The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 11 December 2025 at 09.30 - 13:30
Venue: Boardroom, Alex health Training Block, PAHT

	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	18
09.35: Patient Story: From acute to community					
02 Chair and Chief Executive's reports					
10:00	2.1	Acting Chair's Report	Inform	Acting Chair	20
10:05	2.2	CEO's Report	Inform	Chief Executive	24
		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	30
10:25	3.2	Board Assurance Framework 2025-26 *Diligent Resources: BAF 2025-26*	Review/ Approve	Director of Corporate Governance	33
04 Patients					
10:35	4.1	Reports from Quality and Safety Committee 28 November 2025 • Part I • Part II	Assure	Committee Chairs	40 47
10:45	4.2	Maternity Reports: • Maternity Patient Safety Incidents (MPSIs) • Quarterly Maternity Assurance • Maternity 6 Monthly Staffing Report • Maternity & Perinatal Incentive Scheme Update including Saving Babies Lives	Assure	Interim Chief Nurse/ Director of Midwifery	50 53 58 70
11:15	4.3	Nursing, Midwifery and Care Staff Levels	Assure	Interim Chief Nurse	80
11:25	4.4	Learning from Deaths (Mortality) Report	Assure	Chief Medical Officer	103

11:35	4.5	Health Inequalities	Assure	Chief Medical Officer	111
		BREAK 11:45 to 11:55			
05 People					
11:55	5.1	Report from People Committee 24.11.25	Assure	Committee Chair	127
12:05	5.2	Freedom to Speak Up		Chief People Officer	131
12:15	5.3	Gender Pay Gap		Chief People Officer	165
12:25	5.4	Ethnicity Pay Gap		Chief People Officer	175
12:35	5.5	Disability Pay Gap		Chief People Officer	183
06 Performance/Pounds/Places					
12:45	6.1	Report from Performance and Finance Committee 27.11.25	Assure	Chair of Committee	190
12:50	6.2	Finance Update	Assure	Chief Finance & Infrastructure Officer	198
13:00	6.3	Integrated Performance Report (IPR) including: • Access Report	Discuss	Chief Operating Officer	206 235
07 Governance					
13:10	7.1	Report from Audit Committee 08.12.25	Assure	Chair of Committee	246
13:15	7.2	Report from West Essex Health and Care Partnership Board 18.09.25	Assure	Chair of Committee	250
13:20	7.3	Report from Executive Board Meeting 18.11.25	Assure	Chair of Committee	252
13:25		*Opportunity for members of the public to ask questions about the board discussions or have a question answered.*			
08 Closing administration					
	8.1	Any unresolved issues			
	8.2	Review of Board Charter			
	8.3	Summary of actions and decisions	-	Chair/All	
	8.4	New risks and issues identified	Discuss	All	
	8.5	Any other business	Review	All	
	8.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
13:30		Close			

The Princess Alexandra Hospital NHS Trust

Date of next meeting: 5 February 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	Colin McCready	Chief Operating Officer	Anna Jebb
Non-executive Director	David Baines	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 (on sabbatical)	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 2 October 2025 from 09:30 to 13:15

Present:	
Darshana Bawa	**Acting Trust Chair (ATC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Robbie Ayers (non-voting)	Deputy Chief Transformation Officer (D-CTO)
Liz Baker	Non-Executive Director (NED-LB)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO)
Ralph Coulbeck (non-voting)	Associate Non-Executive Director (ANED-RC)
Parag Jasani (non-voting)	Associate Non-Executive Director (ANED-PJ)
Andrew Kelso	Chief Medical Officer (CMO)
Thom Lafferty	Chief Executive Officer (CEO)
Camelia Melody	Acting Chief Operating Officer (ACOO)
Giovanna Leeks (non-voting)	Chief People Officer (CPO)
Colin McCready	Non-Executive Director (NED-CM)
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)
Jo Ward	Interim Chief Nurse (I-CN)
In attendance (Staff Story):	
Sam Gooden	Deputy Chief People Officer
Freya Cannon	Associate People Business Partner
Hannah Milne	General Manager Anaesthetics/Critical Care/Theatres
Sacha Mann	Change Advisor
Favour Ibekwe	Change Programme Advisor
Amy Hooke	Employee Relations Advisor
Brandon Sita	Employee Relations Advisor
Members of the Public:	
Ian Childs	Liaison
Mark Taylor	XY Laser Services
Russell Edwards	Surgical Consortium
Chloe Bryant-Dunn	NEXT NED Programme
Observing:	
Finola Devaney	Director Clinical Quality & Governance
Shahid Sardar	Associate Director Patient Engagement & Experience
Linda Machakaire	Director of Midwifery
Apologies:	
Marcel Berenblut	Director of Communications (DoC)
Bola Johnson (non-voting)	Associate Non-Executive Director (ANED-BJ)
Jim McLeish (non-voting)	Chief Clinical Transformation Officer (CTO)
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 and members of the public introduced themselves.
1.1 Apologies	
1.2	Apologies were noted as above.

1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 05.06.25 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. In terms of the action log the following were noted: <u>TB1.05.06.25/05 – Corporate Risk Register/Chemotherapy Risk</u> The Chief Medical Officer (CMO) informed members it had been agreed this was a staffing issue rather than an estates issue, and required further mitigation in order to reduce the risk over time. He agreed the action could be closed. <u>TB1.03.05.25/04 – Charity to fund the work around Sexual Safety</u> The Chief Finance & Infrastructure Officer (CFIO) informed members the Charitable Funds Committee only met quarterly so he requested the action date be changed, he would pick it up and the action could be closed.
Staff Story: NHS Graduate Management Training Scheme Experience – One Story, Three Voices	
1.6	Three former NHS Graduate Management Training Scheme (GMTS) trainees shared their recent experiences at the Trust. This included insights into their placements, what aspects of the scheme they found most valuable and challenging, and their reflections on how the programme could be optimally leveraged to support the Trust's future workforce development.
1.7	Their presentation highlighted the strategic value of investing in Graduate Management Trainees as a means of cultivating future NHS leaders. It also provided an insight into what was needed to ensure a positive and impactful experience for graduates and explored how their skills could be effectively harnessed within the Trust. It also raised Board awareness of this sponsored development pathway and the longer term benefits it offered to the organisation. A key action from the presentation was the desire to establish a GMTS network (current trainees & alumni).
1.8	In response to the above the CEO asked about the benefits of a GMTS network and also how the trainees would carve out time for their own teams to learn from the benefits they had experienced in being part of the GMTS. In response it was confirmed one benefit of the network would be to signpost new colleagues as to where to go next. In response to the second question it was highlighted a 'mini-orientation' had recently been provided for a new service manager which had been along the lines of the GMTS orientation which the trainees had found hugely beneficial.
1.9	Associate Non-Executive Director Ralph Coulbeck (ANED-RC) informed members he had been on the GMTS and for him, getting the first three to five years right post completion of the scheme, was key to success. The trainees agreed.
1.10	ANED Ben Molyneux (ANED-BM) then asked what could be done for colleagues who were not on the scheme in terms of getting the best out of them too. In response it was agreed that nurturing colleagues and sharing learning was key
1.11	The CEO then commented that he would fully support the development of a local network. It would be even more powerful for him if this could be pitched in terms of the integration of services and including graduates in the areas of mental health and community services. He then commended how professionally the graduates had all come across that day.
1.12	NED Liz Baker (NED-LB) then stated she would also fully support the development of a local network, which it was then confirmed, would be ICB-wide.
1.13	The ATC thanked the graduate trainees for a very insightful presentation, confirming that the Board fully supported the development of a local GMTS network.
02 Chair and Chief Executive's Reports	
2.1 Acting Chair's Report	
2.1	The ATC presented her update which was taken as read. Members had no questions.

2.2 CEO's Report	
2.2	This update was presented by the CEO and the key headlines were as follows: • **NHS Ten Year Plan:** The CEO's update highlighted the extent of change currently affecting the organisation, both externally and internally. There was a fine balance between driving positive change but at the same time ensuring there was sufficient organisational stability and continuity. The three shifts envisioned within the Plan were 1) Acute to Community 2) Sickness to Prevention and 3) Analogue to Digital. • **Executive Changes:** Sharon McNally, Chief Nurse and Deputy Chief Executive, would be seconded to the role of Chief Nurse at Mid & South Essex NHS Foundation Trust (MSE FT) from 29.09.25 for an initial 6 months. He was hugely grateful for the role that Sharon had played as Acting CEO prior to his commencement in post at PAH in November 2024 and he wished Sharon the very best in her secondment. He was also delighted to announce that, during Sharon's secondment, Tom Burton, the Chief Finance & Infrastructure Officer (CFIO) would act as Deputy Chief Executive, following an internal Expression of Interest process. A similar process had also been run to appoint the Acting Chief Nurse and Jo Ward had been successful and appointed to this role. He also welcomed Anna Jebb as the new Chief Operating Officer to the organisation. Anna would formally commence in post on 06.10.25. He was very grateful for the sterling efforts of Camelia Melody over the past few months as Acting Chief Operating Officer, during a time of considerable operational pressure and external scrutiny. He also welcomed Andrew Kelso Chief Medical Officer (CMO) to his first public Board meeting and also Robbie Ayers Deputy Chief Transformation Officer, covering for Jim McLeish that day. • **Public Engagement:** As the hospital transitioned to a health and care provider at Place, engaging the public in that conversation would be key. An example of that had been the AGM that week and also a recent public event held in Bishop's Stortford for East Hertfordshire patients, led by the Patient Panel. Whilst the public had raised some challenges at both events, overall there had been really positive engagement. • **Organisational Change:** The consultation period for the divisional restructure had now come to an end and colleagues were working hard to take account of the huge amount of feedback that had been received. Colleagues had been very engaged in the process and had come up with some robust alternative options which would now be considered. Staff would soon be updated on what had been learned and how and when change would be implemented. During this time a variety of support options for colleagues would be in place. Following the restructuring process, the organisation would be investing in two important areas of external support: 1) Leadership Development & Support and 2) A Cultural Change Programme. • **UK Health Security Agency (UKHSA) Announcement:** The Government had recently announced the UKHSA would be moving to Harlow. This was great news for the town, providing huge investment, and offers of jobs for the local population. It was also an opportunity for the hospital to undertake some joint working in healthcare and life sciences. • **National Neighbourhood Health Improvement Programme (NNHIP):** West Essex Health & Care Partnership (WEHCP) had been accepted onto the first wave of this programme which would major on neighbourhood health and support access to resources. This was evidence of the traction that had been made here and colleagues should be proud to be leading the system in this first wave.
2.3	In response to the above, Non-Executive Director Liz Baker (NED-LB) asked whether the organisation was ready, on an equal basis, for all three 'shifts' referenced above. The CEO responded that firstly all three shifts were of equal importance. There had been some great work on 'acute to community' and moving the location of services, and changing pathways. In terms of 'sickness to prevention', the hospital's responsibilities went above 'treat and discharge' and this was being tackled by plans for health on the high street, which in turn

	would tackle deprivation and make every contact count. The organisation was yet to step into this space however. In terms of 'analogue to digital' huge steps had been made with the introduction of Alex Health and more recently there had been further progress with the patient portal. Next steps would be to embrace artificial intelligence. In summary, good progress was being made but more needed to be made on 'sickness to prevention'.
Questions from the Public	
2.4	There were no questions from the public.
03 Risk	
3.1 Corporate Risk Register (CRR)	
3.1	This update was presented by the CMO and the paper was taken as read. He drew members' attention to sections 3 and 4 of the paper.
3.2	In terms of section 3 (Summary of risks scoring 20) there was one risk with a score of 20 which related to the Emergency Care access standard. There was a risk that patients may deteriorate as a result of failing to deliver this standard. Actions/mitigations were implementation of a Trust-wide improvement programme including Estate works to support optimisation of ED clinical space and implementation of full capacity process, which included reverse boarding and utilisation of escalation capacity.
3.3	In terms of section 4 (New risks scoring 16), there were two: **CPAP machines:** There was a risk the Trust may not be able to provide appropriate respiratory support to patients as the current CPAP machines had approached end of life and machine consumables were now obsolete. This was a neonatal risk. Actions/mitigations: Three machines were serviced and in use. Optiflow machines were available and a business case was going through Capital Working Group. This had been a risk for a long time and the CMO was confident in terms of reducing the risk score. **Stroke patients**: There was a risk that Stroke patients would not receive the medical, nursing or therapist care they needed. This was a Trust-wide risk. This risk needed more work and the CMO informed members he would bring this back with additional assurance.
3.4	In response to the above, NED Oge Austin-Chukwu (NED-OA) highlighted the stroke risk had been a risk for a while and she asked for more detail. The CMO responded there was a national stroke campaign but this probably required a refresh and there was work to do with commissioners to get those patients into the right place. He shared her concerns and agreed this pathway needed to be right, but he did not want, at that point, to provide a timescale. He provided some assurance this was being discussed at the Medicine divisional meetings.
3.5	Associate NED Parag Jasani (ANED-PJ) asked what the barriers were to the above. The CMO responded that it was a struggle to get these patients into TIA clinics. There were also challenges in terms of transferring patients from an inpatient bed to a inpatient stroke bed which meant time was lost. It would be key to shorten the time between diagnosis and admission.
3.6	In response to a question from the ATC, the CMO agreed to provide an update on the stroke pathway, within the next six months.
ACTION **TB1.02.10.25/08**	**Provide an update on the Stroke Pathway by latest April 2026.** **Lead: Chief Medical Officer**
3.2 Board Assurance Framework 25/26	
3.7	This update was presented by the Director of Corporate Governance (DCG). There were no changes to the risk scores that month, however two risks were included for noting: - New BAF risk 2.1 (staff engagement and morale) – this risk had been approved at Private Board in September scoring 12. - BAF risk 3.2 (system pressures) which was assigned to the Board for review however it was not proposed to change the risk score of 16.
3.8	The CEO then made a point relating to risks 3.1 (Estate & Infrastructure) and 3.5 (New Hospital). In terms of the latter the new hospital had not delivered to time. That risk had

	therefore materialised so was now less of a risk. The risk going forward related to a safe estate, which was described in risk 3.1. Were two separate risks therefore needed. It was agreed to consider this outside the meeting. The new hospital context could be included in risk 3.1.
ACTION **TB1.02.10.25/09**	**Consider whether BAF Risk 3.5 is still required and whether the narrative relating to the new hospital could be included in risk 3.1 (Estate & Infrastructure).** **Lead: Director of Corporate Governance/Chief Strategy Officer/Chief Finance & Infrastructure Officer**
3.9	NED-LB then asked how system risks were overseen/prioritised. The CEO responded a risk register was presented to the West Essex HCP Board which had a great number of partners as part of its membership.
3.10	ANED-RC then asked about risk 3.1 (scoring 20) and what the mitigations were. The CEO responded there was a programme of estates improvement works but some of the issues related to the environment and associated mitigations were limited. Some funding had been provided for works around the fire/electrical systems but the challenge was when and how to programme those into a live environment. Even with the new hospital, this risk would never be fully mitigated. This was a different type of mitigation though. Part of the new hospital was about reprovision of the acute but also about the resourcing of the neighbourhood hubs. It the organisation was successful in shifting services into the community, that in itself was a mitigation although it did not take away the need to provide acute services in a safe environment.
3.11	The CMO then added that as the organisation took over hosting duties, strategies/strategic objectives would be refreshed to reflect both the hospital's but also the HCP strategy. An inevitable refresh therefore of the BAF would follow with that, into a more comprehensive system-based BAF.
3.12	ANED-PJ then asked about the associated mitigations for risk 2.1 (staff engagement and morale). The Chief People Officer (CPO) responded there were a few elements including delivery of a two-part programme designed to support the Trust's cultural transformation and leadership development, some cultural benchmarking and a programme of work for line managers to upskill them. It was also about understanding when people felt unsettled and asking the right questions.
3.13	In response then to a question from NED Colin McCready (NED-CM), the CPO confirmed that the Staff Survey 2025 would launch the following week. In response to a question from ANED Anne Wafula-Strike (ANED-AWS) in relation to recent social unrest nationally, it was confirmed the position was being monitored and there was work underway to support staff, including with the police and local college. Currently the risk related to associated staff turnover was believed to be minimal.
04 Patients	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	<u>Report from QSC (Part 1)</u> This update was presented by NED-OA and the key headlines were as follows: • **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%. • **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. • **Mortality Indices:** A watchful eye would be kept on these and it could not be assumed it was down to coding. • **Urology Update**: Assurance was provided around the service. The MDT and cancer management processes had been externally reviewed. Going forward Urology data

	would be brought to QSC by exception, for continuing oversight and a business case was in train for additional resource. • **Terms of Reference:** Revised ToR were presented for Board approval and had been amended to include the NOF metrics and how QSC would monitor those. A reference to responsibilities in terms of Place monitoring had also been included.
4.2	In response then to a concern that the stroke risk had not come up at QSC, it was agreed that going forward the CMO would provide QSC with a summary of the quality risks from the CRR (in addition to the bi-monthly update on the BAF risk/s).
ACTION **TB1.02.10.25/10**	**QSC to receive a summary of the quality risks from the CRR. (To be included in the monthly Patient Safety Report).** **Lead: Chief Medical Officer**
4.3	Report from QSC (Part II) This update was presented by NED Ben Molyneux (NED-BM) and key headlines were as follows: • **Maternity Dashboard:** This had been presented for the first time and showed some positive trends but also some areas for further focus. • **Monthly Maternity Report:** There had been 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 was planned to address variability and safety. • **Triage Deep Dive:** Estates-related issues were hard to manage but it had been useful to hear the plan. A 24/7 telephone triage services was having a positive impact and was a real step forward. • **Maternity & Perinatal Incentive Scheme Update:** There were a couple of areas of potential risk, but mitigations were in place. • **Horizon Scanning:** Participants in the national Maternity & Neonatal investigation had been announced and PAHT was not amongst the contingent.
4.4	In line with the request, the Board was content to approve the Committees' revised ToR.
4.2 Inpatient Survey	
4.5	This update was presented by the Interim Chief Nurse (I-CN) and the paper was taken as read. She commented that the survey had been undertaken the previous November, at the point when the Trust's new electronic patient record system had gone live, and the results had been disappointing and not where the organisation wanted to be in terms of patient experience. The results aligned with the themes of current complaints which included issues around access, communication, ward-based care and discharge processes. A Fundamentals of Care Nursing Programme was now looking at nursing care with some associated work-streams to tackle the issues and to support improvement. For assurance, the action plan would now be presented to QSC on a quarterly basis and the FFT results would be used as a 'pulse' to evidence progress. It would be everyone's business going forward to address the issues and improve results.
4.6	The CEO responded that he agreed with the assessment above and even if Alex Health was removed from the equation, the results would still have been well below where they should be. The organisation needed to develop a clinical culture where patients felt they received an excellent service and he also agreed with the refocus on the basic fundamentals of care.
4.7	ANED-BM then commented he agreed there was room for improvement in many of the basic elements of nursing care. This was not a new issue for the organisation and improvements would be key that year.
4.8	In response then to a question from ANED-AWS the I-CN responded that colleagues were already working with staff on the shop floor to glean an insight into their working experience, particularly around culture and the delivery of hands-on care. This would help to support minimum standards of basic care for patients, with no variations.
4.9	At this point NED-OA highlighted that communication was a theme which kept coming up. Could any learning be taken from other organisations. The CPO responded that the Violence

	& Aggression Group was looking at how to better support/train staff for when there was the potential for them to back-off (in fear of verbal or physical abuse) when a patient or relative became distraught/angry. This had the potential for the right care not to be delivered.
4.10	In response to the above the Associate Director of Patient Engagement & Experience (AD-E&E) added that there was also some work underway with the voluntary sector on 'waiting well' and 4k calls would be made to patients over the next six months to signpost them to support whilst they waited for the appointment/treatment. There would also be some collaborative work with the CAB to refer patients into the voluntary sector to ensure they were supported.
4.11	The Deputy Chief Transformation Officer (D-CTO) then informed members that the Quality Improvement team was also supporting with this work and the first aspect of this would be to understand the root causes. There would be some support in terms of communication and the Senior Leaders Forum agenda would include elements of focussing in on patient experience – there were ways to communicate and update regardless of other challenges.
4.12	The CEO then commented that the organisation needed to reset its clinical cultures and clinical leaders needed to lead by example and model best practice. There needed to be honesty in terms of the reality of care provision; the same issues were being seen year-on-year and this was unacceptable.
4.13	In response to the above conversation the Acting Chief Operating Officer (ACOO) provided assurance that the longest waiting patients were being contacted.
4.14	The ATC summarised by stating that the Board was assured of the actions in train to address the results of the Inpatient Survey.
4.3 Maternity Reports	
4.15	This update was presented by the Director of Midwifery (DoM). There had been no new maternity PSIIs declared or closed since the last report. There were currently four ongoing investigations; 2 PSIIs and 2 cases with MNSI.
4.16	NED-CM drew members' attention to the fact there were two cases past the ICB deadline as of August 2025. It was noted both were due to be presented to the Incident Management Group in October. ***POST MEETING NOTE:*** It was confirmed after the meeting that the first case referenced above was a skull fracture declared on 02.05.24 and the second was a retained swab declared on 16.01.25.
4.17	The DoM continued that in relation to the Maternity & Perinatal Incentive Scheme Update, four safety actions (1, 6, 7 and 8) were at risk but mitigations were in place to address this.
4.4 Nursing Midwifery and Care Staff Levels	
4.18	This update was presented by the I-CN and the paper was taken as read. There had been a sustained overall registered fill of > 95%. No wards had achieved < 75% overall fill rate in-month. The increase in overall fill rates continued to be multifaceted with an increase of enhanced care needs. The mid-year nursing and midwifery establishment review was currently going through the required governance processes and would be approved at Board in November 2025.
4.19	In response to the above the CPO commented she would welcome the mid-year review. The metrics for bank staff were not where they needed to be and a big driver of this was enhanced care.
4.20	The CEO then reflected that on paper, this looked like good news but did it reflect the reality on the shop floor. During his walkabouts, areas did not feel well staffed and staff shortages also aligned with the Inpatient Survey.
4.21	The I-CN then informed members staffing and healthcare support numbers were improved, but there was now work to do on how to structure shifts.
4.22	NED-CM then commented that he was unclear what was driving the enhanced care requirements at night for healthcare support workers. It was noted that the paper worked in averages which needed to be balanced against the requirement to move people around.

