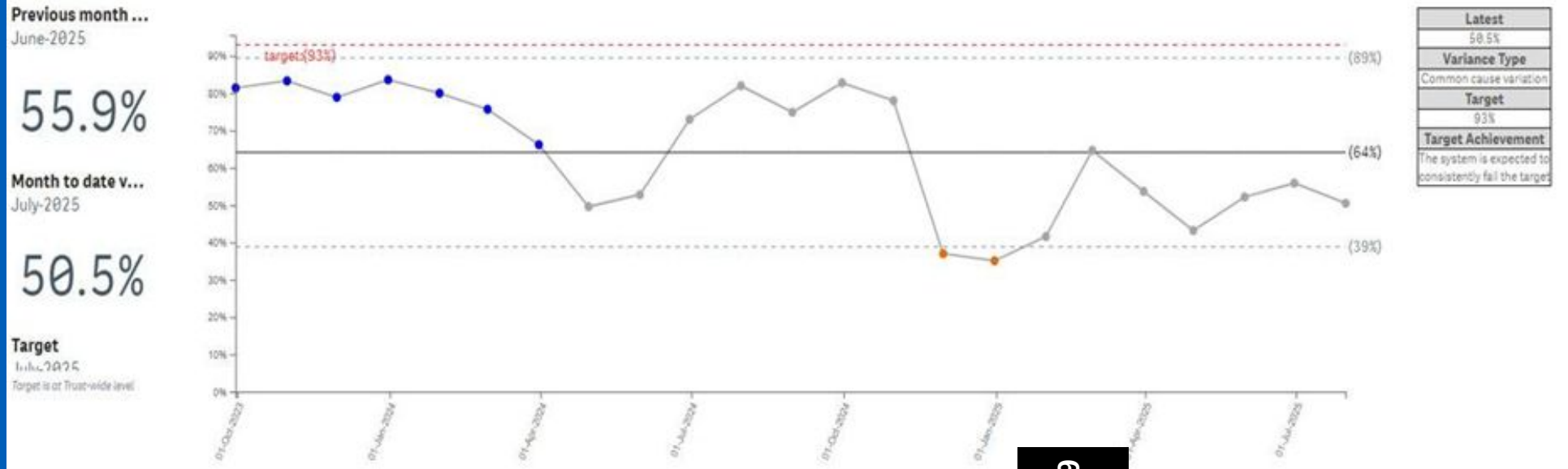
Performance section measures

The Princess Alexandra Hospital NHS Trust

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



SPC for C.20 - Cancer two week waits



Performance section measures

The Princess Alexandra Hospital NHS Trust

SPC for C.22 - Cancer 28 Day Faster Diagnosis

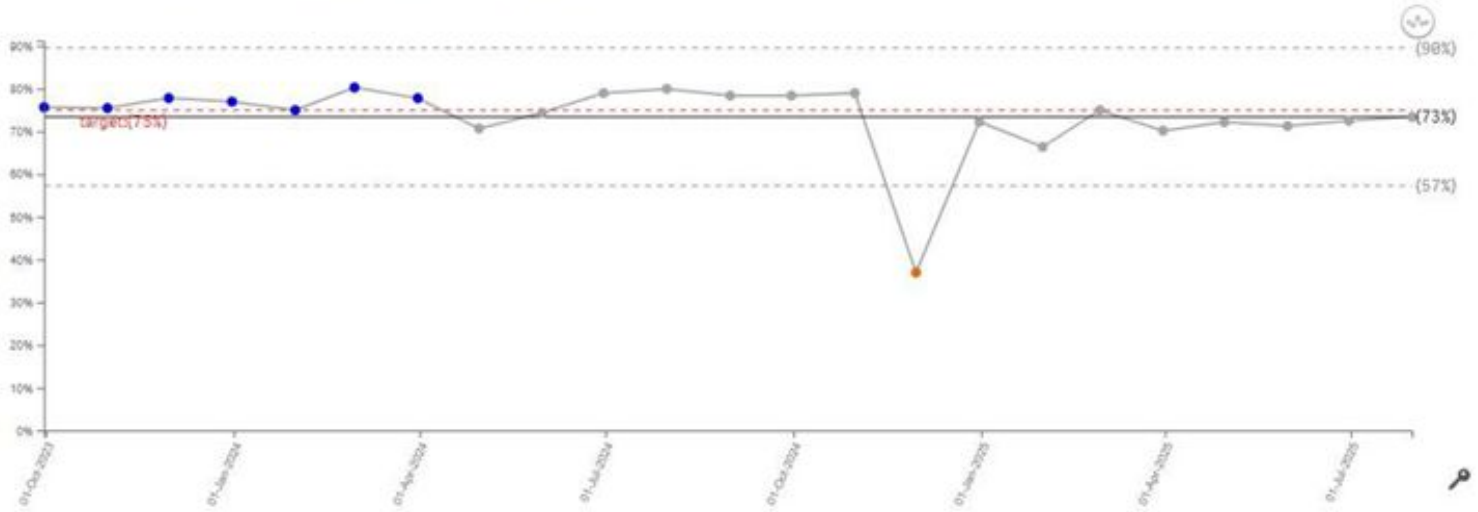
Previous month ...
June-2025

72.5%

Month to date v...
July-2025

73.4%

Target
July-2025
Target is at Trust-wide level



Latest
73.4%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for C.26 - Cancer 62 Day - Shared treatment allocation rules