	This was a point in time and was not static and needed to be triangulated with other data for example on falls and pressure ulcers.
4.23	The ATC suggested triangulating the information around staffing with falls and pressure ulcers . In response the I-CN informed members that falls and pressure ulcers continued to be tracked and she agreed, there was no triangulation with staffing. Colleagues were working through the Fundamentals of Care Programme and she would bring back more tangible actions.
ACTION TB1.02.10.25/11	**Provide information around staffing levels in relation to other quality metrics including pressure ulcers and falls. Lead: Interim Chief Nurse**
4.5 Learning from Deaths Update	
4.24	This update was presented by the CMO and the paper was taken as read.
4.25	Of key to note was that SMR was rising (above expected) and HSMR and SHMI were also rising and would become 'above expected' in the next four to six months. The reason for the increases was twofold. Firstly, the implementation of Alex Health had created a larger number of patient episodes than previously. The second issue was that the way medical records were written did not currently meet coding requirements.
4.26	The CMO continued that following investigation no problems with patient care had been identified. Reviews of CUSUM alerts had confirmed this. The organisation's learning from deaths policy maintained a robust oversight of causes of mortality.
4.27	The CMO then informed members that the coding team could go back in-year to adjust the data. These colleagues were also attending M&M meetings to draw out improvements in practice. As further assurance the Trust had been in contact with other Oracle Health users, all of whom had experienced the same issues and all of whom had introduced the above actions in mitigation.
4.28	ANED-PJ reflected there was now an education piece to be undertaken for the clinicians. The CMO agreed and commented that he too had now changed the way in which he wrote patient notes. The system had been designed for use in a different health system (USA).
4.29	ANED-BM then asked whether the organisation would just need to accept its raised HSMR rating or would training drive this back down. The CMO responded that coding didn't need to be perfect to remain within expected limits but the organisation needed to get it as precise as it possibly could.
4.30	ANED-BM then asked whether going forward, there would always be an issue in August with the incoming new doctors. The CMO responded this might be the case but the rolling year calculation would support a more even overall score.
4.31	The ATC thanked the CMO for his update and commented that the Board could take assurance from the explanation that the CMO had provided. In response to a final question from the ATC the CMO confirmed that in terms of a timeline, there should be some improvements over the next four to six months but this needed to remain a key focus for the next twelve.
BREAK 1122 – 1135	
05 People	
5.1 Report from People Committee (PC)	
5.1	This update was presented by the ATC and the key headlines were as follows: • **Statutory/Mandatory training compliance:** Performance was at 90% and colleagues were to be commended for this. • **Appraisals:** Performance had dipped to 74% so an action plan was now in train. • **Staff Survey:** This was about to be launched with a plan to improve on the 24/25 response rate (49%) to 60%. Some walkabouts were planned across the organisation to

	engage with colleagues and to encourage responses. It was agreed that the programme of NED walkabouts would focus on engaging with clinical staff on this.
ACTION TB1.02.10.25/12	**NED walkabouts to focus on engaging with clinical staff on completing the staff survey.** **Lead: Acting Trust Chair**
5.2	The CEO then flagged that appraisal performance had shot up, but had then dipped again. He asked why performance was so variable. The CPO responded that she believed this had been due to the sheer numbers of people completing their appraisal at the same time in the previous year, and those were now all due to be updated. Communication around appraisal needed to be improved, including to reinforce how important it was. The ATC added it was hoped the Leadership Programme referenced above would support this.
5.2 Annual Report on Medical Revalidation	
5.3	The CMO informed members that the Responsible Officer in each designated body had a duty under the regulations to assure and improve their professional standards function for doctors with whom they held a prescribed connection. The report provided a summary of Appraisal & Revalidation metrics and processes relating to 01.04.24 to 31.03.25 for quality assurance.
5.4	The CMO informed members the report provided high level assurance that PAHT systems were robust for the appraisal and revalidation of medical staff. The majority of actions from the previous year were complete, apart from the review of the MHPS Policy. The focus in the current year would be clinical effectiveness and there would be some new actions in terms including complaints/incidents within appraisals and encouraging doctors to talk about this during the process.
5.5	NED-LB asked about the process for the deferral of revalidation and why that would be necessary. The CMO responded that the revalidation process required a doctor to undertake 5 appraisals in a 5 year period, satisfactorily. The Trust then submitted a report to the GMC. The process also required two 360s for each doctor. On occasion colleagues had to be chased to ensure the process was complete and this could lead to a deferral.
5.6	In line with the recommendation, the Board approved the report.
5.3 Workforce Race Equality Standard (WRES) 2024	
5.7	This update was presented by the CPO and key headlines were as follows: • Improvement in the overall recruitment of ME (minority ethnic) staff into PAHT. • Under-representation of ME staff at Bands 8c to VSM and Clinical ME staff from Band 5 to 6. • Both ME and white staff continued to experience bullying and harassment higher than the national average. • ME staff disproportionately experienced discrimination. • There had been a significant improvement in ME NED Board membership.
5.8	The CPO continued that bullying and harassment within the Trust had reduced from the previous year. However it was still higher than the national average for both ME and white staff and ME staff still experienced bullying and harassment at higher ratios than white staff. The People Business partnering Team would be creating a plan to address bullying and harassment cases by January 2026.
5.9	In terms of career progression, whilst ME staff respondents did believe the Trust provided equal opportunity for career progression, there had been an increase from the previous year in the number of ME staff who believed the Trust provided equal opportunities for career development. This was now in line with the national average for ME staff and almost at the same percentage as white staff within the Trust. In terms of violence and aggression (bullying and harassment) the CEO emphasised that PAHT had a zero tolerance campaign in this respect ('No Excuse for Abuse') aimed at combating the risk of violence and aggressive behaviour towards its People and encouraging patients and visitors to reflect on their actions.

5.10	In terms of patient behaviour, the I-CN then commented the organisation needed to equip staff to be able to escalate things quickly. This linked back to the Inpatient Survey and the Fundamentals of Care, managing violence and aggression and being able to call it out so that colleagues could be supported early on.
5.11	The CPO then suggested it was about working this issue through with the Freedom to Speak Up team and Patient Experience team to ensure data was triangulated with incidents to improve the lives of the organisation's people.
5.12	The Board noted the contents of the report which it approved for publishing in line with national requirements and approved the WRES action plan.
5.4 Workforce Disability Equality Standard (WDES) 2024	
5.13	This update was presented by the CPO and the key headlines were as follows: • 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 is much lower than the national average. • WDES Action Plan for approval to be signed off by the Trust Board.
5.14	The CPO informed members that the organisation's Head of EDI was leading some work with the Network and Communications team to get people to understand why it was so important for colleagues to record if they had a disability.
5.15	The CSO flagged that the Trust's recorded rate for disability was 3.7% against the national figure of 24% so there was a huge disparity. The CPO added that the numbers within the Staff Survey (which was anonymous) were much higher.
5.16	ANED-RC then highlighted that for 'reasonable adjustments' the organisation was trending downwards. The CPO responded there was work underway with the Staff Health & Wellbeing team to see what more could be done for colleagues and to clarify the funding process and what budgets were available.
5.17	The Board noted the contents of the report which it approved for publishing in line with national requirements.
5.5 PAHT Equality, Diversity & Inclusion Annual Report 2024/25	
5.18	This update was presented by the CPO and the key headlines were as follows: • The EDI annual Report 2024 -2025 provided assurance the Trust was meeting its statutory duties under the Equality Act 2010. • The report outlined the progress made towards delivering the Trust's annual equality objectives. • The report provided an update on the progress made against the NHSE High Impact Actions. • The report was mainly a retrospective report showing annual compliance with the national requirements.
5.19	The CEO flagged the report lacked strategic coherence in the round and he asked where this slotted into the Trust's overarching strategy.
5.20	The CSO responded this work was in train and would be complete by the end of the calendar year. As part of that a big engagement piece would be undertaken around what was important to the organisation's people, for example the Green Plan, and how that fitted. As the whole strategy refresh developed he would encourage colleagues to link in with anything that was missing from the existing strategy.
5.21	The Board noted the contents of the report which it approved for publishing in line with national requirements.

06 Performance/Pounds/Places	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This item was presented by NED-CM and key headlines were as follows: **Forecast Outturn:** PAF had a good discussion on this including potential risks and opportunities. **Strategic Developments:** The presentation highlighted the need with which decisions needed to be made as funding arrived, versus the need to have visibility of the pipeline of future activity. It was agreed there would be a Board session early on in the year to provide visibility on the pipeline for the coming year. **UEC Business Case:** The case for 2 additional consultants was endorsed by PAF. **ED 4 Hour Performance:** PAF requested performance be tracked with the Furthers cohort included. **National Oversight Framework (NOF):** A first look was provided for PAF of the NHSE dashboard. **Estate:** Key areas of risk were noted.
6.2	In response to the above the CEO commented it was helpful for PAF to have oversight of the new NOF however, it provided oversight of other metrics not just financial, and his concern was the right colleagues were not present to address any concerns around workforce or quality metrics.
6.3	NED-CM acknowledged the point and responded that whilst PAF did on occasion dip into other areas, assurance was always provided that concerns would be noted, and picked up by other committees. The CFIO added that operational performance and finance were everyone's responsibility.
6.4	The CEO then reflected on the disconnect in the M5 position, with the 25/26 forecast (including underlying position). Given the papers were public, it would be useful going forward for an explanation to be provided around that.
6.5	The CFIO acknowledged the point but the forecasting work had begun earlier that year. Whilst there were potential risks he agreed it was not clear in the paper there were also mitigations and opportunities. The Trust's external forecast was still breakeven but he acknowledged the potential challenges of achieving this had possibly been over-emphasised in the paper.
6.6	In response to the above, ANED-RC stated it needed to be made clear that the forecast was for break-even. In addition, and going back to the update on performance, he agreed it would be important to understand the ED 4 hour performance data without the Furthers cohort removed. The ATC agreed and that the Board needed to see the EM-SDEC performance metrics also.
ACTION **TB1.02.10.25/13**	**ED 4 hour performance data to be presented with the Furthers cohort included.** **Lead: Chief Operating Officer**
ACTION **TB1.02.10.25/14**	**EM-SDEC performance metrics to be provided.** **Lead: Chief Operating Officer**
6.2 Finance Update	
6.7	This update was presented by the CFIO. He informed members there was huge pressure to maintain performance, and finance was also high on the agenda. The Trust was currently holding the forecast position in terms of finance and the risks were reducing particularly in relation to workforce costs, acknowledging the slight blip in August due largely to annual leave. Whilst the PQP programme was delivering, there was some potential risk there. The cash position had been modelled and was okay but would need to be watched moving into 26/27. As mentioned, the organisation was ahead in terms of its forecasting work, with the emphasis now that this needed to be over multiple, not single years.
6.3 Integrated Performance Report	
6.8	Integrated Performance Report (IPR)

	The ACOO introduced this paper and key headlines were as follows: • **Pressure ulcers:** These had increased, mitigations were in place and being overseen by QSC. • **Patient Experience:** FFT (a barometer of experience) had been at an all time high for 25/26 at 88.2% in July. • **28 day cancer performance:** This had taken a dip in August due to annual leave and bank holidays but during September there had been a step change and the hope to be back on plan for 77% in September. • **62 day cancer performance**: This was a major focus and PAHT was currently in tier 1. Performance had taken a dip in July but there had been a significant jump in August of 16% to reach 57%. Performance had continued to improve through September. • **Dermatology/Breast:** There was good news here thanks to Cancer Alliance monies, an additional MRI scanner and additional theatre slots. For dermatology there had been a reduction in routine referrals of 65% due to Telederm and patients being seen in a community setting. 1k additional appointments had been created per month due to additional clinicians and soon there would be no backlog at all in the service. • **Urology/GI:** Urology during July had treated over double the amount of patients but was not quite there yet and GI had seen an improvement but still required some work. • **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, and 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 and 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.
6.9	In response to the above, the CSO commented that Dermatology was a good example of putting a strategy into play and working with partners to transform a service. His suggestion would be to ask the team to showcase their service to the Board – members agreed.
ACTION **TB1.02.10.25/15**	**Dermatology Showcase to be presented to the Board.** **Lead: Chief Operating Officer**
6.10	• **Diagnostics:** There had been a dip in performance but additional capacity had been added and a new MRI scanner had been secured for the CDC. The organisation was providing mutual aid for audiology which was impacting on its own performance. • **UEC:** 4 hour performance had improved due to the removal of Furthers patients from the cohort. 12 hour waits were a concern, but work was underway with UEC colleagues to unpick this. Work was also underway with system partners around ambulance conveyances but ambulance offload performance was good.
6.11	In response to the above ANED-BM highlighted that assurance was needed around ED-SDEC performance ahead of winter. The ACOO responded that this was being tracked and an update would be brought to October PAF as part of the winter plan and as discussed at PAF.
6.12	<u>Appointment Slot Issues</u> This update was presented by the ACOO and the paper was taken as read. She reminded members there had been a discussion at September Board on untracked ASIs due to an error on the manual coordination of patients on ERS. Initial analysis of the 2345 patients on the untracked ASI list had suggested that approximately 650 of those patients were likely to require an appointment. 73% (1,700) did not need a booked appointment (duplicate/treatment no longer required or provided elsewhere). 27% (600) had required an appointment and additional activity had been organised to accommodate this during September/October. In addition, and for the past 3x days, a software solution that continuously monitored ASIs (Appointment Slot Issues) and generated exception reports highlighting referrals that still required action was being used. The process was managed manually. The automated system mitigated this risk by providing a reliable, consistent

	method of tracking referrals and flagging outstanding cases for the team to address. A further automation solution was being worked up with a proposed deadline of December which would put ASIs directly onto our PTL.
6.13	National Oversight Framework: Improvement Actions This item was presented by the ACOO. The NHS Oversight Framework (NHS OF) had been developed to allow NHS England to assess NHS Trusts under the Oversight Framework 2025/26. The dashboard within the paper provided a high-level review of Princess Alexandra Hospital Trust (PAHT) performance against each segment of the framework. The Trust was in Segment 4.
6.14	In response to the ASI issue, ANED-RC asked whether the 2300 patients was the whole cohort or were there likely to be others. The ACOO confirmed she had confidence this was the total cohort.
6.15	ANED-RC then asked in terms of the NOF, how often would the organisation be rated and was it clear on the package of improvements that might change its segmentation for the better. The CEO responded the organisation would be re-rated on a quarterly basis and an improvement in three metrics would be required to move the overall scoring. His view was there was room for improvement on cancer performance and also on the financial position if non-recurrent funding was forthcoming.
6.16	The ATC commended the NOF summary provided.
07 STRATEGY/GOVERNANCE	
7.1 Report from Audit Committee (AC)	
7.1	This update was presented by NED-CM and the key headlines were as follows: • **Terms of Reference:** The proposed amendments had been endorsed by AC for Board approval. • **External Audit Update**: The good work to submit the Annual Report & Accounts prior to the deadline that year was noted. An update was provided on the procurement of new external auditors which was progressing well. • **Internal Audit Update:** AC was assured on the progress of the 25/26 audit. Two reports had been finalised, and one report form the 24/25 audit plan was presented for completeness.
7.2	The Board was content to approve the Audit Committee's revised ToR.
7.2 Report from West Essex Health & Care Partnership Board	
7.3	This update was presented by the CEO and the key headlines were as follows: • **Strengthening Primary Care Representation at Place:** The WEHCPB had discussed 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 would be prepared for ICB discussion. • **Host Provider:** PAHT had been Host Provider for nearly five months now. The only significant change to date was that the HCP Board was now a sub-committee of the PAHT Board rather than the ICB Board. However, the last HCP Board meeting had looked at a proposal for the Host Provider to hold commissioning contracts for services in West Essex instead of within the ICB. The proposal had not been approved but at some point, if it was agreed this was the way forward, then the proposal would come back to the PAH Board for approval.
7.4	In response to a question from the CEO, NED-LB (as a member of the WEHCPB) informed members the meeting was very collaborative with a large number of partners including primary care, ICB, local authority and Rainbow Services.
7.3 Report from Executive Board Meeting	

7.5	The CEO informed members a key topic of discussion had been Health on the High Street and the work with Harlow Council to agree services that might be suitable to move to the town centre.
7.4 Corporate Trustee: Report from Charitable Funds Committee	
7.6	This update was presented by the CFIO and the key highlights were as follows: • **Operational Group:** A new Charity Operational Group was being established to oversee the operational management of the Charity and to review funding requests over £10k (ensuring alignment with the Charities' Scheme of Delegation. • **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.
Questions from the Public	
7.7	In response to a question from Chloe Bryant-Dunn in relation to artificial intelligence (AI), the CMO responded an AI Group had been established and AI was already being used for clinic dictation, radiology, in the recruitment process. The organisation also had a surgical robot.
7.5 Questions from the Public	
7.8	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	ANED-AWS reminded members it was Black History Month.
8.6 Reflections on Meeting	
8.6	NED-CM suggested that it might be an idea for the Board to revisit a 'risk' development session. The CSO responded that risks were discussed, then included in papers but it was more about the Board assuring itself that those risks were being addressed. The ATC commented her view would be it was about how the Board reports were put together – timelines were important. ANED-BM stated that it would be helpful if reports included a timeline for closure of risks.
8.7	The meeting closed at 13:03.

Signed as a correct record of the meeting:	
Date:	06.11.25
Signature:	
Name:	Darshana Bawa
Title:	Acting Trust Chair

ACTION LOG: Trust Board (Public) 04.12.25

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.02.25/35	Board Development: Alex Health Lessons Learned	Board Development: Date for 'Lessons Learned from Alex Health' session to be agreed.	DCG CIO	~~TB.11.09.25~~ BD.06.11.25	Session took place on 06.11.25.	Closed
TB1.02.10.25/08	Stroke Pathway	Provide an update on the Stroke Pathway by latest April 2026.	CMO	TB1.02.04.26	Interim update: Meeting with commissioners on 3/12/25. CMO also joined Essex ICB Stroke Stewardship programme. Diarised for target date.	Proposed for closure
TB1.02.10.25/09	New Hospital BAF Risk (3.5)	Consider whether BAF Risk 3.5 is still required and whether the narrative relating to the new hospital could be included in risk 3.1 (Estate & Infrastructure).	DCG CSO CFIO	PAF.30.10.25	Actioned.	Closed
TB1.02.10.25/10	Corporate Risk Register Quality Risks	QSC to receive a summary of the quality risks from the CRR. (To be included in the monthly Patient Safety Report).	CMO	QSC.30.10.25	Actioned.	Closed
TB1.02.10.25/11	Staffing Levels related to Pressure Ulcers/Falls	Provide information around staffing levels in relation to other quality metrics including pressure ulcers and falls.	I-CN	TB1.04.12.25	See paper at item 4.3. Front sheet updated to reflect the timeframe for the Full Year Establishment review process. Action also addressed in Appendix 5.	Proposed for closure

ACTION LOG: Trust Board (Public) 04.12.25

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.02.10.25/12	NED Walkabouts	NED walkabouts to focus on engaging with clinical staff on completing the staff survey.	ATC	TB1.04.12.25	Actioned.	Closed
TB1.02.10.25/13	ED 4 Hour Performance	ED 4 hour performance data to be presented with the Furthers cohort included.	COO	~~TB1.04.12.25~~ TB2.05.02.26	The 4 hr data with the EMSDEC data in it (or furthers), cannot be presented as it is no longer included and presents us with data issues to do this. However, some EMSDEC metrics can be provided for the Board (alongside the IPR). The proposal is for these to be presented to PAF.18.12.25 and then to TB1.05.02.26.	Proposed for closure
TB1.02.10.25/14	EM-SDEC Metrics	EM-SDEC performance metrics to be provided.	COO	~~TB1.04.12.25~~ TB2.05.02.26	The 4 hr data with the EMSDEC data in it (or furthers), cannot be presented as it is no longer included and presents us with data issues to do this. However, some EMSDEC metrics can be provided for the Board (alongside the IPR). The proposal is for these to be presented to PAF.18.12.25 and then to TB1.05.02.26.	Proposed for closure
TB1.02.10.25/15	Dermatology	Dermatology Showcase to be presented to the Board.	COO	TB1.05.02.26	Item not yet due.	Open

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 11 December 2025

Agenda item:	2.1								
Presented by:	Darshana Bawa, Acting Trust Chair								
Prepared by:	Darshana Bawa, Acting Trust Chair								
Date prepared:	26.11.25								
Subject / title:	Acting Chair's Report								
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**		
Key issues:	To provide an update on my work and activities to date and evidence accountability for what I do.								
Recommendation:	The Board is asked to discuss and note the report.								

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

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

1.0 Purpose/issue

This report outlines my activities since my last report to the Board in October 2025.

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 Non-executive directors:

I am delighted to formally confirm that David Baines was appointed as a non-executive director on 3 November 2025. David's term ends on 2 November 2027. David will be the Chair of the Performance and Finance Committee from December 2025 and will also be a member of the Audit Committee and the Charity Funds Committee.

I would also like to formally note that Ralph Coulbeck, Associate NED has been appointed Interim CEO of the NHS, North East London and we have agreed that he will take a three-month sabbatical from his NED role at PAHT, starting from 17 November 2025. I would like to congratulate Ralph on his appointment, and I look forward to him returning to his Associate NED role on the PAHT Board in due course.

3.0 Recent activity:

I have started to engage and build relationships with our soon to-be Essex ICB colleagues. My recent meeting with Mike Thorn was interesting and insightful, indicating clear intent of working collaboratively in the interests of improving the quality of care and safety of our patients.

We also received excellent feedback from him on our Breast Unit at St Margarets Hospital, for their work supporting the MSE specialist facility for burn care and plastic surgery.

I was delighted to attend the awards ceremony for Our Amazing People on the 19th November and would like to extend my congratulations to all our people who were nominated as well as those who won awards including our long serving staff who were recognised at the Long Service Awards the previous week.

I continue to attend the Aspiring Chair's course which is concluding in March 2026, and which has been invaluable to me in my role as Acting Chair. It provides me with great networking opportunities and peer support with some excellent speakers throughout to date.

As Board members will be aware, the assessment centres for the Clinical Divisional Restructure are underway and I supported the assessments for the Service Delivery Managers on 17 November. I was impressed with the process and strong engagement from candidates. What stood out for me was not just their passion for the role they do daily, but also the self-awareness of their development needs to be better managers.

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 including the ED corridor care visits and a summary of our these with associated actions is attached.

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 engage with staff and patients and receive direct feedback, which is reassuring.

The Board is asked to note the report.

Author: **Darshana Bawa**
Acting Trust Chair

Date: 26.11.25

Chair's action matrix

Team: PAHT Chair and non-executive directors, updated 26 December 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.) BM: Dr Ben Molyneux (Assoc.) PJ: Dr Parag Jasani (Assoc.)	PP: Patient Panel FtSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Due	Action
28/10/2025	DB	ED (CC)	Speaking to staff and patients it was evident that staff knew how to escalate concerns for patient safety as well as concerns on staff related issues. There were 2 patients in C1 (none in C2), both said they were comfortable and felt cared for.	ADON		Confirmation of the average LOS in ED CC.
13/11/2025	DB, CM, BM	SMH Breast Unit	Leading example of a one-stop symptomatic breast cancer service with significant estate challenges noted. Recent feedback from MSE FT hailed the breast unit as 'excellent'.	Consultant Radiologist		With the significant increase in throughput, the family history clinic indicated that potential efficiencies might be possible through system changes, if these proved feasible.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 11 December 2025

Agenda item:	2.2
Presented by:	Thom Lafferty - CEO
Prepared by:	Thom Lafferty - CEO
Date prepared:	1 December 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)

Chief Executive's Report
Trust Board (Public)
11 December 2025

This will be my first public Trust Board meeting following reaching the 1-year anniversary of my tenure as Chief Executive Officer (CEO) at The Princess Alexandra Hospital NHS Trust (PAHT).

I am very grateful to all our fantastic members of staff, Trust Board colleagues and the wider public and external stakeholders for all the support I have received in post to date.

It remains an absolute privilege to lead PAHT and I am personally determined to ensure that we work together to positively change the fortunes of our organisation, the working experience of staff and critically, the experience of patients and members of the public of our services. On this, we are starting to make real progress and have now established a firm foundation on which I am confident we will build as we seek to support our staff, communities and services to 'Rise' to meet their expectations and potential respectively.

1.0 Our Patients

Care Quality Commission (CQC) visit underway

A Care Quality Commission (CQC) inspection began on 11 November and is currently underway.

The 'unannounced inspection' is a process the regulator uses to check that all hospitals are safe, effective, caring, responsive and well-led. This is either in response to a risk-based assessment or as part of a national programme of inspections. The inspections involve observing care, speaking with staff and patients, and reviewing records to ensure services meet quality and safety standards.

Thus far, the areas inspected have been Urgent & Emergency Care (UEC), Surgery and Medicine. We are also aware that the Trust will undergo a 'Well-Led' assessment in January 2026.

I am proud of the responsive and professional way that our clinical teams have responded to the inspections.

Whilst we await the formal outcomes of the inspections, a more detailed interim position will be provided within the Part 2 Trust Board meeting.

Our new InTouch magazine

I am pleased to share the first edition of our new ***InTouch magazine*** for our community – for our people, patients, carers and families.

You can **read the first online edition via this link**, and hard copies are available in public areas across all our sites.

The magazine is a space for us to celebrate the incredible work happening every day across the Trust.

You can read more on our website >

2.0 Our People

Staff Survey

I am delighted to advise Board colleagues that 62.7%[1] of our staff participated in this year's Staff Survey exercise. This surpassed our internally-imposed target of 60% and is significantly above previous years' performance in this regard; setting an historical record for medical participation.

We are nothing without our staff and I am clear that genuine and extensive staff engagement needs to be an integral part of our organisational culture moving forwards. To have achieved such a positive level of engagement during a time of organisational restructure is of particular significance.

Of course, there is likely to be key learning points arising from the Staff Survey outcomes and we look forward to receiving these outcomes from Picker, the independent facilitator of the national Staff Survey.

Resident doctors' industrial action

Resident doctors took continuous industrial action from 7am on Friday 14 November to 7am on Wednesday 19 November.

We adjusted services and our staffing to maintain safe, high-quality care during this time.

I was proud to see all our people coming together, working as one team – thank you to everyone for your support in managing patient flow effectively.

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

There has been successful recruitment to senior clinical and operational management roles for the new divisional structures. There are a small number of vacancies still to be recruited to. This month (December) we are aiming to have confirmed all senior leadership roles in the new divisional structures, ready to commence in January and be fully implemented by February.

We are providing a variety of support for colleagues during this time.

Congratulations to Our Amazing People Award winners and Long Service Award winners

I was delighted to celebrate and recognise colleagues at the Our Amazing People Awards 2025 on 19 November.

Our annual Amazing People Awards recognise colleagues, volunteers and teams who exemplify PAHT values and go above and beyond their roles to support others.

It was fantastic to also celebrate our long-service colleagues at the Long Service Awards on 13 November.

[11] This number is likely to rise once paper surveys are incorporated.

3.0 Our Performance

Our operational performance

Key operational performance highlights in September (the latest reporting month), were that the Trust hit its trajectory of 77% for our *Faster Diagnosis Cancer Standard* (national standard is 80% by March 2026); and we saw significant improvements against our 62-day cancer standard (61.7% in September).

Our ED 4-hour performance remains very strong nationally and locally – with a performance of 80% in September against a trajectory of 73%.

We continue to see pressure at the Emergency Department Front Door however, and we are pushing forward with our innovative GP led triage model. However, our ambulance handover average time has increased in September to 45.3 minutes, which is a key focus for us to improve in conjunction with our ambulance and community partners.

Our most challenged areas of performance are the validation of our diagnostic wait position post go-live of Alex Health; and the very challenging target of reducing our overall 52-week waiters for routine waits to 1% of the waiting list by March 2026. We are currently at 5% against this standard. Our focus is to resolve this is on robust demand and capacity for all the specialties, and a focused non-clinical validation over the last quarter of the financial year.

4.0 Places and Partnerships

New Hospital Programme

The Trust Board is currently considering its strategy and approach to its involvement within the national New Hospital Programme (NHP).

Board colleagues will be aware that the Trust's proposed development at Junction 7A of the M11 has been delayed for many years – to the understandable frustrations of members of the public and staff - with current estimates indicating that building works on the site will commence in 2032 at the very earliest.

In the meantime, the risks associated with the Trust's deteriorating estate continue to grow and this has prompted a review, in close partnership with the national NHP team and local stakeholders.

Whilst this remains a developing picture, a more detailed interim position will be provided within the Part 2 Trust Board meeting.

Blood testing service to improve patient experience by relocating to The Harvey Centre

We are making it easier and more accessible for patients to have blood tests in Harlow, following a partnership with Harlow Council.

We plan to relocate our blood testing (phlebotomy) service from The Princess Alexandra Hospital (PAH) to a new facility on the first floor of The Harvey Centre in spring next year (2026).

Blood testing services will continue to be available at St Margaret's Hospital in Epping and Herts and Essex Hospital in Bishop's Stortford.

This move is part of our commitment to improving patient experiences and offering more accessible services within the local community. We currently see approximately 300 patients for blood tests each day.

The new facility will offer a modern, patient-friendly environment that is close to where patients live and shop, with easier parking. The same high standards of care, infection control, and safety protocols will remain in place, and our experienced phlebotomy team will continue to provide the service – just in a more convenient and efficient setting.

Moving the service also frees up valuable hospital space for more complex clinical services, helping us manage demand across the whole organisation.

This is the first step in a wider plan to make health and wellbeing far more accessible 'on the high street' with work underway to explore how to significantly increase the amount of services out of the hospital and in the town centre.

Our Community Diagnostic Centre (CDC) update

We were delighted to welcome visitors to our new Community Diagnostic Centre (CDC) at St Margaret's Hospital, Epping, as the facility takes shape.

The CDC is part of our plans to support quicker and more local access to diagnostic tests and treatment close to patients' homes.

We showcased this at a series of recent visits, welcoming partners including Matthew Taylor, Chief Executive of NHS Confederation on 21 October; Dr Neil Hudson, MP for Epping Forest on 24 October; and Nick Presmeg, Executive Director of Adult Social Care at Essex Council and Tom Abell, Chief Executive of the new proposed Essex Integrated Care Board (ICB) on 29 October.

The CDC is aimed for a spring 2026 opening.

You can read more on our website >

Host Provider

The Host Provider delegation of commissioning responsibilities have been discussed with the emerging Essex Integrated Care Board (ICB) executive team and they are supportive of the change in operating model in West Essex.

The Essex ICB see the West Essex HCP as a leader in Essex to pilot and develop the future frameworks set out in the new 10 Year NHS Plan. It is likely that the delegated responsibility will commence April 2026 and in the meantime the partnership will establish the governance structure and create the assurance framework to ensure that Essex ICB are confident in WE HCP's capabilities to deliver the delegated responsibilities. This will include agreement on the required staffing capacity and capability along with the financial resourcing.

In addition, Essex ICB has agreed to support conversations with Hertfordshire ICB colleagues to agree a mechanism to bring East Hertfordshire and Broxbourne health services into the West Essex HCP on a more formal basis, mirroring the current patient flows.

The National Neighbourhood Implementation Programme (NNHIP) is progressing well, with the governance in place and good partnership engagement. The next steps are to obtain approval from the Better Care Fund for some short-term financial resourcing and to design the model with community engagement and patient co-production. Outcome measures will be developed with implementation to commence in January. Work with the national team on a future funding model is progressing well and workforce and digital models will follow.

5.0 Our Pounds

We remain on course to deliver our agreed plan in 2025/26, however, we are managing a number of risks around winter, given historic pressures on demand at this time and the potential impacts of flu and COVID on staff availability. Though we feel able to live within our means within our agreed plan, there remains risk around the system position; we are working with system partners in seeking mitigations to this risk.

We have committed to a number of capital developments in year and in addition to the existing programmes, have recently had confirmation of additional funding to complete the move of plain film X-ray into the Community Diagnostic Centre (CDC) and have been successful in bidding for further monies to support some of the critical infrastructure risks that we hold within the Trust. Work continues on our Paediatric Emergency Department (ED) refurbishment and we are confirming final plans on the renovation of the Emergency Medicine Same Day Emergency Care (EMSDEC) corridor.

Thom Lafferty
Chief Executive
December 2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

3.1

Agenda item:	3.1							
Presented by:	Andrew Kelso, Medical director							
Prepared by:	Lisa Flack – Compliance and clinical effectiveness manager							
Date prepared:	01.09.2025							
Subject / title:	Corporate Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents a summary of risks scoring 15 and above for all our services. It is a snapshot taken from our Datix database on 04.11.25. **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 29. **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 no new risks scoring 16 **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:	Risk Management Group 11.11.25							
	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 04.11.25.

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

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

2. Risk data

There are 29 risks that have a current score of 15 or above that have been approved for inclusion onto the corporate risk register.

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

Table 1 - Risks scoring 15 or more	Risk Score				
	15	16	20	25	Totals
Cancer & Clinical Support	0 (0)	3 (7)	0 (0)	0 (0)	**3 (7)**
Corp - Estates & Facilities	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Corp - IM&T	0 (0)	0 (2)	0 (0)	0 (0)	**0 (2)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
CHAWs Child Health	0 (0)	3 (3)	0 (0)	0 (0)	**3 (3)**
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	4 (4)	2 (2)	0 (0)	0 (0)	**6(6)**
Urgent & Emergency Care	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Trust wide	0 (0)	11 (11)	1 (1)	0 (0)	**12 (12)**
Totals	**7 (7)**	**21 (27)**	**1 (1)**	**(0)**	**29(35)**

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	20 (22)	74 (70)	8 (9)	9 (12)	2 (2)	**113 (115)**
Quality – Patient Experience	≥ 12		10 (11)	0 (0)	2 (2)	0 (0)	**12 (13)**
Quality – Clinical Effectiveness	≥ 12		18 (18)	0 (1)	6 (8)	0 (0)	**24 (27)**
People	≥ 15			1 (1)	1 (2)	1(1)	**3 (4)**
Statutory Compliance & Regulation	≥ 12		9 (10)	2 (2)	0 (0)	1 (1)	**12 (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(0)	1 (1)	0 (0)	**1 (1)**
Information and Data	≥ 10	0 (2)	8 (7)	0 (0)	0 (1)	(0)	**8 (10)**
Systems and Partnerships	≥ 15			0 (0)	2(1)	0 (0)	**2 (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 - none

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

Recommendation

Risk management group members are 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 – 11 December 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 November 2025. There are no changes to the risk scores this month, however three risks are included for noting and review: - BAF risk 1.3, Operating Plan: the content has been comprehensively updated by the COO - BAF risk 1.4, EHR: the risk description has been updated by the CCTO - BAF risk 3.2, System Pressures which is assigned to the Board for review however it is not proposed to change the risk score. BAF risk 3.5 New Hospital, is also included for formal closure by the Board following agreement by the Board in October 2025 to merge the risk into the Estates risk. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Formally note the changes to BAF risks 1.3 and 1.4 - Review BAF risk 3.2 System Pressures - Formally approve the closure of BAF risk 3.5, New Hospital - 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 November 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:	BAF risks 1.3, 1.4, 3.2 and 3.5 and BAF summary

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2024-25**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequities in our local population													
BAF 1.3		Operating Plan: Risk of poor outcomes and patient harm due to inability to deliver the national access standards.	Causes: i) Due to increased emergency demand and poor flow through acute and community capacity. ii) Due to infrastructure challenges e.g estates and capacity. iii) Due to lack of elective capacity in services to treat all patients within national standard waiting times for Cancer and RTT. iv) Due to poor data quality which compromises the ability of admin and clinical teams to identify and book patients in appropriate timeframes. v) Workforce challenges in hard to recruit to specialities. vi) Due to insufficient training, expertise and standardisation of practice in the administration of our elective pathways. vii) Due to poor adoption/user error in relation to Alex Health system. viii) Financial constraints which limit the Trust's ability to invest in required capacity to see and treat patients electively.	**5 x 4 = 20**	Chief Operating Officer PAF	* Daily reviews of staffing gaps across professional groups * Annual planning process that forecasts capacity, workforce and financial impact. * Demand & Capacity modelling of pathways including admitted, diagnostics and out patient activity * Health & Wellbeing services in place to support staff, communication of services & encouragement to participate. * Development of clinical strategies, standard operating policies and audits of adherence to national guidance (e.g. NICE/GIRFT). * Linking of Quality Improvement and PQP programmes to the areas of highest need clinically. * Harm reviews of long waiting patients on elective waiting lists including regular review of the patient tracking list. *Host and lead provider opportunities and development of new pathways *Plans in place for CDC and surgical hub for sustained increased capacity * External reviews commissioned (e.g. cancer) which have informed action plans for clinical services - e.g. Cancer Action Plan. * Focussed piece of work reviewing all waiting lists of patients, and ensuring that all cohorts of waiting patients are fully validated and visible to the clinical teams and bookers. * Comprehensive surge plan which outlines steps to be taken at each level of surge to mitigate risk ,and keep patients and staff safe. * Regular regional NHSE led tiering meetings which focus on Elective, RTT, Diagnostics and UEC - to give external focus, support and benchmarked advice to leadership teams on management of challenged patient pathways.	* Testing/exercising of our Surge Plan to ensure response and understanding is robust. * EPRR Annual Self Assessment which indicates compliance with EPRR standards nationally. * 3 x a day patient placement meetings, and sitreps flowing from these meetings. * Regular sequence of waiting list meetings for cancer and RTT pathways - with reportings flowing from these meetings. * Weekly assurance meeting for services with highest/longest waiting lists * Divisional Review meetings - presentation of performance data. * Presentation of Access data in regular report to Operational Board, Executive Board PAF * Data Quality Report update to Operational Board	* IPR report to PAF (being reviewed currently to ensure that data is presented optimally & that metrics are the right ones to demonstrate effectiveness and responsiveness of care) * NHS Operating Framework and segmentation (national report) report presented quarterly to PAF. * Operational Board Access Report - monthly, which gives direct report to Executive Board/PAF/QSC * Annual operating plan report to PAF * Tiering report to NHSE	**5 x3 = 15**	* Access Policy and the 'administration' of pathways associated with elective care under review, alongside interaction with the Alex Health system * Surge processes not consistently applied and embedded. Training and testing of surge plans and responses, to ensure uniformity of response across all workforce, to be implemented. * Controls around diagnostic waits are under review and required reporting is being developed to monitor and take corrective action particualrly around endoscopy waits.	* Evidence that our administration processes around booking and scheduling of patients are robust. Action: Enhanced controls are being put in place. * Evidence of improvement around equality of access to services. Action: To be evidenced in IPR reporting (new format). *Visibility of diagnostic waits in Endoscopy due to delayed implementation of reporting post Alex Health implementation, Action: Reporting is being developed	Nov-25		**5 x 2 = 10** **March 2026**
			Effects: i) Increased numbers of non elective patients and acuity levels in the hospital which compromise the ability of clinicians to treat all patients to a high standard of care. ii) Reduced bed capacity and increased demand on critical services iii) Increased risk of patient harm with use of escalation areas, and potentially stretched staffing skill mix on wards and in ED. iii) Staff fatigue and reduced resilience in both emergency and elective pathways due to a mis-match between demand and capacity in both. iv) Long waiting times for elective treatment and potential lost to follow up along elective pathways if the data quality is very compromised. v) Potential for patient harm due to cancellation of elective surgery & outpatients.												