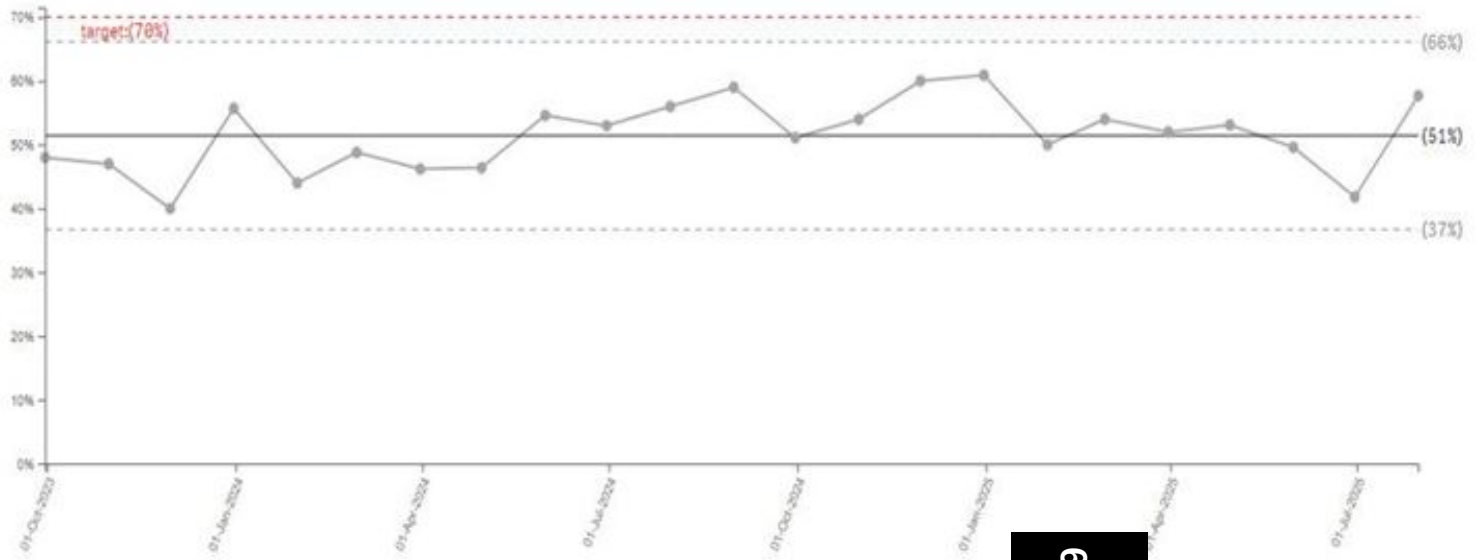
Previous month ...
June-2025

41.8%

Month to date v...
July-2025

57.7%

Target
July-2025
Target is at Trust-wide level



Latest
57.7%
Variance Type
Common cause variation
Target
70%
Target Achievement
The system is expected to consistently fail the target

Performance section measures

The Princess Alexandra Hospital NHS Trust

SPC for D.41 - RTT over 65 week waiters

Previous month ...
June-2025

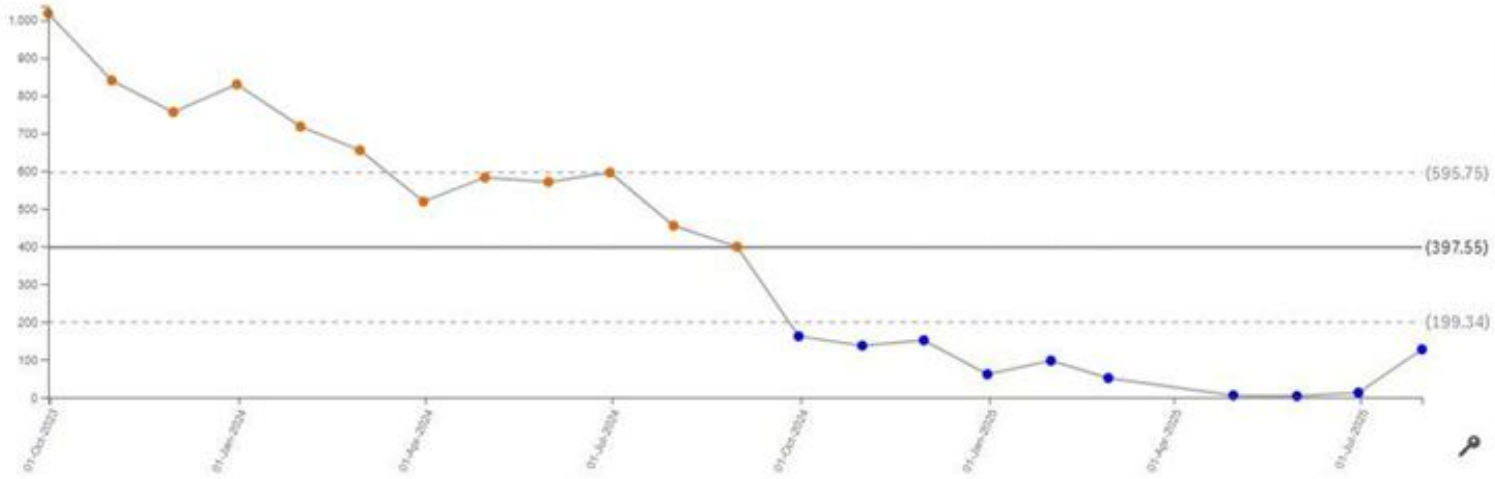
12

Month to date v...
July-2025

127

Target

Target is at Trust-wide level



Latest
127
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

The Princess Alexandra Hospital NHS Trust

Public meeting of the Board of Directors

6.3

Agenda item:	6.3
Presented by:	Camelia Melody Acting Chief Operating Officer (ACOO)
Prepared by:	Rebecca Gildea – Associate Director of Performance (ADoP)
Date prepared:	25th September 2025
Subject / title:	Untracked Appointment Slot Issues (ASI) and the Impact on Elective Recovery

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	This paper outlines risk involving patients referred to The Princess Alexandra Hospital Trust (PAHT) who were placed on the ASI (Appointment Slot Issues) worklist via the Electronic Referral System (eRS) and automatically removed after 180 days. This removal means they are no longer visible or tracked, leading to some patients being added to the Patient Tracking List (PTL) with waits exceeding 65 weeks. This increases service demand and raises risks of performance breaches and patient safety concerns. To date, our patient contact work has not identified significant harm, but this remains under review. Work is ongoing, and further updates have been and will continue to be provided to the Trust Board, Quality and Safety Committee (QSC), and Performance and Finance committee (PAF). The Board is asked to note the issue and associated risks.
Recommendation:	To update Trust Board on the background to the issue and the measures taken to redress the current problem and longer term plans for resolution.

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:	Executive Cabinet, Executive Board, Performance and Finance Committee (PAF) and Private Board
Risk / links with the BAF:	1.1 Variation in Outcomes 1.3 Operating Plan
Legislation, regulatory, equality, diversity and dignity implications:	Statutory performance measures, NHS Contract requirements, EDI considered by regular analysis of the waiting lists. No impact on EDI identified. Regular assessment of performance improvements are undertaken to identify potential impacts on groups of patients
Appendices:	n/a

1.0 Issue

Following the raising of an issue at Private Board in September 2025, this paper describes the risk that was identified relating to patients who had been referred to The Princess Alexandra Hospital Trust (PAHT) who were on the ASI (Appointment Slot Issues) worklist within the eRS System and then removed (automated system functionality) and consequently not visible or tracked. These cases have resulted in patients being added to the Patient Tracking List (PTL), some with waits of over 65 weeks, which places increased demand on services and raises the likelihood of performance breaches and patient safety concerns.

The Performance team have investigated this cohort of patients on the untracked ASIs list, and initial findings indicate that some patients still require appointments. The focus remains on patient safety as well as the Trust's capacity to achieve recovery objectives established by the NHS tiering process.

2.0 Background

The NHS e-Referral Service (e-RS) is a national (NHS-wide) digital platform, used to refer patients to hospital or clinic services, allowing patients to choose their appointment time and location. If there are no available appointments, the referral is 'deferred to the provider', meaning the provider must manually arrange the appointment and the referral transfers to an 'ASI' (Appointment Slot Issue) List.

A limitation of the e-RS system experienced by all Trusts is that referrals on an ASI list expire automatically after 180 days if no action occurs. After expiration, these referrals are deleted from the system, which eliminates visibility and tracking for Trusts. There is currently no automated interface between e-RS ASIs and Electronic Health Record (EHR) systems (including AlexHealth) available in the country.

As a result of the above, this is a known, nationwide patient safety issue. Trusts use varying mitigation strategies such as Robotic Process Automation (RPA) or manual referral re-entry. In our Trust, we are now aware that there has been an inconsistency in the management of this process which has resulted in uneven oversight and risk across specialties.

3.0 Context

Approximately 18 months ago, the Trust identified a cohort of patients whose referrals had unintentionally dropped off the ASI list, prompting a retrospective validation to assess the scale and impact. In response, Standard Operating Procedures (SOP) and a Business-As-Usual (BAU) process were introduced to proactively monitor referrals nearing the 180-day expiry.

Despite these changes, a recent patient response to a digital validation message revealed a further issue, triggering a renewed investigation into ASI referral management and system oversight.

4.0 Immediate Steps Taken

To identify patients removed from the ASI pathway and not readded, the Referral to Treatment Team (RTT) developed a data exception report to identify potential expired referrals. Validation began immediately and is in process. Initial analysis of the 2,345 identified patients on the untracked ASI list suggests that approximately 650 patients are likely to need an appointment.

5.0 Patient Safety

Patient Safety is our priority. Any patient who has been validated and has not already been seen or does not have a subsequent appointment booked has been prioritised for contact by telephone.

All patients still requiring treatment will undergo a clinical harm review in accordance with the 'Clinical Harm Review Policy - Non-Cancer'. An incident report will be created to monitor the harm review process and ensure both clinical and board-level oversight. Due to the nature of this pathway, harm reviews can only be completed once the patient has been seen and treated. The projected plan is to complete the harm review process by the end of October 2025, dependant on patients being seen and treated. The progress can be audited via the incident reporting system, and a comprehensive report detailing the level of harm and any associated risks will be submitted following completion of the reviews. The recommended approach is to continue adhering to our internal policy.

Harm reviews resulting in a grading of moderate or above will be escalated to the Incident Management Group per the 'Incident Management Policy' for further discussion and investigation. Should a significant number of moderate or higher harm incidents be identified, deliberations will occur to determine the necessity for a Patient Safety Incident Investigation (PSII) cluster review.

The emerging risk has also been added to the risk register along with mitigations that have a current risk score of 20+.

6.0 Performance Impact

Whilst PAHT has made significant steps to improve elective performance (which has been acknowledged with the move from Tier 1 to Tier 2 recently), the emerging issue of ASIs will likely negatively impact the delivery of the monthly 65 week reduction forecast, RTT 18 week performance, and 52 week breach reduction. The decline in performance could potentially impact on tier status and will be a dampener on morale of colleagues who have been working very hard, and with ingenuity, to reduce waiting times for our patients.

7.0 Cohort Update

Of the 2,345 patients identified on the untracked ASI list:

- 73% (~1,700) Did not rea booked appointment (Duplicate / treatment no longer required or provided elsewhere)
- 27% (~600) Required an appointment – additional activity organised to accommodate in September and October.

8.0 Immediate Mitigations

The Trust has recently acquired a new AI-based tool called Clear PTL. It is designed to help clean up patient waiting time data, and it’s already making a big impact. Approximately 60% of inaccuracies have been eliminated for patients waiting between 18 and 52 weeks.

For those waiting over a year, there’s a more detailed validation programme in place to ensure accuracy. Specialties with the longest waits, like ENT, Trauma & Orthopaedics, and Gynaecology, are getting extra support to manage their lists, while smaller specialties are being handled on a case-by-case basis. The outcomes of these validation efforts are regularly shared with service teams to help spot trends and drive down waiting times.

Furthermore, unbooked appointments are reviewed weekly to make sure patients are being scheduled without delay. There is also work underway through the Outpatient Transformation Programme to standardise booking processes and clinic templates, and additional admin roles have been brought in to support ASI processes.