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 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 **Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way**													
BAF 1.4		**EHR** There is a risk to delivering safe, high-quality care due to challenges in stabilising and fully adopting the Alex Health EHR system post go-live. This includes ensuring accurate data migration, comprehensive user training, and effective engagement with clinicians and external partners to embed new workflows. Failure to address these issues could compromise patient safety, disrupt clinical operations, and impact regulatory compliance and financial performance.	Causes: I) Errors in data migration due to data quality issues ii) Insufficient training of end users with additional training required iii) Lack of engagement with end users and external users meaning understanding of the changes are not implemented iv) Inability to deliver process changes for team to understand new ways of working effects: I)Patient safety risks and inability to plan and deliver patient care appropriately ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance	**4 X 5= 20**	Chief Clinical Transformation Officer **Performance and Finance Committee**	I) Robust programme governance in place with Digital Board 2) Oversight performance and Finance Committee. 3) Stabilisation phase nearing completion with risks being managed.	I) Digital Board ii) PAF meetings iii) Alex Health governance in place: Digital adoption work streams being overseen by Operational Board led by the divisions. Alex health workstreams being overseen by the PMO	ii)Digital Board which reviews progress, risks and issues on a monthly basis iii) Quarterly digital reports to Performance and Finance Committee iv) Structured cells looking at data validation, end user training for bookers and data quality and cleansing	**4 X 4= 16**	I) Resource availability to support AI and robotic, increased digitisation and demand ii) Capacity within operational teams to ensure delivery of change required iii) Oracle capacity to deliver on the timeline of change requests) Actions to strengthen controls : Deployment of an EHR training programme with mandatory competency assessments for all clinical users Prior to access being granted 2) Dedicated BI informatics team providing on-site and virtual support during stabilisation. Including additional resource from Oracle health 3) Weekly monitoring reviewed by digital operational board and escalations fed to the Digital Board and divisional leads. 4) Enhanced data quality checks pre- and post-migration with support from Oracle health 5) Escalation protocol for system issues with defined SLAs for resolution. Actions: 1) Comprehensive EHR training programme with mandatory competency assessments for all clinical users. 2) Dedicated clinical informatics team providing on-site and virtual support during stabilisation. 3) Weekly adoption monitoring dashboards reviewed through digital governance structure 4) Enhanced data quality checks pre- and post-migration with automated validation scripts. 5) Escalation protocol for system issues with defined SLAs for resolution. 6 Clinical cell structure established with key workstreams associated with end user training validation and data quality leads	None identified	Nov-25	**Score unchanged**	**4x3=12** **March 2026**
			Effects: I)Patient safety risks and inability to plan and deliver patient care appropriately ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2023-24**											
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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								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	**5 X4= 20**	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	01/11/2025	**Risk score to remain at 16.**	**4x3=12** **~~October 2025~~** **March 2026**
			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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2023-24**											
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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		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 3.5		**New Hospital:** There is a risk that funding for the new hospital will not be sufficient to deliver the preferred way forward and that the new development can not be delivered to the timescale needed to meet increasing demand.	**Causes:** i) Funding is not made available for the preferred way forward ii) enabling works are delayed iii) new design guidance from NHP results in a substantial redesign iv) the required SoA can not be delivered within the agreed affordability envelope v) the land purchase is not completed successfully and in a timely manner vi) Development of new standards and programme approach by NHP delays business cases vii) Advisors stood down due to lack of funding **Effects:** i) Hospital remains on existing site and continued investment in existing site will be required ii) Unable to deliver all of the service transformation iii) Unable to manage system demand due to lack of transformation iv) Digital transformation not complete v) Poor staff retention due to failing infrastructure vi) Unable to reach outstanding service provision due to failing infrastructure vii) If delayed, loss of clinical engagement and loss of public confidence	**5 X 4= 20**	Chief Strategy Officer (CSO) Performance and Finance Committee (PAF)	i) National team appointed to drive through programatic benefits of the New Hospital Programme. Regular meetings with NHP and other schemes to gain understanding of impact of their work on the new hospital. ii) Regular meetings with stakeholders, MPs, Council leaders. iii) Update of the demand and capacity modelling to a 2041/42 horizon year. Adopting a D&C model owned by the Trust. iv) SoS announcement that the scheme will be 'fully funded'. Although the funding profile and timeframe requires a plan to remain on site for a longer period of time (approx 4 years from the pre 2025 position). v) Consultation with NHP Executive, Programme and Finance Teams to agree a site acquisition plan and associated budget requirements.	i) New Hospital Programme Board ii) Strategic Transformation Committee iii) Trust Board iv) External advisory meetings as required (e.g. HOSC) v) Reviews undertaken by NHP	i) Bi-Monthly reports to Trust Board and Performance and Finance Committee (PAF). ii) MOU for £2.47m has been issued to the Trust. NHP has confirmed that funding can be allocated against wider strategic estates activity as well as site acquisition activity. Also confirmed any unspent funding from 25/26 can be rolled over to 26/27.	**5 x 4 = 20**	**Gaps:** ~~i) Confirmation from NHP that site acquisition activity/de-risk activity can proceed and funding is available for 25/26.~~ i) Plan of work for confirmed site and full funding requirements agreed by NHP. ii) Co-ordination with integration strategy, estates strategy and development control plan ensure consistency across NHP requirements with organisational strategy. **Actions:** i) Continual engagement with system, regional team and NHP team	None.	Oct-25	**RISK CLOSED Referenced in Estates risk**	**5x3 = 15 by 2026/27 Site Acq** **5x2 = 10 by 2032 FBC approval**

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	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	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 PAF	EHR There is a risk to delivering safe, high-quality care due to challenges in stabilising and fully adopting the Alex Health EHR system post go-live. This includes ensuring accurate data migration, comprehensive user training, and effective engagement with clinicians and external partners to embed new workflows. Failure to address these issues could compromise patient safety, disrupt clinical operations, and impact regulatory compliance and financial performance	16	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	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	12				↔	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	20				↔	8	CFIO
3.2 Trust Board	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16	16				↔	12	CSO

Board Assurance Framework Summary 2025.26

3.5 STC	New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.	20	20	20	**20 Proposed for closure**				↔	15	CSO
	Strategic Objective 4: Our Performance - we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators										
4.1 PAF	Seasonal pressures: Risk that the Trust will be unable to sustain and deliver safe, high quality care during seasonal periods due to the increased demand on its services.	12	**Closed (included in new BAF risk 1.3)**							8	COO
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	20	**Closed (included in new BAF risk 1.3)**							12	COO
	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	16				↔	12	CFIO

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1. M7 Integrated Performance Report	Y	Y	N	Key M7 headlines were that there had been an increase in complaints, (linked to long waits) and a worsening trend in ambulance handovers. In contrast there had been an improvement in ED 4 hour performance and RTT performance. Work was now underway to focus on an analysis of demand and capacity going forward to improve access, and in turn reduce the number of complaints. Some additional resource had been provided for Surgery to help support with complaint responses. Going forward it was agreed to categorise complaints into new/reopened and to clarify the 'offer'/communication to all those waiting for appointments/treatment.
2.2 Access Performance Report	Y	Y	N	Key in-month headlines were: **Alert Measures:** • DM01 and RTT 65+ weeks / 52+ 1st OPA booked off forecast, requiring 1) Urgent validation of reporting output 2) Specialty-level recovery planning and 3) Accelerated booking activity. • Endoscopy DM01 data accuracy is a critical dependency for performance recovery. **Advise Measures:**

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Cancer 62-day and RTT incomplete pathways show improvement due to 1) Additional capacity 2) Validation resource and 3) Strengthened PTL governance. • Urgent and Emergency Care performance is stabilising with 1) Winter actions underway 2) EMSDEC redesignation and 3) GP streaming implementation **Assured Measures:** • Improved performance across 1) Cancer 31-day and 28-day FDS standards 2) A&E 4-hour performance and 3) Diagnostics (MRI, CT, Echocardiography). All showing consistent improvement and on-track compliance trajectory.
3.1 Infection Prevention & Control Updates	Y	Y	N	Key headlines included: • C. difficile: 12 cases reviewed; 3 avoidable, 9 unavoidable. • Blood stream infections: No MRSA; 4 MSSA HOHA (hospital onset healthcare associated) cases; 10 GNBSIs (Trust rates below regional average); 1 CPO (carbapenemase-producing organism) case. • COVID-19: 68 community-acquired, 18 hospital-onset cases; 4 small outbreaks. • Influenza A: 29 cases; no outbreaks.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Winter Preparedness: Point-of-care testing and Cepheid molecular diagnostic platform launched for respiratory viruses. • Estates: Ventilation and water safety issues addressed; ITU/HDU redesigns and relocations underway. • Alex Health IPC Module: Launched; system workflows under review. <u>Report from Infection Prevention & Control Committee</u> The key headline was that a well-established process remains in place to maintain enhanced oversight of IPC compliance across all divisions. Key performance metrics, including audit results, are systematically monitored through the IPC Steering Group, ensuring timely review of actions and provision of targeted support to drive continuous improvement.
3.2 Learning from Deaths Update	Y	Y	N	Work continues to address the issues that have come to light in relation to the number of episodes of care and comorbidity recording. It was agreed for the next update to explore the possibility of including an HSMR projection for the next 12 months, in order to provide further assurance.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 Trauma Team Showcase	Y	Y	N	Deferred to December.
3.4 Patient Safety & Quality Monthly Update	Y	Y	N	The committee discussed: • Prioritising the validation of the 503 open incidents. • The oversight of procedural documents and audit compliance. • NatSSips and LocSSIPS. • The use of FFT feedback to inform divisional action plans and staff engagement strategies. The outputs of a deep dive into the detail of Regulation 28s (Prevention of Future Deaths) will be provided for January's meeting, and any risk in relation to feedback on NatSSIps and LocSSIPS not being provided until May 26 would be clarified.
3.5 CQC Core Services and Well-Led Inspection 2025	Y	Y	N	The paper provided an update on the current CQC inspection of core services and the well led inspection. The Trust is in 'live' inspection phase until end of Jan 2026. This is a risk-based inspection including.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Unannounced visit on 11 and 12 November – Urgent Care and Surgery. • On site documentation review 26 and 27 November – 4 inspectors for 2 days on site. • Medicine inspection during w/b 24.11.25. • Well-Led – 27, 28 and 29 Jan 2026. • More core services unannounced visits are anticipated. • Pre-enforcement notice received 14.11.25 with assurance to return by 20.11.25. Update to be provided for December's meeting on recommendations to date and associated actions.
3.6 Harm Reviews	Y	Y	N	The report identified a thorough and robust process is in place for overview and monitoring of cancer harm reviews. As part of the oversight process and to increase transparency, all outstanding harm reviews are now noted at IMG and this includes ASI patients to ensure that the process is consistent across all pathways as of September 2025. A report on the harm review process within all other tumour sites will be provided for December's meeting.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.7 Update from Patient Panel	Y	Y	N	Key headlines included: • **Lunch and Learn:** Following a successful session on Diabetes and having the opportunity to talk about patients admitted with additional needs, the Panel is now working on a schedule of future sessions around Sepsis, Crohn's/IBS, Sunflower lanyards and Research and Innovation. • **Razed Roof:** The Panel has been introduced to Razed Roof, a group of young adults with additional needs who have received funding to design and deliver a play on cancer services. In October, the Panel had been delighted to show a small group around the hospital and it will continue to develop this partnership working with Harlow Council and local voluntary sector organisations. • **Delivering Eye Care Closer to Home:** The Chief Medical Officer has submitted a bid to pilot this initiative and the Patient Panel will be part of the team. • **National Neighbourhood Health Implementation Programme (NNHIP):** The Patient Panel has been asked to join this pilot and is currently being briefed on involvement and has developed the West Essex Citizen's Contract for Working Together in coproduction. • **Phlebotomy:** A small group from the Panel made a site visit, asked questions and offered to conduct a local

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**28.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				survey. The panel were very pleased with the new location for the service.
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.
4.1 Horizon Scanning Update	Y	Y	N	QSC noted that the Care Quality Commission had published its annual 'State of Care' Report in October. It advised that the demand for services is increasing across the health and social care system that is already under severe pressure – affecting how easily people can access care and the quality of care they receive.
4.2 Reports from Feeder Groups	Y	Y	N	Reports were noted from the following feeder groups: • Report from Strategic Learning from Deaths Group • Report from Clinical Effectiveness Group • Report from Patient Experience Group

BOARD OF DIRECTORS: **Trust Board 11.12.25** **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: **28 November 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: • All key metrics remain within normal variation, no areas of concern or significant improvement were identified. • Bookings performance is improving, especially for minority ethnic groups, but the 90% target is not consistently met. • Triage and massive obstetric haemorrhage rates are below target; improvement plans and audits are in progress. • All incidents of obstetric anal sphincter injury are reviewed by specialists. • One stillbirth is under review; no immediate actions required. • MOSS maternity signal system has launched; further updates will follow.
2.2 Maternity Monthly Report	Y	Y	N	Highlights included: • Staffing challenges were addressed with increased use of bank and agency staff, resulting in reduced red flag events. • Labour ward activity showed a rise in women needing intensive care, both during and after birth. • Culture improvement initiatives are ongoing, including civility saves lives training, after action reviews, and enhanced staff feedback mechanisms. • Recruitment event led to 28 midwife job offers; onboarding is in progress. • New neonatal readmission pathway has launched, which allows direct referrals to the birth centre for enhanced care. • Continued focus on health inequalities and personalised care, with mandatory training planned for all staff.
2.3 Perinatal Mortality Review Tool (PMRT)	Y	N	N	There were three reportable cases in the quarter, all are compliant with national standards and reported to MBRRACE. There had been no common themes or systemic care issues identified; only incidental learning was noted, with all actions closed. One case was reported outside the two-month timeframe due to a new staff member's misunderstanding of the process; improved tracking and support have since been implemented. Bereavement care issues were addressed immediately, with no wider systemic concerns identified.

BOARD OF DIRECTORS: **Trust Board 11.12.25** **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: **28 November 2025**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 Quarterly Maternity Assurance (Oversight) Report	Y	Y	N	Progress has been made on overdue guideline compliance, with extensions requested where national guidance had not changed and a plan is in place to clear all overdue documents by early next year. A bi-weekly local complaints management group has been established to address both new and historic complaints, with 25 open maternity complaints currently being managed. A trajectory was set to reduce overdue incidents to under 100 within three months, with ongoing monitoring and support for staff involved in incident tracking and external reviews. The Committee was assured on the clear plans and accountability for improving document compliance, complaints resolution, and incident management.
2.5 Maternity 6 Monthly Staffing Report	Y	Y	N	The report detailed the maternity staffing position over the previous 6 months. The proactive over-recruitment of 14 midwives was undertaken to address anticipated service needs, including increased triage and higher complexity of care. Turnover rates had improved significantly, halving from over 10% to just under 6% due to focused retention and professional development efforts. The division has met all maternity incentive scheme staffing metrics throughout the year. The Birthrate Plus October 2025 review had been validated and sent to the Trust on the 18 November 2025. The report had yet to go through governance processes within the division, it would be presented to the Committee in January.
2.6 Maternity & Perinatal Incentive Scheme Update	Y	N	N	Full compliance was reported with the Maternity & Perinatal Incentive Scheme (MPIS), except for historic non-compliance in two areas that cannot be rectified. Saving Babies Lives requirements were met and signed off by the LMNS, with manual audits and business intelligence support ensuring data quality despite IT system changes. All training compliance targets were achieved across disciplines. Ongoing work is in place to address future MNVP funding requirements as per MPIS standards.

BOARD OF DIRECTORS:	**Trust Board 11.12.25**			**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:	**28 November 2025**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.7 Maternity Patient Safety Incidents	Y	N	N	There are currently four ongoing maternity patient safety incident investigations, including two with MNSI; one was completed with no safety recommendations, and the other is undergoing external review following a challenge to the initial recommendations. Positive feedback was noted regarding teamwork and resuscitation efforts in one case, and the division anticipates receiving the external review report in December
2.8 Maternity Safety Champions Update	Y	N	N	The maternity safety champions reported on their recent visit, highlighting engagement with junior doctors and the sharing of feedback with educational leads at People Committee. They noted ongoing monitoring of midwife resourcing for Caesarean sections and plans to increase nursing support. The champions are planning further listening exercises with staff to identify and address issues, with outcomes to be reported to the Committee.

Other items discussed include:

- Horizon Scanning

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

4.2

Agenda item:	4.2							
Presented by:	Linda Machakaire – Director of Midwifery							
Prepared by:	Emma Rose – Head of Women's Health Governance & Assurance							
Date prepared:	02/12/2025							
Subject / title:	Overview of Patient Safety Incidents within maternity services (Q2 summary)							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues:	There have been no new maternity PSII declared in Q2. There have not been any closures of reports in Q2. Maternity services currently have 4 PSII investigations ongoing: PSII - 2 MNSI - 2							
Recommendation:	To provide assurance to the Trust 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:	CHAWS Governance CHAWS Divisional Board PSG (Oct 2025) Quality & Safety Committee (Nov 2025)
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity:	Ockenden Report (2022) Three Year Delivery Plan for Maternity and Neonatal Services (2023) Maternity (and Perinatal) Incentive Scheme Year 7 (2025)
Appendices:	1. Open Patient Safety Incident Investigations under investigation

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.

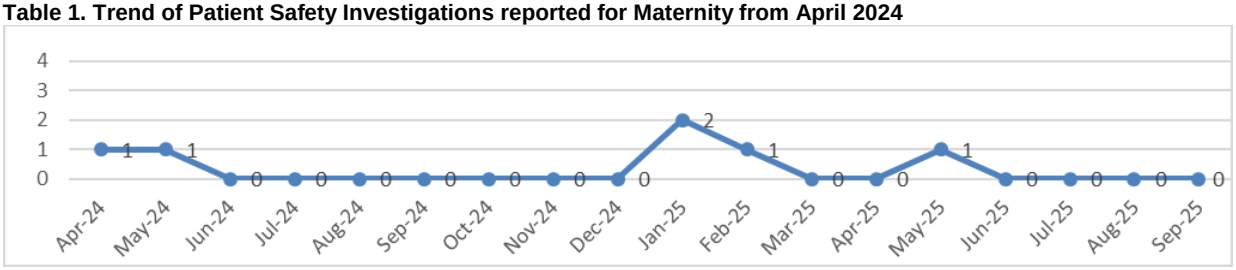
2.0 Background

The Ockenden Report (2022) recommended that all maternity Serious Incidents (SIs) reports and a summary of the key issues are shared with Trust boards. This is similarly reflected in the Maternity and Perinatal Incentive Scheme (MIS) Year 7 Safety Action 9. With the implementation of PSIRF the service will continue this practice by reporting Patient Safety Incident Investigations.

3.0 Analysis

Maternity currently have 4 open PSIIs, 2 of which are being investigated by Maternity and Neonatal Safety Investigations (MNSI). Table 1 details the trend of declared Patient Safety Incident Investigations from April 2024.

Table 1. Trend of Patient Safety Investigations reported for Maternity from April 2024



There were no new Maternity PSIIs declared in Q2 July-Sept 2025 and none that were closed.

The MNSI report (Paweb165618, maternal death at caesarean birth) has been received and no recommendations or safety actions were made. Positive feedback was received regarding the teamwork and quality of resuscitation. Staff will be updated via the December Mortality and Morbidity audit session, and this has been reported into Patient Safety Incidents Assurance Panel (PSIAP) and accepted for closure.

The remaining three PSIIs are expected to be closed by the end of January 2026. Learning actions have been completed and are in progress for all three investigations.

4.0 Themes

Table 2 details the top themes identified in maternity SI/PSIIs within the last 24 months to September 2025.

Table 2: Top Themes

Total Number of SI/PSIIs	Theme	Number
22	Neonatal death	4
	Cardiotocograph (CTG) interpretation	2
	Obstetric Haemorrhage	2
	Intrauterine death	2
	Hypoxic ischaemic encephalopathy	2
	Retained Object	2

Escalation	2
Medical Equipment	2
Screening Incident	1
Therapeutic Cooling	1
Maternal death	2

5.0 Oversight

All incidents are initially reviewed weekdays by an MDT of senior clinicians. Any that require further information or 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. PSII declared.

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

Further assurance is achieved though triangulation of outcomes from investigations; this includes those from complaints and legal cases.

The quality improvement agenda continues and is monitored via the Maternity Improvement Board and all the workstreams are tracked via the PM3 project management tool.

7.0 Recommendation

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

Author: Emma Rose, Head of Women's Health Governance & Assurance
Date: 02/12/2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery, Gynaecology and Assistant Chief Nurse
Prepared by:	Emma Rose – Head of Women's Health Governance & Assurance
Date prepared:	02/12/2025
Subject / title:	Women's Health Assurance Report – Quarterly review Jul-Sept 2025 (Q2)

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

Key issues:	• Clinical guideline compliance • Demand and capacity for Gynaecology Services reflected in incidents, PALS and complaints • Open PALS and complaints • Incidents open >30 days
Recommendation:	To provide assurance to Trust Board that the maternity and gynaecology services (Women's Health) are continually monitoring incidents, risks, complaints/PALS, document compliance and learning from complaints and incidents.

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

Previously considered by:	CHAWS Governance CHAWS Divisional Board Quality & Safety Committee (Nov 2025)
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	Ockenden Report (2022) Three Year Delivery Plan for Maternity and Neonatal Services (2023) Maternity (and perinatal) Incentive Scheme Year 7 (2025)
Appendices:	None

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

This paper is to provide assurance to the Trust Board regarding clinical governance within Women's Health services.

2.0 Background

The maternity service includes an inpatient facility comprising four wards. Outpatient care is provided both within the hospital's Antenatal Clinic and through community midwifery teams serving a diverse population across Harlow, Uttlesford, and parts of East Hertfordshire. A 24-hour Maternity Triage service is in place to assess and direct individuals to the most appropriate area of care based on their clinical needs.

Gynaecology services encompass hysteroscopy, colposcopy, the Early Pregnancy Unit, Gynaecology Ambulatory Care, and Gynaecology Theatres.

3.0 Analysis

Patient Safety Incident Investigations

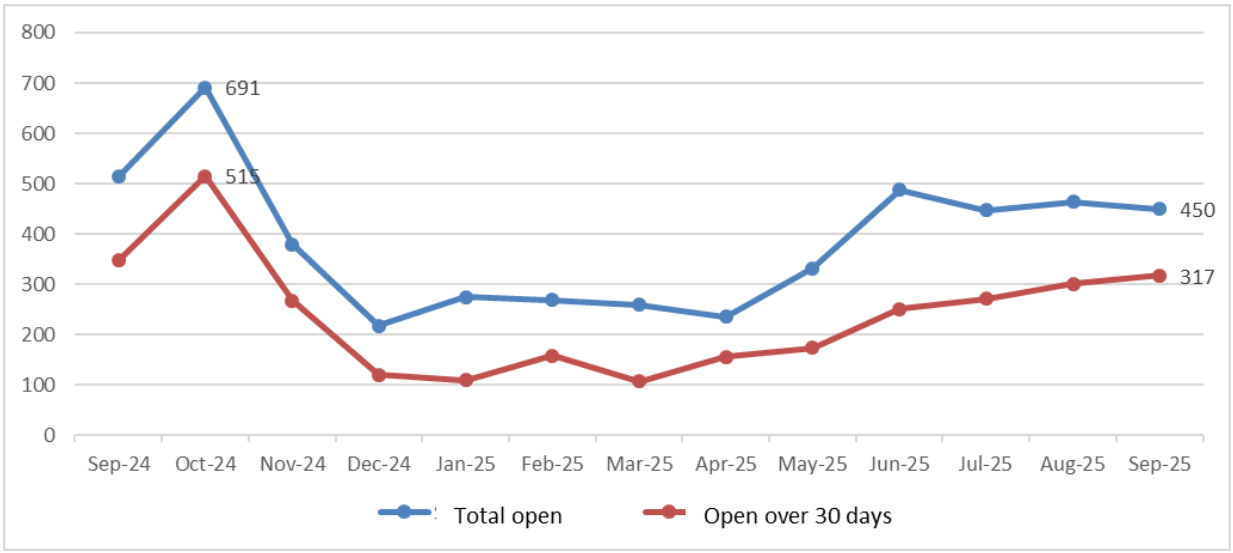
There were no new PSIIs reported in Q2 Jul-Sept. Therefore, for Q1+2 there has been a total of 1 PSII compared to 4 in the equivalent quarters in 2024.