9.0 Recurrent Solution

We continue to work on short- and long-term solutions for the technically known national issue. Progress continues across active projects, with particular focus on ASI list automation, including handover, testing, and governance considerations:

ASI List Automation Handover Testing of the ASI automated process will begin on 29th September. During the initial phase, the process will be handled manually, gradually shifting to semi-automated methods to ensure thorough testing of all scenarios before full automation is implemented. Governance and oversight arrangements have been confirmed to support this transition. Throughout the testing period (29th September to 15th October), business-as-usual operations will continue, with strict manual procedures maintained to ensure consistency and control.

10.0 Next steps

The team is continuing to contact and treat patients while also carrying out harm reviews, with findings being reported to PAF, QSC and Trust Board. Alongside this, there's a strong focus on tightening up referral management processes to avoid similar issues in the future. The plan is to roll out RPA Automation, which has been agreed and will be fully funded and implemented. This will replace the current manual tracking with a more structured, automated system. Development will be supported externally, but internal resources will be put in place to make sure it's sustainable in the long run.

Public Meeting of the Board of Directors – 2 October 2025

Agenda item:	6.3
Presented by:	Camelia Melody, Acting Chief Operating Officer
Prepared by:	Rebecca Gildea, Associate Director of Performance
Date prepared:	September 2025
Subject / title:	Oversight Framework –Princess Alexandra Hospital Trust (PAHT) Metrics Summary

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 NHS Oversight Framework (NHS OF) has been developed to allow NHS England to assess NHS Trusts under the Oversight Framework 2025/26. The dashboard within this report provides a high-level review of Princess Alexandra Hospital Trust (PAHT) performance against each segment of the framework: • At overall headline level, including segment rating and Trust rank • At detailed domain and subdomain metric level • Against all Trusts at metric level
Recommendation:	For Board to note the oversight framework and improvements against key metrics

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.25.09.25
Risk / links with the BAF:	1.3 Operating Plan
Legislation, regulatory, equality, diversity and dignity implications:	Statutory performance measures, NHS Contract requirements, EDI considered by regular analysis of the waiting lists. No impact on EDI identified. Regular assessment of performance improvements are undertaken to identify potential impacts on groups of patients
Appendices:	n/a

NHS Oversight Framework – Board Report Summary

The NHS Oversight Framework (NHS OF) is the national system for assessing NHS Trusts, including Princess Alexandra Hospital NHS Trust (PAHT), for 2025/26. It provides a structured approach for reviewing performance across domains such as patient access, experience, finance, productivity, safety, and workforce. The framework benchmarks Trusts against each other, highlighting both strengths and areas for improvement.

For PAHT, the framework is a practical tool for identifying where we are performing well and where further focus is needed. The Board is asked to note both the framework itself and the progress made against key metrics.

Access to Services

PAHT's performance in access to services shows improvement, though challenges remain. The 62-day cancer standard has risen from 41.8% in June to 57.7% in July and August, with targeted actions in urology and gastrointestinal services supporting recovery. Weekly meetings and pathway reviews are helping to drive progress, although the Trust remains below the national trajectory of 72%.

Referral to Treatment (RTT) performance for the 18-week standard has improved from 41.8% in December 2024 to 52.8% in August 2025. This is due to new validation strategies, digital surveys, and AI solutions for patient tracking. Some specialties, such as ENT and gastroenterology, continue to face pressure, and further triage and agency support are being explored.

The number of patients waiting over 52 weeks for treatment remains above plan, with 2,449 breaches in August against a target of 2,300. Targeted validation and operational reporting are helping, but further work is required to reduce long waits.

Emergency care performance is positive, with the four-hour standard achieved at 75% in August and further improvement in September. However, the proportion of patients spending over 12 hours in the emergency department has increased to 12% in August, which is above the target. The Discharge Improvement Programme is making progress, but winter planning and bed occupancy remain priorities.

Effectiveness and Experience

The latest CQC report, published in September 2025, confirms PAHT's hospital mortality indicators are within expected national and regional ranges. Patient experience is being closely monitored, with actions underway to address gaps in admission, ward experience, and discharge. Initiatives include noise reduction at night, improved pain control, enhanced nutrition support, and better communication about care and discharge planning.

Learning from deaths is being strengthened through new AI tools and revised policies, and SMART training continues for junior doctors. The Trust is also working to ensure accessibility needs are met, supported by digital campaigns and staff training.

Finance and Productivity

PAHT receives deficit support funding, which limits its segmentation rating under the framework. This means the Trust is capped at a segmentation score of 3, regardless of other financial indicators. Productivity is being actively managed, with efforts to maximise internal capacity and reduce reliance on agency staff. The Trust is on plan year-to-date, with robust forecasting and system-level collaboration to deliver efficiency targets.

Patient Safety

Patient safety remains a priority, with strong controls in place for infection prevention and control. C. difficile and MRSA cases are closely monitored, and improvement groups have been established to address device management and stewardship. E. coli infection rates are low and within thresholds. IPC governance is robust, with executive oversight and multidisciplinary engagement.

People and Workforce

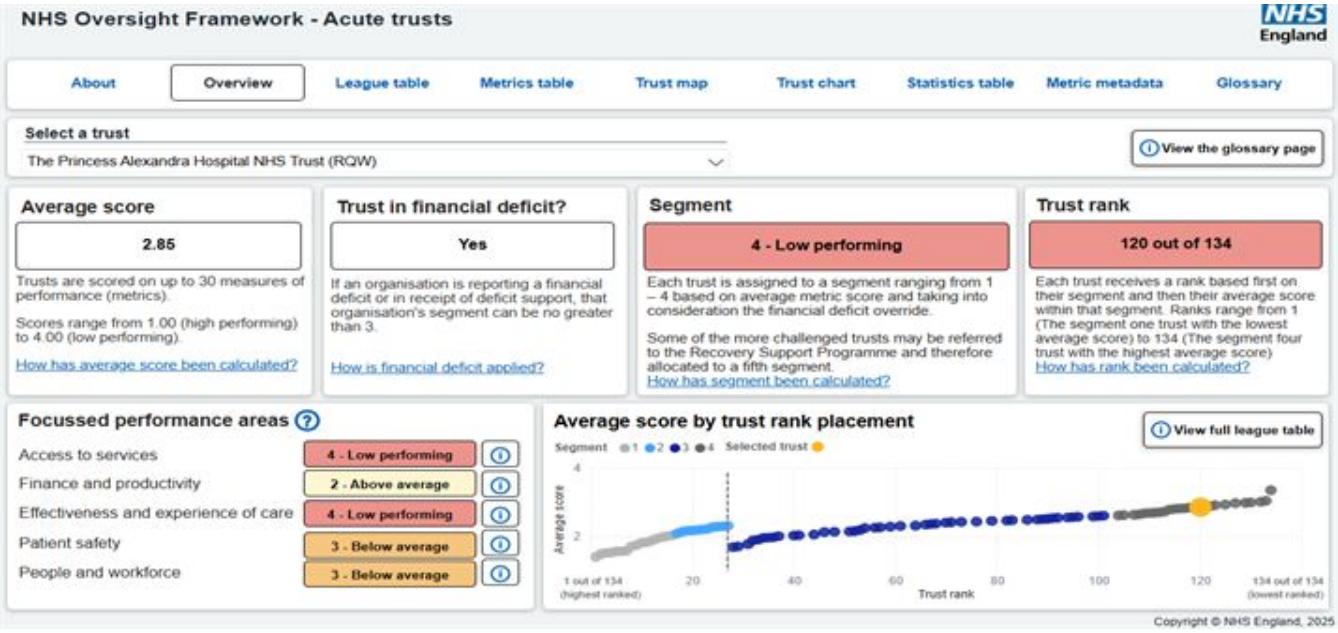
Staff engagement is being boosted through personalised communications, executive visits, and a range of activities responding to feedback. The Freedom to Speak Up Lead is promoted to foster a safe culture, with regular reporting and sharing of themes across the organisation. Delays in addressing concerns are minimal, and data is triangulated through a newly established Staff Feedback group. The Trust is also sharing best practice examples nationally.

Conclusion

PAHT's progress against the NHS Oversight Framework demonstrates a Trust that is actively responding to challenges and making improvements in key areas. There are clear gains in cancer and RTT standards, and emergency care is moving in the right direction, though some metrics remain difficult. Patient experience and safety are prioritised, and financial management is robust despite structural limitations.

The Board is asked to note the framework as a valuable tool for oversight and assurance, and to recognise the ongoing work to improve performance across all domains. Continued focus on targeted actions, operational improvements, and staff engagement will be essential to sustain and build on current progress.

Current NHS OF Score for PAHT – September 2025



To support navigation of the pack:

- **Focus on the five Domains and their subdomain performance –** The charts display services split by sub-domain and the metric scores are shown in descending order (bad to good) which indicates areas for focus
- **Performance is largely reflective of Q1 (or older)** – the 'live' position narrative provides a more accurate reflection of current performance

BOARD OF DIRECTORS: Trust Board 2 October 2025 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: Colin McCready, Non-Executive Director – Committee Chair

DATE OF COMMITTEE MEETING: 8 September 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
1.6 Annual Committee Effectiveness Review and Terms of Reference	Yes	No	No	The Committee discussed the effectiveness review. Overall the responses to the questions were positive with no areas of concern raised. The proposed amendments to the ToR relate to updates to the membership/attendees and job titles. The following sections have been deleted: -The Committee's responsibility for reviewing the Quality Account and external audit opinion on the Quality account; this duty is now fulfilled by the Quality and Safety Committee and the requirement for an external audit has been dispensed with. -The requirement for the committee to provide an annual report to the Board to account for its duties. It was previously agreed that this was no longer required as the Board receives a detailed report following each meeting of the committee. The terms of reference were endorsed by the Committee for Board approval and are attached at **Appendix 1**.
2.1 External Audit Update	Yes	No	No	The Committee noted the good work to submit the Annual Report and Accounts prior to the deadline this year. An update was provided on the procurement of new external auditors which was progressing well.

BOARD OF DIRECTORS: Trust Board 2 October 2025 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: Colin McCready, Non-Executive Director – Committee Chair

DATE OF COMMITTEE MEETING: 8 September 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.1 Internal Audit Progress Report and	Yes	Yes	Yes	The Committee was assured on the progress of the 2025/26 audit, two reports had been finalised. Additionally, one report from the 2024/25 audit plan was presented for completeness. Reports Finalised: • 24/25 KFS (Contract and Catalogue Management) - Moderate (Design) & Moderate (Effectiveness) Assurance • 25/26 DSPT - Overall Risk Assessment -Low & Confidence Level - High • 25/26 Response to Coroner Requests - Limited (Design) & Limited (Effectiveness) Assurance. Th is report will be presented to QSC in September and improvement actions will be monitored via QSC.
3.2 Internal Audit Follow Up Report	Yes	Yes	No	3 recommendations had been completed and 6 were in progress. Good progress was being made.
3.3 Counter Fraud Progress Report	Yes	Yes	No	The Committee was assured in regards to the progress against the 2025/26 counter fraud plan. The new “failure to prevent fraud” legislation was discussed. It mainly targets the private sector, where fraud is often committed to benefit the organisation. In the NHS and public sector, most frauds are for personal gain, so the law is less likely to apply directly. However, public bodies like NHS trusts must still maintain strong anti-fraud measures, which are already required by existing NHS standards.

BOARD OF DIRECTORS: Trust Board 2 October 2025				**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM: Audit Committee				
REPORT FROM: Colin McCready, Non-Executive Director – Committee Chair				
DATE OF COMMITTEE MEETING: 8 September 2025				
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 Waivers, Losses, Special Payments & Debt Write Offs	Yes	No	No	During the period 1st April 2025 to 30th June 2025: •The value of losses and special payments totalled £10k (3 cases). •No bad debt write offs have occurred in this period •29 waivers totalled £2,790k of which 3 (£108k) were non-compliant

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE 2025/26

PURPOSE:

The Audit Committee (the Committee) shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.