Total number of PSIIs ongoing: 4, two have finalised reports and are on track to be closed before end Nov.

Open actions against SIs/PSIIs are monitored via the Women's Health Incident Management Group (established September 2025) and the Trust Incident Management Group.

Clinical Incidents

Figure 1: Current incidents open and closed



The number of incidents reported in the Q2 was 453 (maternity) and 58 (gynae), which is comparable to Q1. 39 were moderate harm, 0 severe. This is a decrease in moderate harm incidents compared to 47 in Q1. The leading themes remain comparable to previous quarters and these issues are reflected in complaints and PALS themes:

Maternity = PPH, unexpected readmission/reattendance of neonate, lack of suitably trained staff, delays in case, and labour/delivery care incidents.

Gynaecology = failure in referral process, delays in care, treatment cancellation, lack of clinical or risk assessment, urgent appointment availability.

Incidents open over 30 days at end of Q2 was 317 (70% of open incidents). Governance processes include daily Datix multidisciplinary review meetings where all incidents over the previous 24 hours are reviewed, harm grading checked, allocated and identified for escalation up to Incident Management Group. This supports rapid response to high concern incidents A weekly Women's Health Incident Management Group has also been initiated (in September) to support timely closure of incidents, support staff and ensure learning is being shared via appropriate channels.

There is currently governance team vacancy and additional resource has been allocated to support advertising 1 WTE replacement for the team which is in process. Appointment to this post will support improvements in incident management and responsiveness. The current trajectory for closing the overdue incident backlog is end February 2026.

Duty of Candour (DoC) letters have been completed for 84% of moderate harm and above incidents since April 2024, but only 21% for Q2. The process is under review to support more timely initiation of written DoC.

Claims and Inquests

At the time of writing this report, the Q2 report has not been received.

Document compliance

Local Document Tracker	New Draft	Due Review	Under Review	Expired	Approved and Published	Total
Women's Health	2	12	1	23	105	143

16% of documents were overdue their routine review at end of Q2. This is a decrease compared to Q1 (20%). The expired documents have been reviewed against the risk register to support prioritisation of key documents for December and January Trust policy group, and request for extensions are being sought where no risks are associated and national guidance hasn't changed.

Ongoing issue with review of expired documents due to:

- Lack of specialist availability to review documents – both as authors and for timely peer review

Audit

Audit schedule 2024-2025 has previously been agreed, the programme can be shared upon request. Audits are on track and are presented at the Divisional Mortality & Morbidity MDT meeting.

Risk Register

At the end of Q2 Women's Health had 30 risks open on the register. From December 2025 WH are initiating a quarterly local risk management group to ensure effective oversight of the risk register and supporting timely reviewing of risks, controls and gaps in assurance.

Table 1 – WH risks by grading

	4 - 6 Moderate Risk	8 - 12 High Risk	15 - 25 Extreme Risk	Total

Gynaecology - Colposcopy	0	1	0	1
Gynaecology - Gynaecology	0	3	0	3
Obstetrics - Antenatal Care	0	3	0	3
Obstetrics - Community Midwifery	0	0	0	0
Obstetrics - Labour Care	0	2	0	2
Obstetrics - Maternity	1	18	2	21
Total	1	27	2	30

Of these risks 2 score >15.

Risk 647 has since been closed as the risk has been resolved and the associated MHRA alert addressed.

ID	Specialty	Description	Rating (current)	Controls
614	Obstetrics	There is a risk that there are insufficient evacuation routes for staff and service users This is caused by the locality of the service and the cohort of patients that utilise the service. This could result in serious harm	15	1. The stretcher is currently located in the cardiac corridor which is through the discharge lounge. The access is via the emergency exit, across the roof and through another door which has a digi-lock. 2. The stretcher does not go to the floor and therefore we need to use a “Hoverjack device” to lift patients to a safe height to transfer from the floor to the trolley 3. Live drill of patient collapse in ANC which identified a total time of 35 minutes to transfer the patient 4. EVACUsafe chair installed at the top of the stairs 5. Ski Mat installed in the waiting room
647	Obstetrics	There is a risk of serious Harm/Death from wrong route of epidural medication. This is due to lack of availability of preloaded syringes available for procurement with the NRFIT Connector. This could result in noncompliance with national safety standards and patient safety alerts	15	1. Transition to using NRFit for epidural top ups and combined spinal/epidurals in maternity 2. Additional pumps to be ordered for labour ward if required 3. Training for midwives if required (if using pumps) 4. Contact pharmacy to ascertain if ready made epidural “top ups” are NRFit compliant - they are not And Engage with NHS Supply Chain to agree a timeline for transition to NRFit™. 5. Prioritise the establishment of a short-life working group to scope out and coordinate the transition to NRFit™ across all relevant clinical specialties: a. Identify a clinical lead to chair the group. 6. Ensure local procurement leads are included to identify all devices that need to transition to NRFit™. 7. Plan and risk assess the most appropriate and safe process for transition and to monitor implementation. 8. Identity all device locations and order codes and revise stock management systems. 9. Ensure all relevant policies, procedures and educational and training resources for intrathecal, epidural and regional block procedures are updated with reference to use of NRFit™ devices and are fully accessible. 10. Anaesthetic lead to contact reps to come in to trial 2 different companies in regards to changing epidural kits 30/06 NRFIT spinal and CSE kits are in use in maternity theatres NRFIT epidural kits will be in use on the labour ward when the new epidural kits arrive which is projected to be end of July2025. To reduce the risk of inadvertently putting a non-epidural drug intrathecally in theatre (via nonNRFIT set) a coloured syringe will be used for use of medications to be given intrathecally. **Dec update – since been closed**

Complaints/PALS

Maternity

PALs received in Q2: 38 (increase on Q1)
Total PALS issue or concern open: 18

Complaints received in Q2: 13 (increase on Q1)
Total complaints open: 25

Themes: staff behaviours and communication, pain relief, antenatal information, listening to women's concerns

Gynaecology

PALs received in Q2: 32
Total PALS issue or concern open: 93

Complaints received in Q2: 10
Total complaints open: 31
Themes: communication of care plans, appointment cancellations and delays, follow-up of results

4.0 Oversight

All identified concerns have been escalated to the CHAWS Divisional Board. Incidents, risks, complaints and PALS are reviewed through the Divisional Governance structure and the Trust Incident Management Group, Risk Management Group and Patient Safety Group, with further escalation initiated where appropriate for in-depth investigation.

The service remains committed to meeting the requirements of MIS Year 7, SBLCBv3.2 and our wider maternity improvement plan. Any anticipated or identified areas of non-compliance will be escalated through the appropriate board channels for timely resolution.

5.0 Recommendation

The committee is requested to receive this report and note the information provided, along with the ongoing work to ensure compliance with both local and national standards.

Author: Emma Rose – Head of Women's Health Governance & Assurance
Date: 02/12/2025

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery, Gynaecology and Assistant Chief Nurse
Prepared by:	Linda Machakaire
Date prepared:	21 November 2025
Subject / title:	Midwifery and Maternity Support Worker Staffing – 6-Month Report

Purpose:	Approval		Decision		Information	X	Assurance	X

Key points:	• Birthrate Plus® October 2025 review now validated and sent to Trust 18 November 2025. This report **has yet to go through** governance processes within the division. • Birthrate Plus® 2025 Report declares a 9.89wte deficit in clinical midwives, and 3.81wte in specialist/ managerial posts compared to the previous 2021 report; the new report demonstrates an increase in medical complexity of women and service users who book and birth at PAHT • Current vacancies at 14.05wte in Bands 5-7 will disappear from job offers made in September 2025 to 28 newly qualified midwives • Trajectory of decreased Agency and Bank usage by Q4 of 25/26 with onboarding of newly qualified midwives • Staffing requirements meet key targets for the Incentive Scheme Year 7 • Retention plan includes enhanced support for new midwives and ongoing improvements for our people's working lives
Recommendation:	For the Trust Board to accept this report as an accurate reflection of current maternity staffing and note the actions required to address the workforce gap identified in the latest Birthrate Plus® Report (October 2025). The maternity senior leadership will be collaborating with Finance and Human Resources colleagues to develop and implement a robust, evidence-based workforce plan for the next three years, ensuring compliance with national safe staffing standards and sustainability of the maternity service, at which time, this plan will be presented to the Committee for endorsement

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

Previously considered by:	QSCII June 2025
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Maternity (Perinatal) Incentive Scheme Year 7. NHSE Core Competency Framework 2023 Safe Midwifery Staffing for Maternity Settings NICE 2015 Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe sustainable and productive staffing Standards for Competence for Registered Midwives NMC 2020 Maternity Workforce Strategy – Transforming the Maternity Workforce – Health Education England, 2019
Appendices:	1. Birthrate Plus® Labour Ward Metrics 2. NHS Staff Survey 2024 actions

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Purpose

This paper is to give key stakeholders the information and assurance regarding the current position on midwifery and maternity support worker staffing at the Princess Alexandra Hospital NHS Trust (PAHT) as part of a six-monthly review for the purposes of ensuring our maternity service has adequate staffing to provide quality care for mothers and babies, and meeting recommendations from Safe Midwifery Staffing for Maternity Settings (NICE, 2015) and the Maternity (Perinatal) Incentive Scheme Year 7 (NHSE, 2025).

It will also provide a forward look at stabilising the workforce, reducing temporary staff usage, and ensuring that the staffing within maternity meets service delivery needs in the next three years, when the next review is due.

1.0 Current Staffing Levels

Tables 1. and **2**. below outline the current midwifery and maternity support worker staffing levels. The funded establishment was set (and met) against the last workforce review completed in November 2021 by Birthrate Plus®, the maternity workforce planning tool that was developed in collaboration with the Royal College of Midwives. During this six-month period, the service had an average of **12.2wte** on maternity leave.

The maternity service has completed a Birthrate Plus® workforce review, with the final report sent to the service middle of November 2025. The final report was verified with support from the East of England workforce lead. The figures in the tables below *do not* reflect the recently completed workforce review (October 2025) as key stakeholders are yet to meet to review the recommendations and formulate a workforce plan fit for the next three years.

As at Month 7 (October 2025), the maternity service establishment is demonstrated below. Monthly updates are provided to the Quality and Safety committee demonstrating the variance in the midwifery and support worker staffing groups.

Table 1 – Midwifery posts as at Month 7 – October 2025

Banding	Funded wte	In-post wte	Actual worked wte	Variance wte
Band 5	0.00	12.04	11.04	-12.04
Band 6	125.42	100.06	87.00	25.36
Band 7	40.10	39.37	36.97	0.73
TOTAL	**165.52**	**151.47**	**135.01**	**14.05**

Table 2 – Maternity Support Worker posts as at Month 7 – October 2025

Banding	Funded wte	In post wte		Variance wte
Nurse Band 4	7.24	5.12		2.12
Midwife Band 2	0.00	6.00		-6.00
Midwife Band 3	52.43	39.68		12.75
Midwife Band 4	0.00	0.00		0.00
TOTAL	**59.67**	**50.80**		**8.87**

Midwifery Workforce

The midwifery workforce is still largely dependent on a yearly pipeline when the midwifery students qualify from the two local Higher Educational Institutions of Anglia Ruskin and Hertfordshire in September of each year. For several years, the pattern has been that the vacancies slowly increase over the year, and that recruitment into vacant posts needs to be year-round. However, after the bulk qualification of midwives every September, it is difficult to recruit during the year as they are just not there. Whilst keeping the vacancy rate low with be wholly advantageous, it also means that the vacancies available at time of qualification of the students would be less. Metrics around the midwifery workforce are further explored in point 2.0

Maternity Support Workers

Since the trust-wide up-banding of clinical support workers in line with national recommendations and job profiles, there has been a steady decrease of support worker vacancies which have stabilised between 8-9wte. Six posts have been recently used to temporarily up-band MSW with additional funding from NHS England to Band 5 midwifery posts. This has enabled maternity services nationwide, PAHT included, to recruit more of their qualifying students as many were nearing completion of their three-year midwifery course without the prospect of securing employment.

There has been further investment in the MSW workforce in providing apprenticeship opportunities for two staff each year to study midwifery. This brings the total apprentices to four and has been well received as it provides a progression opportunity.

The maternity service has committed to training colleagues previously holding Band 2 Health Care Assistant roles so that they attain the level of skill to work in all parts of the maternity service and be more involved the postnatal pathway where appropriate. This has been well received and reviewed. Earlier this month there was an MSW Away Day which gained positive feedback. These are to continue for the foreseeable future, building on what is positively reviewed.

Temporary Staffing

Staffing shortfalls, whether from long or short-term absence, are met via the redeployment of staff, temporary staffing, mainly through our own staff via NHSP Bank, but Agency Midwives on occasion. There are robust systems in place to ensure that staff-planning and addressing shortfalls has senior oversight. Rosters are released 8 weeks in advance whenever possible. Twice weekly meetings review current requirements and provide a lookahead. Any pressure areas are addressed in advance to ensure that the staffing resources available can meet demand.

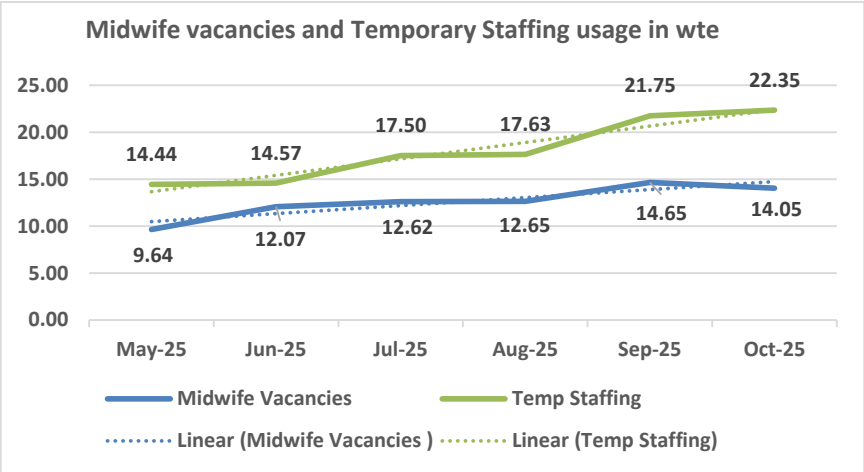
Figure 1. below demonstrates the utilisation of temporary staffing in the last six months. Increasing vacancies has meant that there has also been an increase in temporary staff usage.

Temporary staffing usage in October 2025 of **22.35wte (Bands 5-7).** When combined with the 'actual worked' figure of **135.01wte** (Table 1), this totals **157.36wte**, which remains *below* the funded establishment of **165.52wte** for Bands 5-7. Feedback from maternity staff consistently highlights that "more staffing" would improve their working lives – a message strongly echoed in the NHS Staff Survey 2024, where staff reported significant fatigue and burnout. The recruitment and retention plan outlined in this paper directly addresses these concerns by

increasing substantive staffing, reducing reliance on temporary cover, and prioritising staff well-being initiatives to mitigate fatigue and improve sustainability.

With 28 midwives recruited since October and further new starters planned for December and January, the vacancy trajectory is improving, supporting assurance that reliance on agency (and Bank) will reduce significantly by Q4 of 2025.

Figure 1: Midwife Bank and agency usage for last six months



2.0 Workforce assessment

Using the Birthrate Plus® tool, the maternity service is able to make a dynamic assessment of staffing versus workload every 4 hours and thus, when needed, can have a weekly, monthly, or six-monthly overview (**Appendix 1**). The Quality and Safety Committee Part II (maternity focused) receive a monthly (bi-monthly since September 2025) overview at each meeting where overall staffing numbers, vacancies, red-flags and temporary staffing are discussed. **Figure A.** in **Appendix 1** demonstrates that the compliance for data completion on Birthrate Plus® for that period was 77.99% (above average for East of England). It also highlights the peak times where the entries are not completed which is 14:00 and 18:00. Different strategies have been employed to improve the compliance including setting alarms, which has enabled a marginal improvement.

The funded establishment is determined not only by the total activity (not just births) that a maternity service undertakes, but also on its staff being able to take annual leave, study leave and training and makes allowances for inevitable sickness absence. This allowance is called “headroom” and is set at 22% for PAHT maternity services, split as below:

- Annual leave – 15%
- Study Leave – 2%
- Sickness Absence – 3%
- Maternity Leave – 2%

With robust workforce planning that utilises all tools available, and a sustained focus on wellbeing and flexibility of work patterns, sickness absence should be kept at a minimum.

Staffing related factors in the past six months are detailed in **Figures B.** and **C** (showing same period in 2021). in **Appendix 1**. The former shows that staffing was matched to workload 65% of the time (like previous six months), and 2 or more Registered Midwives short 6% of the time (slightly higher than six-month period before). The escalation pathway is utilised flexibly to manage staffing shortfalls with temporary staffing, the redeployment of staff, or the halting of planned activity e.g. inductions of labour. This is managed daily via a multi-disciplinary approach.

It is also important to note that the staffing model used in 2021 was a case loading model of five teams covering a significant part of the communities served by PAHT maternity services. 'Caseload midwife present' accounted for 43% of activities in 2021, compared to 10% in 2025.

The recently completed workforce review by Birthrate Plus® is demonstrated in the Table 3 below:

Table 3: Workforce Comparison Table

Category	Birthrate Plus® Recommended wte	Current funded wte	Variance (Deficit) wte
Clinical Staffing (Bands 3-7)	194.21	184.32	-9.89
Specialists & Management roles	23.31	19.50	-3.81
Total Workforce	**217.52**	**203.82**	**-13.70**

It is for the maternity leadership to work collaboratively with the Finance and Human Resources Teams and the Executive Board to develop an evidence-based workforce plan that will ensure the maternity service is sustainable over the next few years. Through improvement work, the need had already been identified and commitment from the Executive Board gained to invest in the Maternity Triage workforce in response to increased demand and feedback from staff who are based there.

2.1 Workforce assessment against Maternity and Perinatal Incentive Scheme Year 7

During this six-month reporting period, the staffing has met the following metrics:

- Maintaining supernumerary status of the coordinator at 100% (actual 99.8%)
- Maintained 1:1 care in labour (actual 99.5%)
- Completed a Birthrate Plus® review in October 2025
- Key elements of Saving Babies Lives, Safety Action 6 of Incentive Scheme Year 7
    - Element 4: A dedicated lead midwife for Fetal Monitoring 0.6wte (and lead obstetrician 0.1wte)
    - Element 5: Named Preterm Birth Lead Midwife (also, lead obstetrician and lead optimisation neonatal nurse and neonatal consultant)
    - Element 6: intervention 6.2 not yet met but an action plan is underway to implement provision of hybrid closed loop within the Trust diabetes service and will include allocation of the required staff roles (diabetes consultant and diabetes specialist nurse within maternity antenatal clinic) for SBL in 2026.
        - The assessment of the whole of Element 6 is above the 50% threshold

2.2 Activity assessment

The other significant differences of note between 2021 and 2025 are the unexpected midwife absences, and inability to fill vacant shifts. Both changes align with reported burnout from staff.

It would also explain the rise in agency usage as the Bank pool usually is drawn from substantive staff picking up extra shifts.

'Care Categories' has also shifted significantly. Women who can be cared for in the Birth Centre are those in Categories I and II. A comparison of 2021 and 2025 shows a shift, with far fewer women in these categories (which need fewer care hours) than those with more complexities (Categories IV and V) who require more care hours, have a postnatal period requiring a longer stay on Labour Ward, and a longer length of stay. This shift has been well documented in each Quality and Safety Committee Part II meeting (subcommittee to Trust Board) and the reasons for this are multifactorial. These changing dynamics reinforce the need to have a workforce that is adaptive to these changes with services and specialists to meet the growing complex care needs.

3.0 Training and professional development

Maternity services utilise the NHSE Core Competency Framework (CCF) first introduced in 2020 as part of the Maternity Transformation Programme. The Mandatory Midwifery Training at PAHT is based on this CCF, and the Royal College of Midwives (RCM) guidelines on continuing professional development. Preceptee midwives receive more focused and individualised support from the two Preceptee Support Specialist Midwives, the Clinical Support Facilitator, and the Practice Development Midwife. As the Education Team, and under the line-management of the Head of Women's Health Governance and Assurance, they are responsible for all the training and support of staff in the clinical areas, conducting simulations, proposing training props, and overseeing the process of continual professional development (CPD) by signposting staff to courses, how to apply, and ensuring the funding is secured. Through tight administration, they also ensure that the whole perinatal service meets the training requirements for the Maternity and Perinatal Incentive Scheme Safety Action 8 on multidisciplinary training. The service is pleased to announce that it has met this safety action for Year 7 (2025).

Currently, the maternity service via CPD funding is enabling midwives to complete master's degree studies, at least two midwives to complete the non-medical prescriber course which will improve future care pathways, and is supporting two further maternity support staff to study midwifery via the apprenticeship route.

4.0 Staff Wellbeing and Retention

The staff turnover rate reflected in Table 4. is on average currently 5.82% per month for this six-month period which is the lowest it has been for several years. Understanding why *our people* leave is important to the service and on-going piece of work within maternity and Trust-wide. Reasons to leave include moving back closer to family, and/ or to where accommodation is cheaper. In the past, lack of training opportunities has *not* presented as a reason for leaving PAHT maternity services.