For the purposes of procuring the Trust's External Auditor, the Trust Board has nominated the Audit Committee to acts as its Auditor Panel in line with Schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

DUTIES:

The following comprise the Committee's main responsibilities:

Annual Work Plan and Committee Effectiveness

Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.
2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.
4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.
5. Review the adequacy and effectiveness of policies and procedures:
    a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
    b. to ensure compliance with relevant regulatory, legal and conduct requirements.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

1. Reviewing and approving the Internal Audit Strategy and annual Internal Audit Plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework).
2. Considering the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring co-ordination between the work of internal audit and external audit to optimise audit resources.
3. Conducting a regular review of the effectiveness of the internal audit function.
4. Periodically consider the provision, cost and independence of the internal audit service (not more than every five years unless circumstances require otherwise).

External Audit

The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular the Committee shall:

1. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the annual plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
2. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board;
3. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
4. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.
5. Review the performance of the external audit service and report to the Public Sector Audit Appointments Ltd (PSAA) on any matters relating to the external audit service.

Annual Report and Accounts Review

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee shall review the annual report and financial statements before submission to the Board, particularly focusing on:

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.

5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
6. Explanation of estimates or provisions having material effect.
7. The schedule of losses and payments.
8. Any unadjusted (mis)statements.
9. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
10. The letter of representation.

~~**Annual Quality Account**~~

~~The Committee shall seek assurance that:~~

1. ~~The reporting in the Trust's Quality Account is in line with the Trust's quality priorities and performance and consistent with other sources of assurance on quality available to the Committee~~
2. ~~The Quality Account presents a fair and balanced representation of the Trust's quality performance~~
3. ~~The priorities for quality focus concur with those of the Trust's patients and its plans~~
4. ~~External audit opinion confirms that the Quality Account meets statutory guidelines.~~

Governance Manual

1. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
2. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
3. Review the schemes of delegation and authority.

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

1. Adequate measures to comply with the Government Functional Standard GovS 013: Counter Fraud.
2. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
3. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions on Fraud and Corruption.

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit

In its capacity as Auditor Panel, the Committee shall:
1. Agree and oversee a robust process for selecting the external auditors in line with the Trust's procurement processes and rules.
2. Advise the Board on the selection and appointment of the External Auditor.
3. Ensure that any conflicts of interest are dealt with effectively.
4. Advise the Board on the maintenance of an independent relationship with the appointed External Auditor.
5. Advise the Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
6. Approve the Trust's policy on the purchase of non-audit services from the appointed external auditor.
7. Advise the Board on any decision about the resignation or removal of the External Auditor.

ACCOUNTABLE TO: Trust Board.

REPORTING ARRANGEMENTS: A regular written report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive. It shall highlight areas of focus from the last meeting and demonstrate progress against the Committee annual work plan.

~~The Committee shall report to the Board of Directors at least annually:~~

- ~~on its work in support of the Annual Governance Statement, (specifically commenting on the fitness for purpose of the Assurance Framework)~~
- ~~the extent to which risk management processes are embedded within the organisation~~
- ~~the integration of governance arrangements~~
- ~~the appropriateness of evidence compiled to demonstrate fitness to register with the Care Quality Commission~~
- ~~the robustness of the processes behind the Quality Account and the development of the Quality Report~~

The Chair of the Auditor Panel shall produce a report from the Panel outlining how it has discharged its duties.

CHAIR Non-Executive Director.

COMPOSITION OF MEMBERSHIP: Members of the Committee shall be appointed from amongst the Non-Executive Directors and shall consist of not less than three members including the Committee Chairman, at least one of whom shall have recent and relevant financial experience.

The Trust Chair will not be a member of the Committee.
Members of the Performance & Finance Committee and the Quality & Safety Committee shall be among the members of the Audit Committee.

The Auditor Panel shall comprise the entire membership of the Audit Committee. All members of the Auditor Panel will be independent Non-Executives Directors.

ATTENDANCE Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee

meetings within each reporting year. An attendance record will be held for each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.

In addition to the members of the Committee, the following will be invited to attend each Committee meeting:

- Chief Finance and Infrastructure Officer and Deputy Director of Finance
- Chief Medical Officer, Executive Lead for Risk Management
- Representatives from Internal Audit, External Audit and the Local Counter Fraud Service.

At least once a year, the Committee shall meet privately with the internal and external auditors.

The Chief Executive shall be invited to attend the Committee at least annually to discuss the process for assurance that supports the Annual Governance Statement. This shall be when the Committee formally considers the annual reports and accounts prior to Board approval.

To ensure appropriate accountability, other Executive Directors and, if required, members of the management team will be invited to attend when the Committee is discussing areas of risk or operation that are their responsibility.

The Chair of the Auditor Panel may invite Executive Directors and others to attend meetings of the Panel. However, these attendees will not be members of the Auditor Panel.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chair, the Audit Committee shall be chaired by one of the Non-Executive Director members of the Committee.

Other deputies may attend but must be suitably briefed and designated and notified in advance, where possible.

QUORUM:

The quorum for any meeting of the Committee shall be the attendance of a minimum of two members. Each member shall have one vote and in the event of votes being equal, the Chairman of the Committee shall have the casting vote.

The quorum for any meeting of the Auditor Panel shall be the attendance of a minimum of two members.

DECLARATION OF INTERESTS

All members, ex-officio 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.

MEETING FREQUENCY:

There shall be four meetings of the Committee each year with additional meetings where necessary. This includes a meeting to focus on the pre-Board consideration of the Annual Reports and Accounts which will only consider usual business by exception.

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Committee.

The Princess Alexandra Hospital NHS Trust

MEETING ORGANISATION

Audit Committee

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting shall 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.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.

Auditor Panel

- The meeting shall 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.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.
- The agenda items for discussion by the Auditor Panel shall be clearly distinguished from the items for discussion by the Committee.
- The minutes of the Auditor Panel shall be separate from the minutes of the Committee.

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

AUTHORITY

The 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 Committee and the Auditor Panel are authorised by the Board of Directors to investigate any activity within these terms of reference. They are authorised to seek any information they require from any employee, and all employees are directed to co-operate with any request made by the Committee and Auditor Panel.

The Committee and the Auditor Panel are authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if they consider this necessary and to seek advice and support from the Head of Corporate Affairs and external experts as required.

TERMS OF REFERENCE

The terms of reference of the Committee shall be reviewed at least annually and approved by the Trust Board.

DATE APPROVED

By Committee: 08.09.2025
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: September 2026

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE MEMBERSHIP

Membership and Those in Attendance	
Members	
Colin McCready	**Non-Executive Director and Committee Chair**
Ben Molyneux	Associate Non-Executive Director
Bola Johnson	Associate Non-Executive Director
In Attendance	
Tom Burton	Chief Finance and Infrastructure Officer
Bethany Potton	Deputy Director of Finance
Thom Lafferty	Chief Executive Officer
Andrew Kelso	Chief Medical Officer (Executive risk lead)
In Attendance (Internal & External Audit)	
James Shortall	BDO (LCFS)
Michael Evans	BDO (LCFS)
Aaron Winter	Partner, BDO (Head of Internal Audit)
Claire-Louise Hutchinson	BDO (Senior Internal Audit Manager)
TBC	(External Audit)
Secretariat	
Heather Schultz	Director of Corporate Affairs
Becky Warwick	Corporate Governance Officer

BOARD OF DIRECTORS:	**Trust Board (Private) –October 2025**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board**			
REPORT FROM:	**Chair: Tom Lafferty**			
DATE OF COMMITTEE MEETING:	**18th September 2025**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 Neighbourhood Health model	Y	Y	Y	WEHCP Neighbourhood Health Implementation Programme successful application as wave one site. One of 42 out of 141 national applications. Our initial focus is on adults with multiple long-term conditions and rising risk, starting in Harlow, our most deprived area, with plans to scale across West Essex. All partner organisations will be involved in the design & delivery of Neighbourhood Health and the Board is requested to support the commitment required.
2.2 West Essex Winter Plan	Y	Y	N	Robust winter plan for West Essex health services has been drawn up, social care plan being finalised and will be incorporated with health. Will identify key measures to monitor the learning from this year's plans.
2.3 Planning Framework	Y	Y	N	The planning framework discussion included a request for focused work on children's waiting lists and joint assessment with the ICB of the risk in this area of commissioning sufficient capacity to meet the demand.
2.4 Locality Highlight reports	Y	Y	N	Locality reports highlighted a successful implementation of integrated training posts with CUH and primary care in North Uttlesford, EPUT looking at developing for other areas of West Essex. Whipps Cross have implemented a centre of excellence for older people which primary care are involved with.

BOARD OF DIRECTORS:	**Trust Board (Private) –October 2025**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board**			
REPORT FROM:	**Chair: Tom Lafferty**			
DATE OF COMMITTEE MEETING:	**18th September 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Strengthening Primary care Representation at place	Y	Y	N	Discussion regarding the resourcing of primary care clinical leads in the future ICB resourcing models focused on the importance of primary care inclusion in Neighbourhood Health developments and care closer to home. A proposal will be prepared for ICB discussion.
3.1 Host Provider Delegation Proposal	Y	Y	Y	The WE HCP Board approved the principle to progress with a phased approach to delegating commissioning and contract responsibility. Request to amend to give a particular focus to mitigate any separation of physical from mental health in service delivery. Further detail is to be added to the paper and circulated to Board members. Following recommendations supported: recommend approval to the PAHT Board and Essex Joint Committee (TBC); To continue working with PAHT to complete due diligence on the proposed contract, managed via the Finance and Commissioning Committee; Work with ICBs to secure resources needed to implement the host provider model, aiming for a decision by end of October; Complete a self-assessment of readiness for delegation and agree on an assurance and governance framework with ICBs for the transition.

BOARD OF DIRECTORS:	**Trust Board (Private) –October 2025**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board**			
REPORT FROM:	**Chair: Tom Lafferty**			
DATE OF COMMITTEE MEETING:	**18th September 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.2 Host Provider Governance Framework	Y	N	N	The amendment of the Host Provider governance structure was approved with an acknowledgement that further revision will be required as the ICB structures develop. Main changes are to change the HCP Committees name to HCP Groups, widen the membership to deputy director/head of staff and set up a small HCP Executive team to streamline recommendations to the HCP Board.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 October 2025**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Executive Board (EB)**			
REPORT FROM:	**Acting Committee Chair – Sharon McNally**			
DATE OF COMMITTEE MEETING:	**16 September 2025**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 CEO Strategic Update	Y	Y	N	Key headlines were: • **National Neighbourhood Health Implementation Programme (NNHIP):** West Essex successful in its bid for Wave 1. • **National Oversight Framework:** Formally published with PAHT in Segment 4. • **Cancer Summit:** This had taken place on 17.09.25 following external reviews by BHRUT/NHSE. • **National Maternity Investigation:** 14 participating organisations now announced – PAHT not chosen.
2.2 Health on the High Street	Y	Y	N	The New Hospital Programme Director (NHP-D) presented an update on moving services to the high street as well as the current plans/progress for a Phlebotomy Service in the Harvey Centre in Harlow, a move which was fully supported by Harlow District Council. Assuming formal approval of the move by the end of September, it was anticipated the service would go-live by the end of January 2026.

3.1 Restructure Update	Y	Y	N	**Organisational Restructure**: Feedback still being collated and final structure to be published in mid-October. **Medical Secretariat Consultation:** Launch delayed until after the final restructure had been published mid-October with final structure to be re-presented to EB in October
4.1 OD Proposal	Y	Y	N	This item was presented by the CPO. There was a need to invest in strengthening the senior leadership teams, including building a more inclusive and values-based culture. Three different approaches from three different providers had been explored in order to provide the best value for money and best fit for the organisation. All three options were presented in the paper. The Executive Board reviewed all three options and approved the proposal to move forward with the third one, Max&.
4.2 Non-Resident On-Call Bank Rate for Medical Staff	Y	Y	N	The paper set out a proposal to introduce a differentiated bank rate for non-resident on-call shifts. Currently the Trust paid a flat hourly rate to all bank doctors covering on-call duties, regardless of whether they were resident on-site or non-resident and available remotely. This approach did not reflect the differing levels of clinical intensity and commitment between the two models and was inconsistent with current practice across other acute providers within the Integrated Care Board (ICB). Benchmarking confirmed that all neighbouring trusts had introduced a distinct “availability” rate for non-resident bank shifts, with additional payment only when work was undertaken. The current model made the Trust an outlier and created unnecessary spend. The EB endorsed the proposal.