Table 4 – Midwifery voluntary turnover rates – 6 months

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
6.81%	6.16%	6.14%	5.30%	5.24%	5.24%

Average turnover for past 6 months - 5.82%
***Average turnover for same period in 2021 - 9.41%**

The newly recruited midwives will be supported within their first year as Preceptees. In addition, the Preceptee Support Specialist Midwives role will be reinforced for an additional four months using additional funding from NHS Engand.

All staff at PAHT are supported via a Staff Health and Wellbeing (SHAW) and the senior leadership ensure they publicise this service at every opportunity e.g. return to work interviews, when staff escalate problems with work/ life harmony or when an incident occurs. A regular message that is reiterated is the presence of (and access to) Freedom to Speak Up Guardian, and/ or Ambassadors.

As part of ongoing support of staff, communication and collaboration, the maternity team hold monthly Maternity Unit Meetings where staff are encouraged to attend an online meeting for the very purpose of receiving important updates, sharing best practice and collectively addressing challenges. This is a well-attended meeting which is recorded enabling those who cannot attend live, to watch at their own convenience.

From the NHS Staff Survey of 2024 results, PAHT committed to focus on these areas of the People Promise:

- (Leadership is) compassionate and inclusive
- Teamwork
- Reward and Recognition

The service has launched several programmes in the last few months as part of quality improvement and Reward and Recognition. These include peer nominations for the “Penfriends” scheme, the coproduced House Rules, a sterile water injection QI project to give more choice to women for non-pharmacological methods of pain relief, and launched the FiveXMore *6-Steps to advocate for yourself* to empower women, and the *5-Steps for health care professional to reduce inequalities.* These have been well received. These initiative and culture programmes have all been brought through the Committee in the last few months.

Other improvements from the 2024 NHS Staff Survey are shown in Appendix 2.

5.0 Future Staff Projections

As previously stated, the maternity department recently completed a workforce review with Birthrate Plus® and must now collaborate with key stakeholders to plan workforce requirements for the next few years using evidence gathered from current activity.

The parts of the service that are known to have grown are summarised below:

- The activity through the Maternity Triage has increased significantly in the last year due to several reasons which include the change of attendance to Maternity Triage (as opposed to Early Pregnancy Unit and Emergency Department). This prompted the service to write a paper to the Executive Board at PAHT to recruit above additional midwifery posts (14.0wte in total) that would enable an extra midwife in Triage specifically to have 24/7 cover for Telephone Triage. This will be a significant improvement towards meeting the Royal College of Obstetrics and Gynaecology recommendations for maternity triage outline in the Good Practice Paper (Dec,2023)

- The need for more specialised roles which included Multiple Births (launched in May 2025 using external funding) and a Maternal Medicine midwifery role as recommended in the Ockenden Final Report 2022 and the Three year delivery plan for maternity and

neonatal services (NHSE, 2023). The maternity leadership has been creative and proactive in trying to meet the demand via external funding or temporarily moving unused establishment to fund the Perinatal Mortality Review Tool Specialist Midwife role for a fixed-term period, for example. The sustainability of such roles is dependent on maternity being able to build a case for funding to meet the needs of the service and national recommendations.

- The psychosocial support for women/ service users has increased over the last few years which translates as more midwifery time invested. The Birth Reflections Service is also demonstrative of one whose demand has increased exponentially, and a post was recently recruited into (Band 6) to carry out an improvement project to eliminate the backlog/ long waiting times and ascertain future resource requirements and evaluate the effectiveness of this service.

- The service would also like to start a second caseload team to expand the continuity of carer offer to more vulnerable women which will include black and brown service users, those with refugee asylum status, travellers, and those with complex psychosocial problems requiring enhanced support and wrap-around care from multiple professionals, with the midwife central to the coordination of such pathways.

6.0 Recommendations

For the Trust Board to accept this report as an accurate reflection of current maternity staffing and note the actions required to address the workforce gap identified in the latest Birthrate Plus® Report (October 2025). The maternity senior leadership will be collaborating with Finance and Human Resources colleagues to develop and implement a robust, evidence-based workforce plan for the next three years, ensuring compliance with national safe staffing standards and sustainability of the maternity service at which time, this plan will be presented to the Committee for endorsement

Author: Linda Machakaire Director of Midwifery, Gynaecology and Assistant Chief Nurse
Date: 21 November 2025

The Princess Alexandra Hospital NHS Trust

Appendix 1 - Birthrate Plus® Labour Ward Metrics

Figure A: Compliance in May 2025 – October 2025

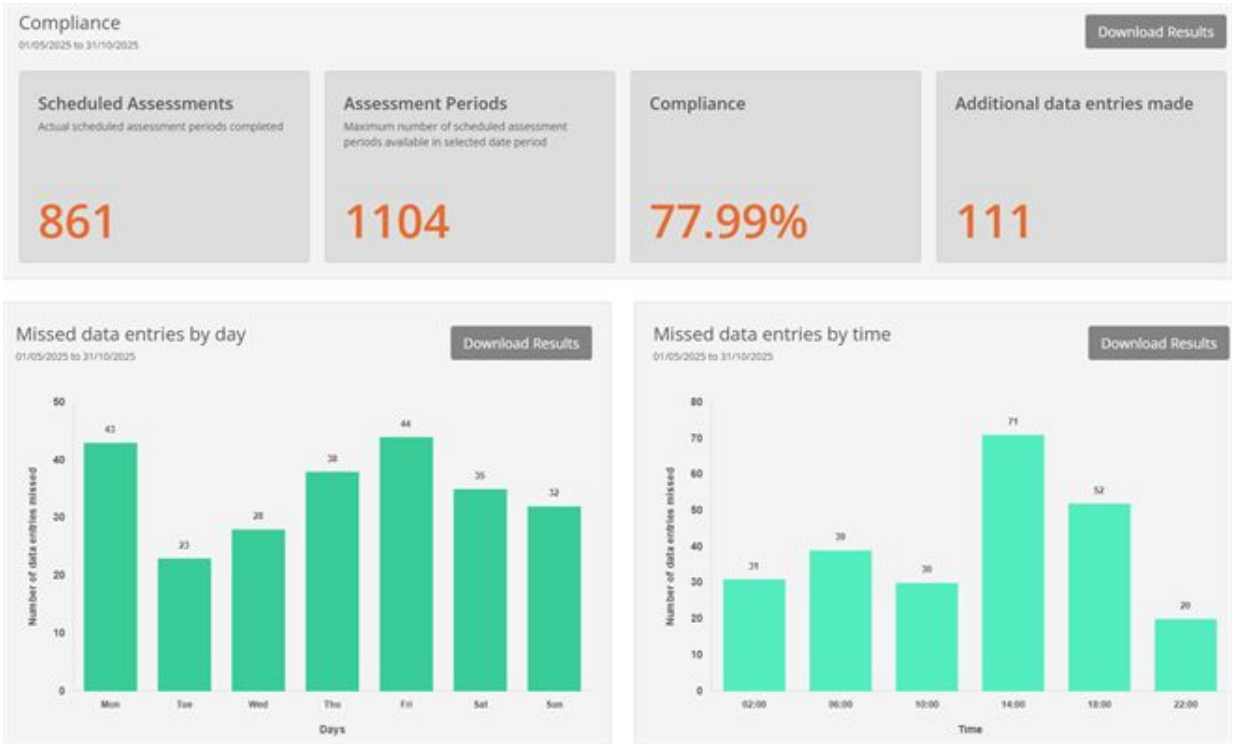
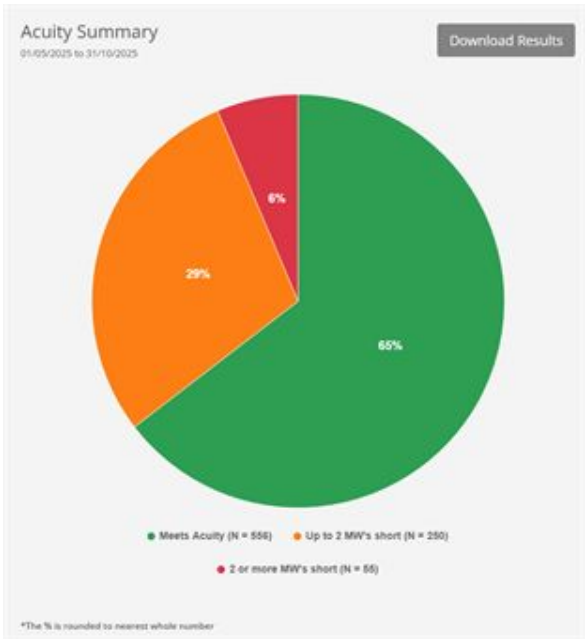


Figure B: Staffing Summary for May 2025 – October 2025



May 2025 – Oct 2025

- Service met acuity 65% in previous six months
- Up to 2 midwives short 29% of the time
- Two or more midwives short 6% in this period

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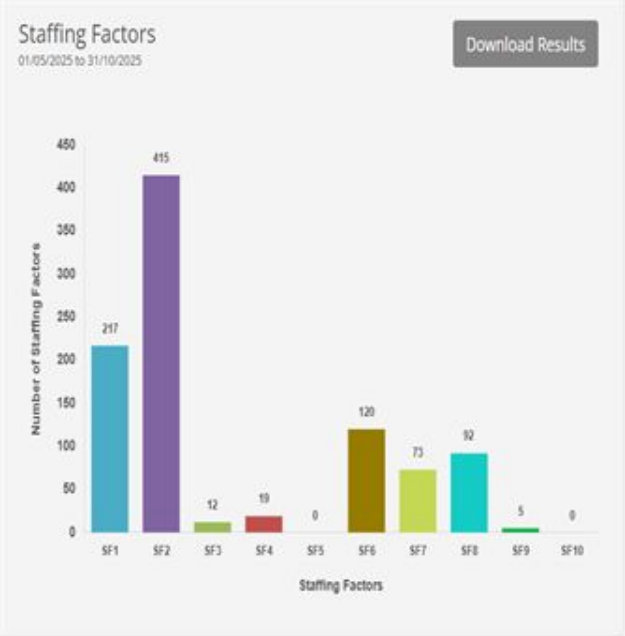
Figure C1: Staffing Factors in May 2025 – October 2025



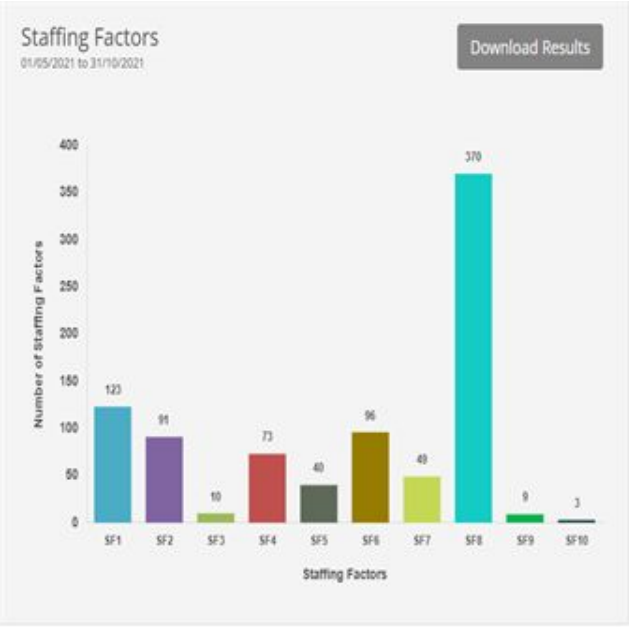
Number of Staffing Factors
01/05/2025 to 31/10/2025

Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	217	23%
SF2	Unable to fill vacant shifts	415	44%
SF3	Midwife on transfer duties	12	1%
SF4	Midwife redeployed to other area	19	2%
SF5	Nurse redeployed to other area	0	0%
SF6	Support staff less than rostered numbers	120	13%
SF7	MW scrubbed in theatre	73	8%
SF8	Caseload MW present	92	10%
SF9	Caseload MW unavailable	5	1%
SF10	No support staff available	0	0%
TOTAL		953	

*The % is rounded to nearest whole number

Figure C2: Staffing Factors in May 2021 – October 2021



Number of Staffing Factors
01/05/2021 to 31/10/2021

Download Results

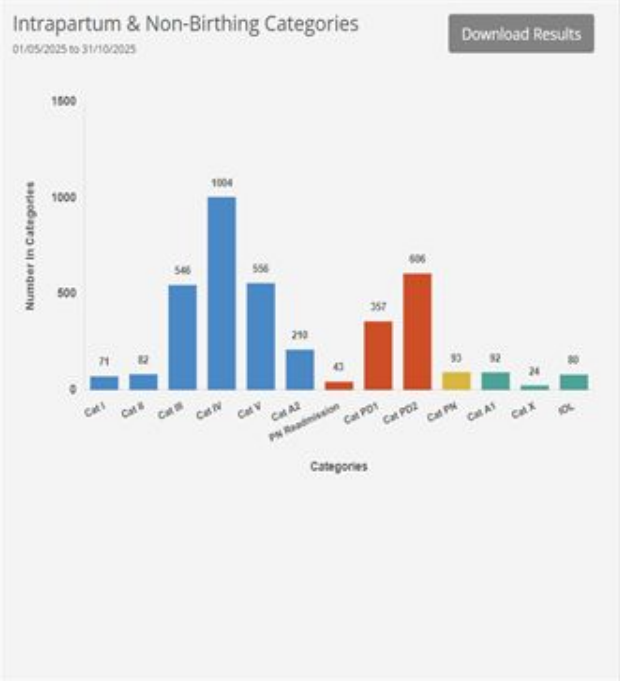
Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	123	14%
SF2	Unable to fill vacant shifts	91	11%
SF3	Midwife on transfer duties	10	1%
SF4	Midwife redeployed to other area	73	8%
SF5	Nurse redeployed to other area	40	5%
SF6	Support staff less than rostered numbers	96	11%
SF7	MW scrubbed in theatre	49	6%
SF8	Caseload MW present	370	43%
SF9	Caseload MW unavailable	9	1%
SF10	No support staff available	3	0%
TOTAL		864	

*The % is rounded to nearest whole number

The Princess Alexandra Hospital NHS Trust

4.2

Figure D1: Care Categories in May 2025 – October 2025

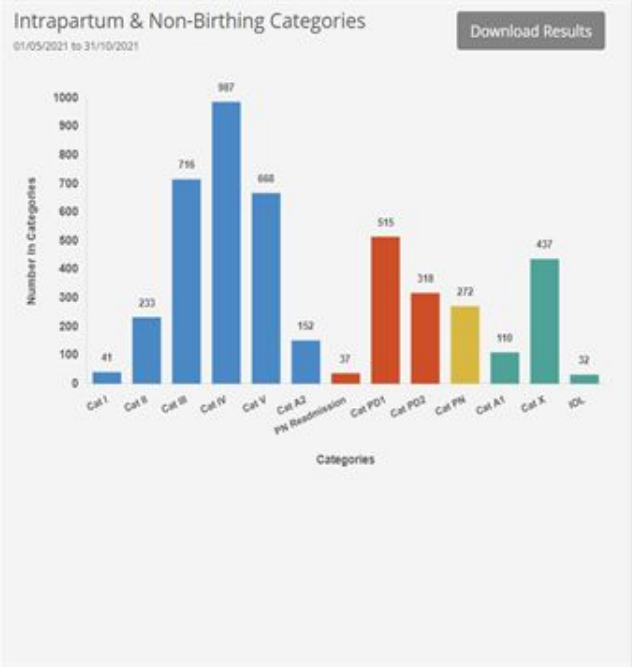


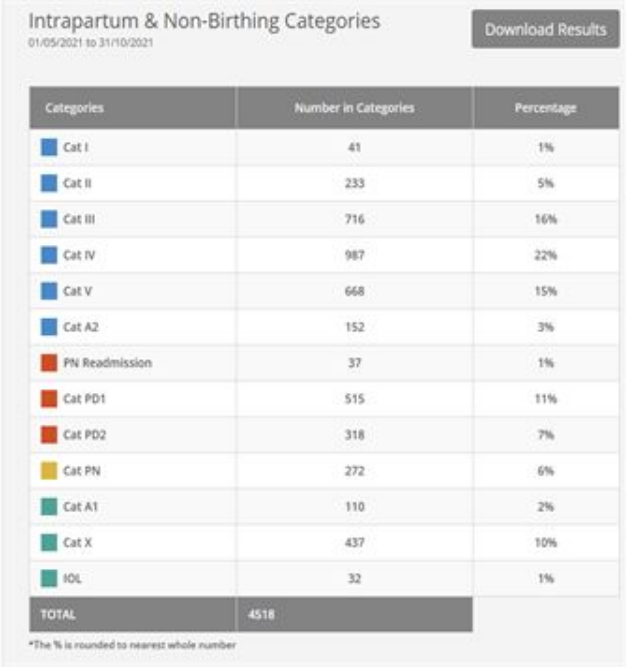
Intrapartum & Non-Birthing Categories
01/05/2025 to 31/10/2025
Download Results

Categories	Number in Categories	Percentage
Cat I	71	2%
Cat II	82	2%
Cat III	546	15%
Cat IV	1004	27%
Cat V	556	15%
Cat A2	210	6%
PN Readmission	43	1%
Cat PD1	357	9%
Cat PD2	606	16%
Cat PN	93	2%
Cat A1	92	2%
Cat X	24	1%
IOL	80	2%
TOTAL	3764	

*The % is rounded to nearest whole number

Figure D2: Care Categories in May 2021 – October 2021





Intrapartum & Non-Birthing Categories
01/05/2021 to 31/10/2021
Download Results

Categories	Number in Categories	Percentage
Cat I	41	1%
Cat II	233	5%
Cat III	716	16%
Cat IV	987	22%
Cat V	668	15%
Cat A2	152	3%
PN Readmission	37	1%
Cat PD1	515	11%
Cat PD2	318	7%
Cat PN	272	6%
Cat A1	110	2%
Cat X	437	10%
IOL	32	1%
TOTAL	4518	

*The % is rounded to nearest whole number

The Princess Alexandra Hospital NHS Trust

4.2

Appendix 2 – NHS Staff Survey 2024 Improvements

NHS STAFF SURVEY 2024
WHAT YOU TOLD US & WHAT WE'VE DONE

NHS The Princess Alexandra Hospital

1 | STAFFING AND EQUIPMENT

- 28 midwives posts offered & starting ~ Nov 2025
- Supported 2 more MSWs into midwifery apprenticeships
- Ongoing: Reviewing equipment needs to help you work better.

2 | EMOTIONAL WELL-BEING AND BURNOUT

- Summer Party
- End of Year Celebration
- Regular PMA Support and Well-being days
- CHaWS Dance Group rocked the PAHT Cultural Festival
- Ongoing: Planning more inclusive and frequent events

3 | RECOGNITION AND APPRAISAL

- Pen–Friends
- Peer nominations: Star of the Month, Daisy Awards, Amazing People, This is Us
- Intentional appreciation and applause

Ongoing: training for managers to enable more meaningful appraisals and year–round 1:1s, thus getting to know (and support) you better.
Away Days

THESE IMPROVEMENTS WOULD NOT HAVE HAPPENED HAD YOU NOT HAD YOUR SAY IN 2024

4 | COMMUNICATION AND TEAM CULTURE

- Launch of Civility Saves Lives Campaign
- House Rules
- Five X More campaigns for service users and HCPs
- Maternity Unit Meeting
- Community Forum
- Matron of the Day

Planned/ Ongoing – CPD monies allocated to enable training and career development

Active Bystander Training

birthrights

NEXT STEPS

THE 2025 NHS STAFF SURVEY LAUNCHED 6 OCTOBER 2025. NOW IS THE TIME TO HAVE YOUR SAY. REMEMBER:

- The survey is anonymous, so get typing ...
- Look for your personal link from picker_surveys@picker.org
- Get your friends to fill it out too, and help those who cannot find it.
- To ask your line manager for time to complete it.

PRINCESS ALEXANDRA MATERNITY

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery, Gynaecology and Assistant Chief Nurse
Prepared by:	Emma Rose – Head of Women's Health Governance & Assurance
Date prepared:	02/12/2025
Subject / title:	Maternity Incentive Scheme (MIS) Year 7

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

Key issues:	1. Two at risk safety actions (SA): 1 and 2 2. Digital issues impacting SA 2 and 6
Recommendation:	1. To note that the MIS year 7 reporting period ends on 30 November. 2. To note the at-risk safety actions. 3. To note SA7 MNVP Route 1 action plan HWE (Oct 2025) – appendix 2

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:	CHAWS Divisional Board QSC (Nov 2025)
Risk / links with the BAF:	BAF Risk 1.1
Legislation, regulatory, equality, diversity and	Ockenden Report (2022) Three Year Delivery Plan for Maternity and Neonatal Services (2023) Maternity (and perinatal) Incentive Scheme Year 7 (2025)

Appendices:	Appendix 1: SA7 MNVP Route 1 action plan HWE (Oct 2025)

1.0 Purpose

This report provides an update on the Division's progress towards evidencing achievement of the ten safety actions for the Maternity (Perinatal) Incentive Scheme (MIS). This encompasses implementation of the Saving Babies Lives care bundle version 3.2 (SBL) and compliance against mandatory multidisciplinary (MDT) training. This also provides assurance of the service's achievement to maintain action three of the local maternity sustainability plan: service improvement and progress against actions plans linked to national drivers such as Saving Babies Lives and the Maternity Incentive Scheme.

2.0 Background

NHS Resolution's MIS programme of safety actions is in its seventh year. The Trust met the requirement for year 6. An update was provided to QSC in November 2025, reporting that this year safety actions 1 and 2 are at risk.