5.1 Report from Operational Board	Y	Y	N	Key headlines were: • **Performance:** Teams were commended on current performance, particularly in Breast and Dermatology. The Trust had also been successful in securing Cancer Alliance monies to improve performance further to year-end and also to support some pilots. • **RTT/ASIs:** RTT performance for July had been met along with the waiting list reduction target. However, the organisation was struggling with the 52 and 65 week cohorts. • **UEC Performance:** EM-SDEC had been approved and since implementation had had a positive impact on performance with the August position being ahead of trajectory. However there had been a decline in performance for 12 hour waits and ambulance offloads. That week however both had slightly improved. The aim now was for 65 discharges per day and this target had already been reached on a number of days. • **Surgical Hub:** This had been delayed to the start of 2026 which would require a review of currently surgery plans. The decision had been taken anyway to recruit some registrars as circa 2k patients were waiting for an outpatient appointment. • **Winter Planning & Transformation Plans:** These had also been discussed. • **Cervical Screening:** An action plan was in place.

5.2 Report from Risk Management Group	Y	Y	N	<u>Risk ID 786 – Maternity Lone Working (for awareness)</u> Elements of Health & Safety pertinent to the People Committee would be agreed. <u>Risk ID 388 – Fire Alarm System (for addition to the Corporate Risk Register (CRR))</u> Risk score of 20 to be reviewed with the possibility of reducing it to 16. Revised risk and action plan to be presented to October EB. <u>Risk ID 793 – Un-outcomed Clinics (for inclusion in the CRR)</u> This risk relating to un-outcomed clinics was approved for the Corporate Risk Register. <u>Risk ID 692 – Anticoagulants (for inclusion in Trust-wide Risk Register)</u> This risk relating to the risk of harm for patients commenced on anticoagulants whilst an inpatient was approved for the Trust-wide Risk Register.
5.3 Corporate Risk Register	Y	Y	N	Not discussed.
8.3 UEC Additional Consultants Business Case	Y	Y	N	The Executive Board was content to endorse the case for 2 WTE emergency medicine consultants.
8.1 Uniform Business Case	Y	Y	N	The Executive Board was content to endorse the case, agreeing it was a huge step forward in terms of standardisation and in terms of identifying colleagues more easily.
8.2 Urology Business Case	Y	Y	N	It was agreed the case would be reviewed further and presented to the next Executive Board, once it had been through the appropriate governance channels.

7.1 Finance Update	Y	Y	N	The Trust had declared a deficit of £0.5m in month 5 of 25/26 against a planned deficit of £0.6m so was on plan year-to-date. Agency expenditure in month was higher than it had been in the last 3 months and bank costs remained high and were not reducing in line with the target set by NHSE.

BOARD OF DIRECTORS: Trust Board 2 October 2025 **AGENDA ITEM: 7.4**

REPORT TO THE BOARD FROM: Charitable Funds Committee

REPORT FROM: Committee Chair- Helen Howe

QUORACY: The meeting was not quorate, items were approved subject to the CFIO's (lead exec) approval following the meeting.

DATE OF COMMITTEE MEETING: 9 September 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
Charity Video	-	-	-	The Committee watched a video produced following the recently held Full Vision Charity Golf Day raising funds for the neonatal department. The Committee commented it was great video showcasing an important fundraising effort.
2.1 Breast Unit Fundraising Update	Y	N	N	The Committee **approved** three upcoming fundraising events: • GR11 Trek – 12-19 September 2026 • CBT for Gynaecology Patients • Shopping Day & Breast Cancer Awareness event – 23 October 2025
2.2 Charity Update	Y	N	N	Highlights included: **Financials:** As of June, the closing balance was £659,000 across all funds, with £140,000 income so far this year. The breast unit remains the largest contributor. **Corporate Engagement:** The charity golf day raised £75,000 **Community and Staff Initiatives:** Funding for a second scalp cooling machine, staff well-being events, and the opening of a new sensory garden were noted. **Well-being Proposals:** the "library privacy pods" project had been selected for the application for NHS Charities Together workforce wellbeing grant. **Project Management:** Introduction of PM3 to support delivery of the charity's 2025-28 strategy and action plan

BOARD OF DIRECTORS: Trust Board 2 October 2025 **AGENDA ITEM: 7.4**

REPORT TO THE BOARD FROM: Charitable Funds Committee

REPORT FROM: Committee Chair- Helen Howe

QUORACY: The meeting was not quorate, items were approved subject to the CFIO's (lead exec) approval following the meeting.

DATE OF COMMITTEE MEETING: 9 September 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.3 Charity Operational Group Update – Membership & Terms of Reference	Y	N	N	A new Charity Operational Group is being established to oversee the operational management of the Charity and review funding requests over £10,000, ensuring alignment with the Charities scheme of delegation. Membership will include representatives from various departments. The Committee supported the proposal and **approved** the Terms of Reference for the group.
2.4 'My Thank You' digital platform proposal	Y	N	N	A proposal to invest in a digital platform allowing patients and families to send messages of appreciation to staff, with optional donations and GDPR consent was received. The platform is expected to increase engagement and donor data, with a pilot planned for later in the year. The Committee **approved** the proposal.
3.1 Charity Annual Report and Accounts	Y	Y	Y (audit)	The Committee reviewed the draft annual report and accounts and noted they would be audited over the next few weeks. The final report would be presented to the Committee in December.
3.1 Charitable Funds Finance Report	Y	N	N	Total fund balances at M03 is £659k (£743k as at 31st March 2024). Return on Investment of Breast Unit Funds and other Funds are £45k & £71k respectively.