3.0 Maternity Incentive Scheme current position, including SBL Q1 review summary and training trajectory

Full guidance and safety action evidence requirements can be seen here: MIS-Year-7-guidance.pdf

Safety Action	Status	Issues and updates
1. Use of PMRT tool	Not met	As previously reported, two standards will not meet target compliance due to one late notification (standard a) and one late commencement of reviews (standard c). Both reviews were undertaken in full. All other standards exceed compliance. Mitigations and actions in section 4.
2. MSDS data quality	At risk	This data set was submitted and passed the 80% threshold. However, it was only a third of our birth (Alex Health issues). MSDS have been notified, awaiting response.
3. Transitional care and ATAIN quality improvement	Met	
4. Clinical workforce planning – medical and neonatal nursing	On track	
5. Midwifery workforce planning	Met	
6. Saving Babies Lives implementation	Met	Additional detail in section 4
7. Listen to women, parents and families, and coproduction of services with users	Met	Additional detail in section 4
8. Evidence 3 elements of local training plans in in-house, one day multi-professional training	Met	

9. Assurance to Board on maternity and neonatal safety and quality issues	Met	
10. 100% qualifying cases reported to MNSI and NHSR early notification scheme	Met	100% compliant to date and have commenced use of SPEN as of 20 October 2025, (the new "submit a perinatal event notification" portal).

SA6: Saving Babies Lives Q2 review status (as of 30 Nov 2025 final LMNS review)

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	85%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	94%	Partially implemented	90%

Q1+2 comparison

	Baseline Assessment	Assessment 1	Assessment 2
Review Quarter		Q1 25	Q2 25
Assurance Review Date		October	November
Element 1		60%	80%
Element 2		65%	85%
Element 3		50%	100%
Element 4		100%	100%
Element 5		81%	100%
Element 6		33%	67%
TOTAL		70%	90%

The Local Maternity and Neonatal System (LMNS) have approved the service as meeting required compliance for 2025. Mitigations are in place for the gap around Diabetes care provision – the service has an action plan to meet full implementation of hybrid closed loop provision and a full MDT service as per SBL and NICE requirements. Additionally, an action plan is in place for fetal growth restriction to improve compliance.

4.0 Mitigations and actions

Safety action 1

Service plans to increase the hours of the PMRT Midwife having completed a service needs review of how much time is needed weekly to meet the requirements of the role.

Safety action 2

The Digital Midwife worked with the Head of Business Intelligence and the CHAWS Information Manager to assess the problem where not all our births were reported. Improvements have been realised and the MSDS team have been regularly updated, and they are closely monitoring our submissions.

Safety action 6

While this Safety Action has been met, there have been significant challenges with providing timely assurance. This is due to the implementation of the electronic health record 'AlexHealth'. The service was advised that the reporting features of the previous EHR 'Cosmic' which enabled easy extraction of the data required for evidencing SBL would be replicated. However, this has not yet been fully realised with AlexHealth. This impacts reporting of compliance across five of the elements and therefore manual audits were undertaken requiring clinical team resource.

Safety action 7

While the service has fully met the requirements for engagement with the MNVP, the MNVP infrastructure is not set up as per national MNVP guidance. This responsibility sits with the LMNS and has been escalated at LMNS Partnership Board. Appendix 1 shows the route we are using to meet this Safety Action

5.0 Oversight

The service's position for MIS year 7 has been shared with the Board Safety Champions, LMNS and NHSE East of England regional team.

6.0 Recommendations

1. To note that the MIS year 7 reporting period ends on 30 November.
2. To note the at-risk safety actions.
3. To note SA7 MNVP Route 1 action plan HWE (Oct 2025) – appendix 2

Author: Emma Rose
Date: 2 December 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Project Charter
MNVP Sustainable Plan

25 October 2025

Working together
for a healthier future

Name: MNVP Expansion			
ICB Exec Lead:	Natalie Hammond	**ICB Programme Manager**	Caroline Zwierzchowska-Dod
Programme Overview:	Expansion of the Maternity & Neonatal Voices Partnerships to meet national guidance		
Programme Aims:	To increase capacity within the MNVPs to meet statutory requirements. To ensure the voices of women, birthing people and families are heard within service development and evaluation in HWE provider Trusts and the ICB		
Programme Objectives:	To put in place a strategic lead as per MNVP guidance, at 8a. To increase the size of the leadership team to avoid reliance on one individual or local lead and to provide a skills mix appropriate to the tasks. To ensure that the local team along with the strategic lead can meet Trust SBL requirements including attendance at PMRT, Safety and Quality and divisional governance meetings. To ensure that the MNVP team resources allow them to adequately reach and meet the engagement expectations of the Trust, ICB and service user community.		
Programme Deliverables:	To meet the national guidance objective from Maternity (perinatal) Incentive Scheme, Safety Action 7: "Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the 3-Year Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Infrastructure b) Strategic influence and decision-making c) Engagement and listening to families."		
Key Performance Indicators:	1) New structure and budget is approved providing cross-cluster equity 2) Team members are recruited and onboarded into their roles 3) MIS, SA7 Route 2 can be met via Increased resource in line with national guidance		

What difference does it make to be in line with MNVP Guidance? Larry Weatherall, national SUV Rep

NHS England

Aspect	MNVP commissioned and functioning in line with guidance	MNVP *not* commissioned and functioning in line with guidance
Strategic Leadership	Employed, professional senior lead with lived experience	Led by people on PPV or remunerated volunteers OR led by clinicians or people *without* lived experience
Contracting	Robust commissioning process leading to awarding of contract for service OR employment contracts	No robust commissioning process, no contracts or inappropriate contracts in place
Recruitment	Agreed and banded job descriptions, values-based recruitment process	No transparent recruitment process, job description absent or not reflective of development of role from chair to lead
Team	Team with capacity and the right skill mix including strategic leadership, programme management, engagement, data analysis, comms and marketing	Relying on a single individual or volunteers to deliver critical functions, lack of capacity
Support functions	IT, HR, accounts, training, admin provided in house through direct employment or through commissioning arrangements	Non-existent or slow to respond support functions
Governance meetings	Strategic Lead with capacity and capability to consistently attend and meaningfully contribute	Lack of seniority, experience and knowledge in strategic leadership and limited time to attend
Personal wellbeing & development	Regular access to supervision, wellbeing support, training & development opportunities	Limited or no process in place for support

Current HWE MNVP						Scoped model				
System	None						Stragetic lead	Band 8a	1 FTE	77,759
West Essex MNVP	Maternity Lead	In post		0.18	Band 7 £ 11,213.00	System	Comms/social media lead	Band 5	0.2 WTE	£ 8,349.00
	Neonatal Lead	In post		0.09	Band 7 £ 4,541.00		Equity Lead	Band 7	0.2 WTE	£ 12,827.00
West Herts MNVP	Maternity Lead	In post		0.18	Band 7 £ 11,213.00	West Essex MNVP	Maternity Lead	Band 7	0.6 WTE	£ 39,982.00
	Neonatal Lead	In post		0.09	Band 7 £ 4,541.00		Neonatal Lead	Band 7	0.4 WTE	£ 26,405.00
Lister MNVP	Maternity Lead	In post		0.18	Band 7 £ 11,213.00	West Herts MNVP	Maternity Lead	Band 7	0.6 WTE	£ 39,982.00
	Neonatal Lead	In post		0.09	Band 7 £ 4,541.00		Neonatal Lead	Band 7	0.4 WTE	£ 26,405.00
Resource budget	Per MNVP	N/A	N/A	N/A	£ 1,500.00	Lister MNVP	Maternity Lead	Band 7	0.6 WTE	£ 39,982.00
	Per MNVP	N/A	N/A	N/A	£ 1,500.00		Neonatal Lead	Band 7	0.4 WTE	£ 26,405.00
	Per MNVP	N/A	N/A	N/A	£ 1,500.00	Resource budget	Per MNVP	N/A	N/A	£ 1,500.00
Expenses	Per MNVP	N/A	N/A	N/A	£ 1,000.00		Per MNVP	N/A	N/A	£ 1,500.00
	Per MNVP	N/A	N/A	N/A	£ 1,000.00		Per MNVP	N/A	N/A	£ 1,500.00
	Per MNVP	N/A	N/A	N/A	£ 1,000.00	Expenses	Per MNVP	N/A	N/A	£ 1,000.00
Total					£ 54,762.00		Per MNVP	N/A	N/A	£ 1,000.00
							Per MNVP	N/A	N/A	£ 1,000.00
						Total				£ 227,837.00

Name: Initial Action Planning					
Task	**Start date**	**End date**	**Owner**	**KPI**	**Comments**
Review cluster MNVP models to determine alignments	Nov-25	Dec-25	Rebecca Wilkie	Cluster model produced	
Break point: Await Cluster decision on where MNVPs will sit within the ICBs					
Produce financial case study	Jan-26	March-26	Caroline Zwierzchowska-Dod	Financial costings & case study produced	
Finance case submission to workforce panel / new cluster model	April-26	June-26	Caroline Zwierzchowska-Dod	Finance case submitted	
Partnership Board agreement	June-26	July-26	Natalie Hammond/new SRO	Partnership board item minuted	
Recruitment of new staff	July-26	Sept-26	Caroline Zwierzchowska-Dod	HR processes followed & staff in post	
Onboarding of new staff	Oct-26	Dec-26	Caroline Zwierzchowska-Dod	Staff have attended ICB and MNVP training	

Programme Risks & Issues:

Top 3 Risks:	Likelihood (1-5)	Impact (1-5)	Risk Score	Actions to be taken to reduce the risk
Cluster/merger recruitment freeze	4	4	16	Perinatal team structure document prepared including uplevelled team costings
Financial constraints within new ICB	3	4	12	Alignment of workforce cases to NHS 10 year plan and ICB blueprint deliverables alongside MNVP guidance
Key personnel made redundant	3	4	12	Plans shared across the new cluster maximising involved personnel

Top 3 Issues (if applicable):	Actions to be taken to reduce the risk
Need to align model across 2 other ICBs to ensure equity	Cluster MNVP liaison meetings in place; sharing of guidance, prepared model levelling up to BLMK hours
Unknown LMNS structure/whether MNVPs will be within ICB remit	Perinatal team structure submitted for SRO consideration

Likelihood \ Severity	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

4.3

Trust Board (Public) – 11 December 2025

Agenda item:	4.3
Presented by:	Jo Ward- Interim Chief Nurse
Prepared by:	Charlotte Collings, Lead Nurse for Safer Staffing and Workforce
Date prepared:	December 2025
Subject / title:	Report on Nursing and Midwifery staff levels for October 2025 to Board.

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 February 2026 The end of year nursing and midwifery establishment review commenced in							
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:	NA
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 **Appendix 5:** Comparison of staffing fill rates, staffing incidents raised, HAPUs and falls.

1.0 Introduction

This paper illustrates how PAHT's nursing and midwifery staffing has been deployed for October 2025. It shows how safe staffing has been achieved and how this is supported by nursing and midwifery recruitment and deployment.

A request was made at Trust Board in November 2025 to review staffing levels in relation to other quality metrics, this information is available in Appendix 5 of this paper.

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 show staffing and actions taken in October 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 October 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 less than 75% average fill rate through October.

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. The Board approved changes have been applied to the roster commencing 22 December 2025.

Greater than 100% fill rate for Registered Nurse (RN) shifts continues to be mainly attributable to high patient acuity / enhanced care requirements, a task and finish group is now in place reviewing enhanced care requirements.

The Trust continues to use NHS Professionals to mitigate vacant shifts and in addition agency nursing to support patients that need Registered Mental Health Nurse's. Additional control measures continue to be in place about the creation of additional duties.

Furthermore, our senior nurses and midwives are also supporting individual areas when needed. SafeCare data continues to be collected three times a day to enhance staffing governance across the organisation.

Further detail can be found in Appendix 1.

Table 1. Overall fill rate

Average day fill rate - registered nurses/midwives	Average day fill rate - care staff	Average night fill rate - registered nurses/midwives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
94.2%	112.8%	102.0%	135.5%	97.7%	123.1%	106.0%

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.

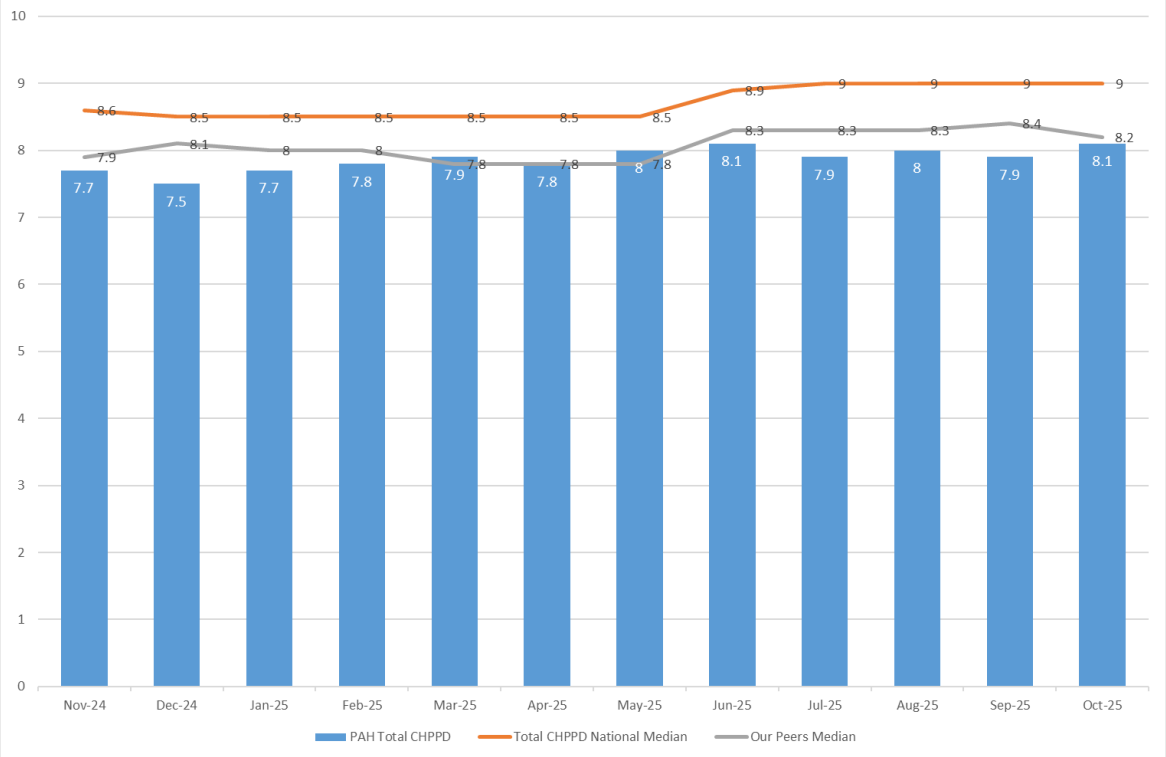
Table 3. Overall Care Hours Per Patient Day (CHPPD) October 2025

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.0	3.1	8.1

The Model Hospital data (August 2025) shows the Trust with a CHPPD of 8.0 against the national median of 9.0**.** 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 October 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 distributing additional nursing staff to the ward or other appropriate responses. Appendix 3 details the NICE (2014) definition of Nursing Red Flags. This includes the number of occasions when registered staffing fell below 75% of the standard template with trend, and the number of Red Flags raised in SafeCare.

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

October data shows a slight increase in falls (78 vs 75), with Kingsmoor and Ray remaining the highest contributors. Pressure ulcers increased to 30 from 24, including Category 3 cases; however, professional review indicates these were largely unavoidable. Two wards remain under quality surveillance, both with high enhanced care needs, while nine wards reported zero HAPUs – one of these has maintained this for over 12 months. Complaints and PALS volumes were highest in ED and Kingsmoor, with themes of delays and communication. Compliment data continues to be inconsistently captured, limiting opportunities to share positive experiences and celebrate good practice. Red Flags increased to 120 (from 75), mainly due to RN shortfalls and unmet enhanced care needs, with Tye Green and OPAL recording the most. 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% and staffing levels are safe. However, acuity-driven pressures persist, reflected in continued high enhanced care demand.

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 October 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	87.6%	145.7%	100.3%	162.7%	92.8%	153.8%	114.9%
Henry Moore	136.5%	165.1%	184.9%	177.2%	155.9%	170.8%	162.4%
ITU & HDU	95.6%	73.1%	99.4%	117.9%	97.5%	94.5%	97.2%
John Snow	103.4%	55.8%	98.5%	48.2%	101.1%	52.2%	84.7%
Penn	95.2%	115.9%	99.2%	179.0%	96.9%	139.8%	112.3%
Saunders	89.7%	109.8%	122.4%	173.8%	101.9%	134.0%	114.0%
Surgery Total	98.2%	118.9%	109.9%	155.1%	103.4%	134.6%	112.5%
Fleming	85.9%	106.4%	99.2%	125.7%	91.5%	115.6%	98.9%
Harold	90.8%	115.5%	103.8%	136.4%	96.5%	125.5%	105.6%
Kingsmoor	86.6%	144.7%	105.4%	167.1%	93.7%	155.4%	116.7%
Lister	92.0%	121.3%	100.2%	150.6%	95.4%	135.3%	111.4%
Locke	86.0%	110.6%	100.1%	121.5%	92.0%	115.8%	101.5%
Nightingale	114.3%	44.0%	80.9%	62.8%	98.3%	53.0%	75.7%
Opal	101.4%	134.2%	93.9%	147.3%	97.8%	140.5%	114.9%
Ray	93.7%	105.7%	109.8%	171.8%	100.5%	130.8%	111.4%
Tye Green	89.5%	128.7%	100.5%	164.6%	94.2%	143.3%	113.4%
Winter	92.6%	129.1%	104.3%	171.7%	97.5%	149.5%	118.3%
Medicine Total	91.3%	116.6%	101.1%	144.3%	95.5%	129.3%	108.3%
AAU	87.5%	134.6%	97.6%	140.2%	92.0%	137.3%	101.5%
Charnley	95.0%	143.8%	100.2%	161.5%	97.5%	152.2%	113.1%
UEC Total	90.4%	139.2%	98.7%	150.8%	94.2%	144.8%	106.4%
Birthing	86.1%	76.2%	84.2%	84.0%	85.2%	79.9%	83.4%
Chamberlen	91.8%	87.5%	92.2%	80.6%	92.0%	84.2%	90.0%
Dolphin	104.7%	97.9%	114.7%	101.4%	109.1%	99.1%	106.6%
Labour	95.6%	87.9%	92.8%	92.6%	94.3%	90.1%	93.4%
Neo-Natal Unit	99.4%	80.6%	98.7%	83.9%	99.0%	82.3%	96.2%
Samson	100.3%	84.3%	91.6%	83.9%	96.1%	84.1%	89.3%
CHAWS Total	95.0%	100.7%	97.5%	105.2%	96.2%	102.8%	98.0%
Total	94.2%	112.8%	102.0%	135.5%	97.7%	123.1%	106.0%

Trust wide – there has been multiple successful recruitment events for newly qualified nurses to join trust wide positions, it is expected they will join teams throughout the Autumn and Winter.

The end of year establishment review (which underpins the rota templates) commenced in September 2025 and finished 14th October 2025 This is for adult and paediatric inpatient wards and assessment units along with main and paediatric emergency departments. This will be presented and need approval through Winter via the various meetings and committees.

John Snow Ward – the HCSW shifts are often under template by 1 WTE, this is due to fluctuating ward capacity throughout the month in addition to the HCSW being re-deployed to other areas through the daily safe staffing meetings. This was reviewed in the September SNCT which will be presented to Board in December.

Neonatal Unit – Fill rate has improved in October because of new starters joining the team.

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 needed. 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. We are currently pending this data.

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.

Appendix 1a: ED data and narrative: fill rates October 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
96.8%	90.8%	111.7%	111.1%	103.5%	99.8%	102.3%

Adult Emergency Department – Fill rate is typically above template for nights shifts with a lower fill rate in the day, more noticeable for unregistered staffing.

Appendix 1b: Paediatric ED data and narrative: fill rates September 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
118.9%	58.2%	147.7%	92.4%	131.7%	75.3%	114.4%

Paediatric Emergency Department – Shows a low overall fill rate for HCSW's and higher than template for RNs in ED. Shift profiling has been reviewed and the team commenced middle and twilight shifts to mitigate this. This should be reflected in next months report.

Appendix 1c: Enhanced Care data submitted to NHSE ETOC Collaborative October 2025

Registered	**Hours**
Overall number of ETOC hours provided in month	1038
Number of ETOC hours provided by **substantive staff**	0
Number of ETOC hours provided by **bank staff**	912
Number of ETOC hours provided by **agency staff**	126
Number of unfilled hours for staff relating to ETOC	59
Unregistered	
Overall number of ETOC hours provided in month	8962
Number of ETOC hours provided by **substantive staff**	995
Number of ETOC hours provided by **bank staff**	7967
Number of ETOC hours provided by **agency staff**	0
Number of unfilled hours for staff relating to ETOC	8353

Enhanced Care – Data collected in October indicates high volumes of care that was unfilled by both registered and unregistered staff, with the majority of this being provided by temporary staffing. This could indicate insufficient substantive posts to meet actual demands for enhanced care needs.

Appendix 2: Ward level data: CHPPD October 2025

Care Hours Per Patient Day (CHPPD)			
Ward	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total	***5.0***	***3.1***	***8.1***
Harvey Ward	3.8	3.5	7.3
Henry Moore Ward	3.5	2.9	6.5
ITU & HDU	18.8	1.8	20.7
John Snow Ward	5.5	1.4	6.9
Penn Ward	3.7	3.0	6.7
Saunders Unit	3.6	2.9	6.5
Surgery Total	***5.3***	***2.8***	***8.1***
Fleming Ward	3.7	2.1	5.7
Harold Ward	4.6	2.7	7.3
Kingsmoor General	3.4	3.4	6.8
Lister Ward	3.8	3.6	7.5
Locke Ward	3.6	3.0	6.5
Nightingale Ward	9.2	4.9	14.1
Opal Unit	4.9	4.7	9.6
Ray Ward	3.8	2.7	6.5
Tye Green Ward	3.9	3.8	7.7
Winter Ward	3.7	3.7	7.4
Medicine Total	***4.0***	***3.3***	***7.2***
AAU	6.2	2.5	8.7
Charnley Ward	4.2	2.7	6.9
UEC Total	***6.2***	***2.5***	***8.7***
Birthing Unit	17.1	8.0	25.1
Chamberlen Ward	7.1	2.2	9.2
Dolphin Ward	10.5	3.2	13.6
Labour Ward	27.4	7.5	34.8
Neo-Natal Unit	11.0	1.8	12.8
Samson Ward	2.5	2.9	5.4
CHAWS Total	***8.5***	***3.3***	***11.8***

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

Table 1 shows the number of shifts across all clinical areas – including maternity – where fill rates fell below 75%, with a monthly trend in Table 2. In October 2025, this decreased by 43 to 81 occasions.

The highest volume of red flags consistently remains in maternity accounting for 43 red flags, a decrease of 5 from last month.

The 2-month period of increased red flags for staffing are attributed to the temporary closure of Nightingale ward and ward relocations and are not of concern.

Nightingale and OPAL recorded the highest red flags for this period. Nightingale was partially closed at the start of October which accounts for this. OPAL had high sickness through October, accounting for 7.87% of total unavailability which is a contributing factor to these red flags.

Table 1. Occasions when registered staffing fell below 75% of standard template Oct-25

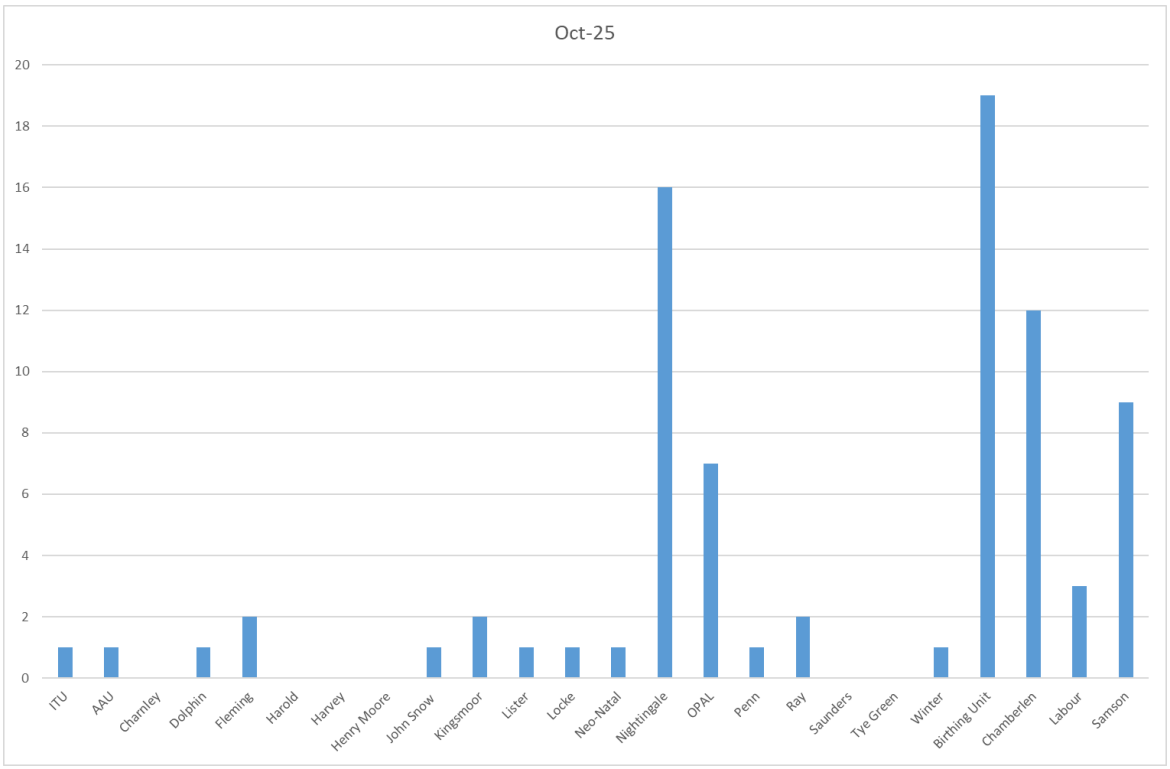


Table 2a. Occasions when all registered staffing fell below 75% of standard template. Trend Data Nov-24 – Oct-25

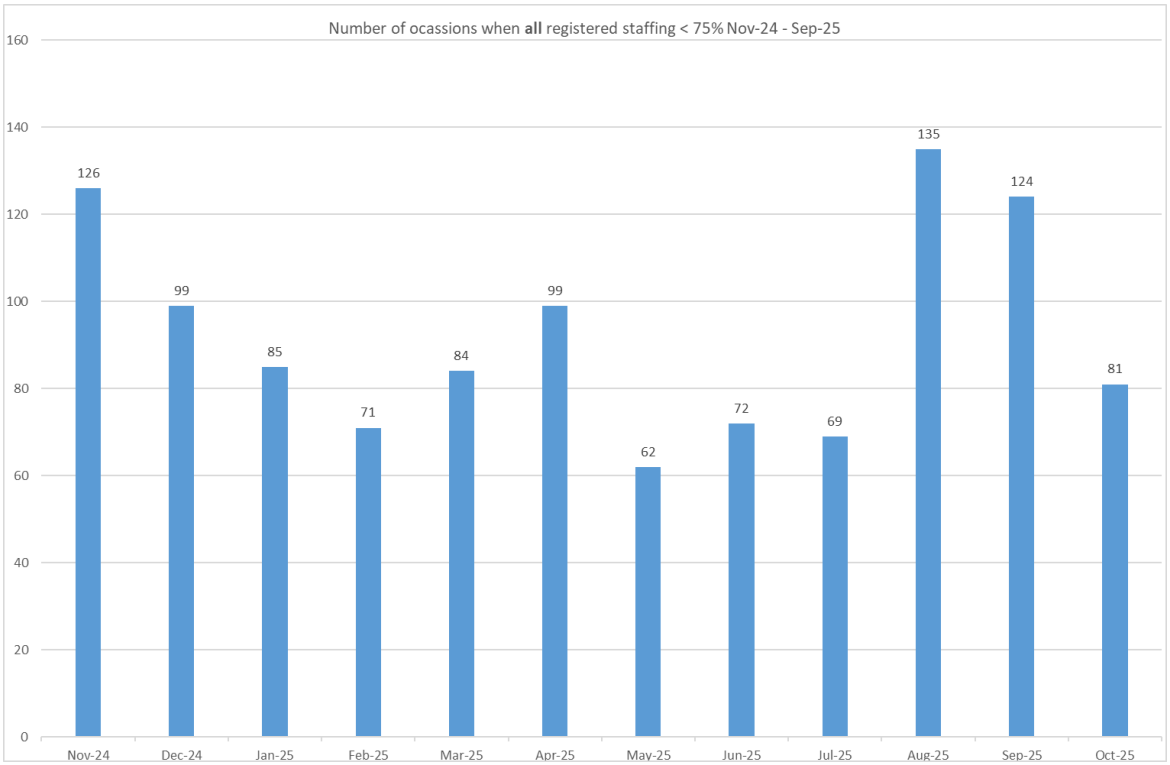
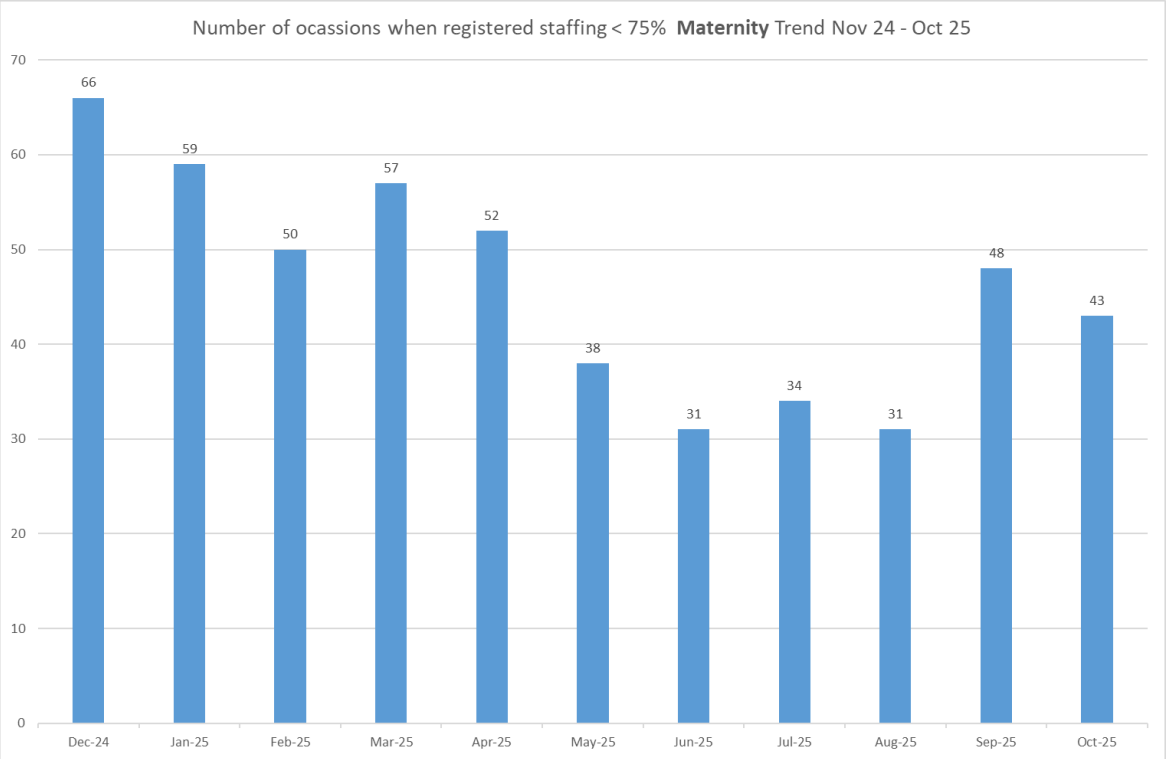


Table 2b. Occasions when registered maternity staffing fell below 75% of standard template. Trend Data Nov-24 – Oct-25



All adult inpatient areas record staffing shortfalls in SafeCare via Red Flags. In October 2025, 120 Red Flags were raised (Table 3a), up from 75 in September (Table 3b and chart). The main drivers were shortfalls in RN time (47) and inability to provide Enhanced Care (53), with Tye Green (35) and OPAL (17) raising the most red flags this month.

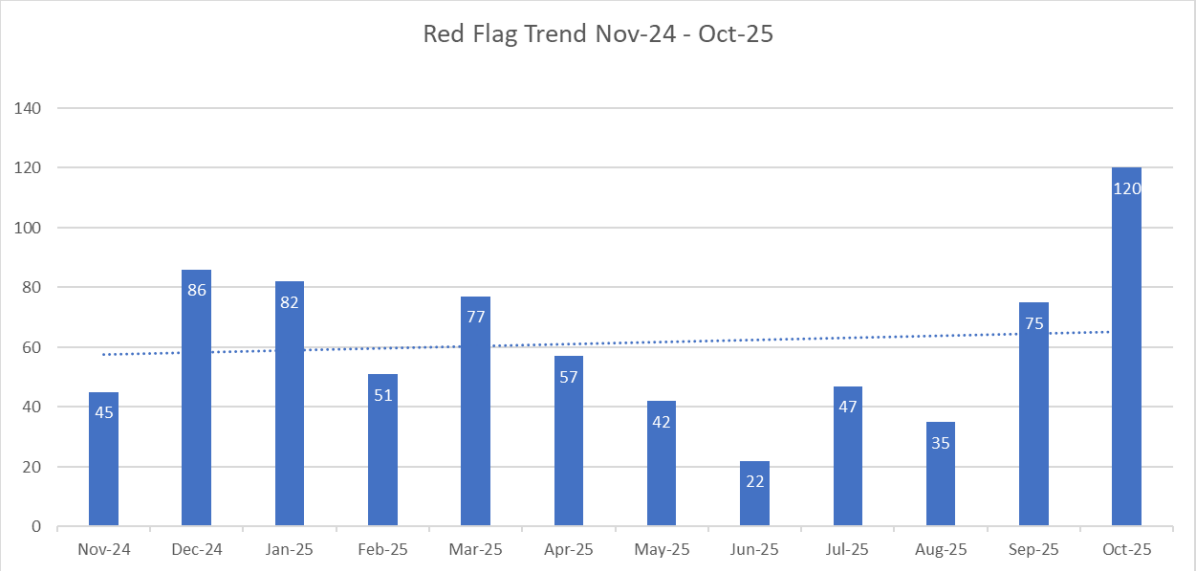
A local Red Flag for unmet Enhanced Care and a Level 3 Enhanced Care patient task have been introduced across adult inpatient wards to improve oversight and support data sharing with the Enhanced Care Collaborative. Adult ED has now adopted this functionality from September 2025, and the team continues to raise awareness among staff to use this.

Of the 120 Red Flags raised, 16 remain open and only 10 have been resolved, highlighting inconsistent use of SafeCare and under-utilisation of the system, however we recognise a 2 monthly trend of improved use. While Red Flags support daily staffing decisions when used effectively, further training and communication are needed to improve reporting and closure rates. This has been addressed on the daily staffing huddles and including open red flags to the staffing deployment decisions and is part of staff training in preceptorship and band 6 development days.

Table 3a. Red Flags raised via SafeCare Oct-25

Row Labels	Delay in providing pain relief	Missed 'intentional rounding'	Shortfall in RN time	Unable to provide Enhanced Care	Grand Total
A&E Nursing				6	6
AAU			2	1	3
Charnley Ward			2	5	7
Fleming Ward			2	1	3
Harvey Ward				1	1
Kingsmoor General		1	1		2
Lister Ward			2		2
Locke Ward			12	2	14
OPAL Unit		1	11	5	17
Penn Ward	1		4	5	10
Ray Ward		2	3		5
Saunders Unit			1	2	3
Tye Green Ward	1	10	4	20	35
Winter Ward	1	3	3	5	12
Grand Total	**3**	**17**	**47**	**53**	**120**

Table 3b. Red Flags raised via SafeCare trend Nov-24 – Oct-25



Redeployment

Redeployment of staff continues to support safe staffing through daily huddles. In October 2025, 158 substantive staff redeployments were recorded, a decrease of 158 occasions compared to September (Table 5). Nightingale redeployed the most staff, followed by Tye Green while A&E and Locke were the largest net receivers (Table 4).

Redeployed hours accounted for 1.79% of substantive staff hours and 2.07% of total hours worked (Tables 6 & 7). These figures exclude agency, bank, and multi-post holders.

There has been a considerable drop in redeployment throughout October compared to the prior two months. Governance and oversight remain strong.

Table 4. Hours of substantive staff redeployed October 2025

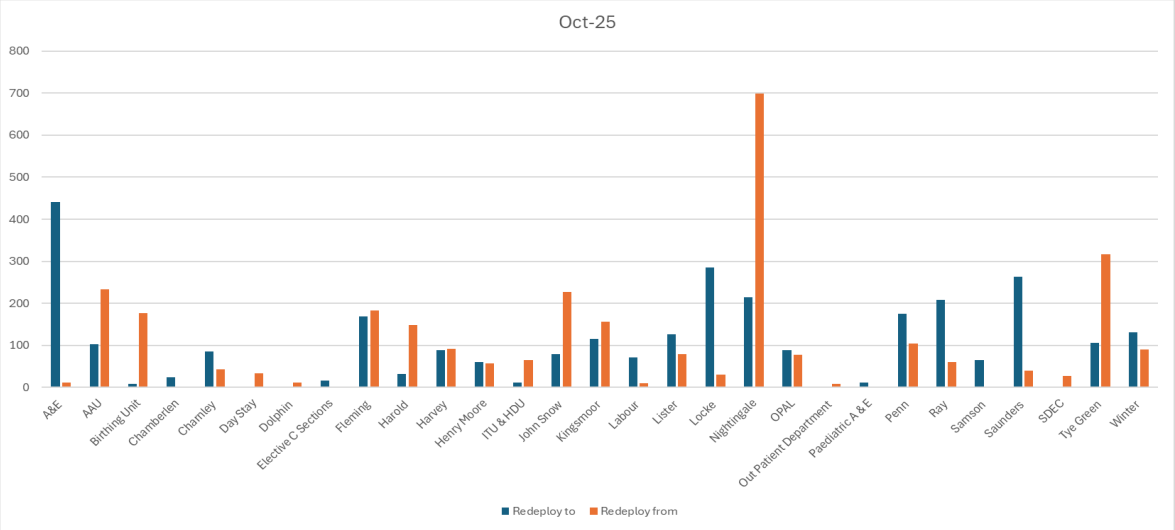


Table 5. Substantive staff redeployment trend

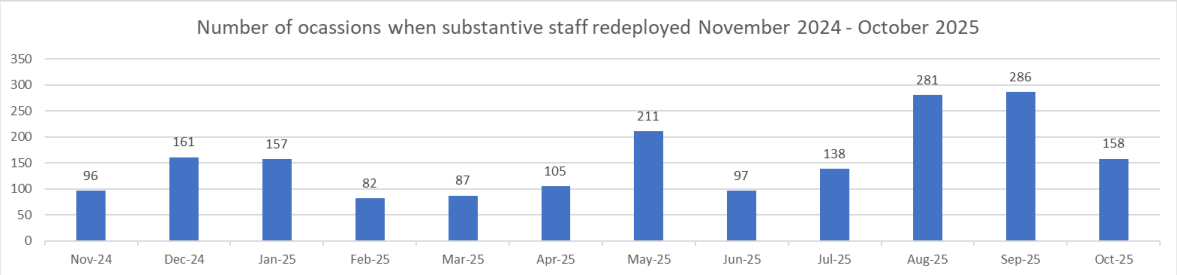


Table 6. % of substantive staff redeployed as % of total hours worked

Substantive staff hours redeployed	Total hours worked (inc. bank and agency)	% of total hours worked / substantive staff redeployed
2579.5	144321	1.79%

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)
2982.5	144321	2.07%

Appendix 4: Nursing quality indicators

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

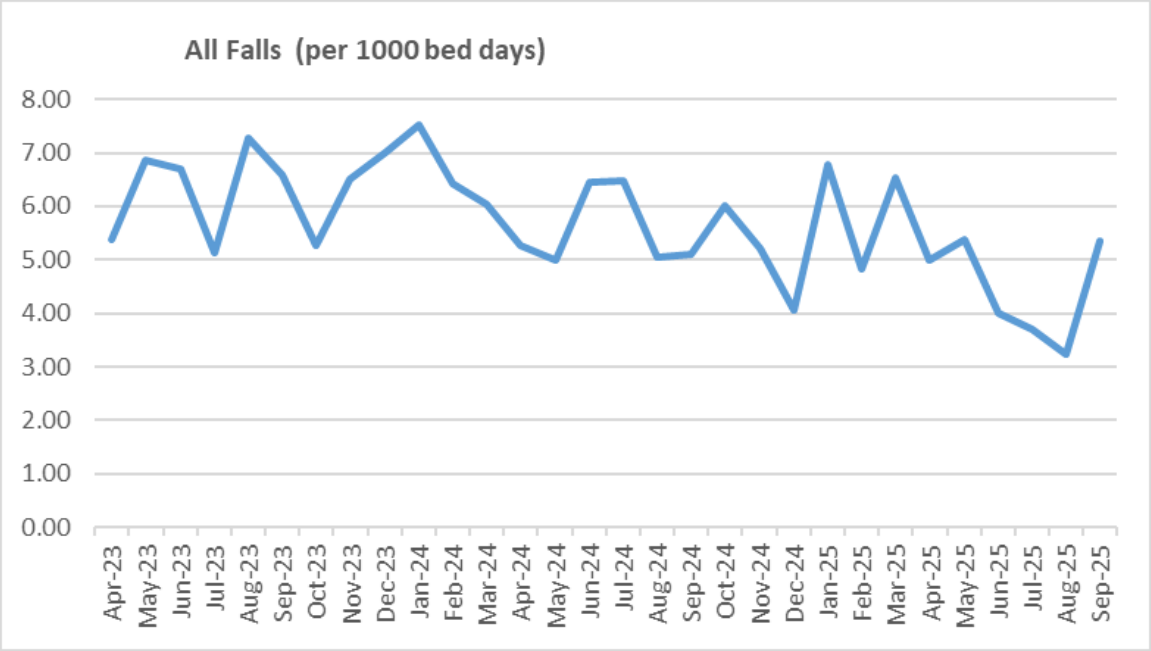
	Total falls in month	Top 3 wards		
Total falls	78	Kingsmoor – 13	Ray – 9	A&E – 7
Unwitnessed falls	57	Kingsmoor – 7	Ray – 6	A&E, Lister – 4
Falls with harm *	14	Winter, OPAL, AAU – 2		

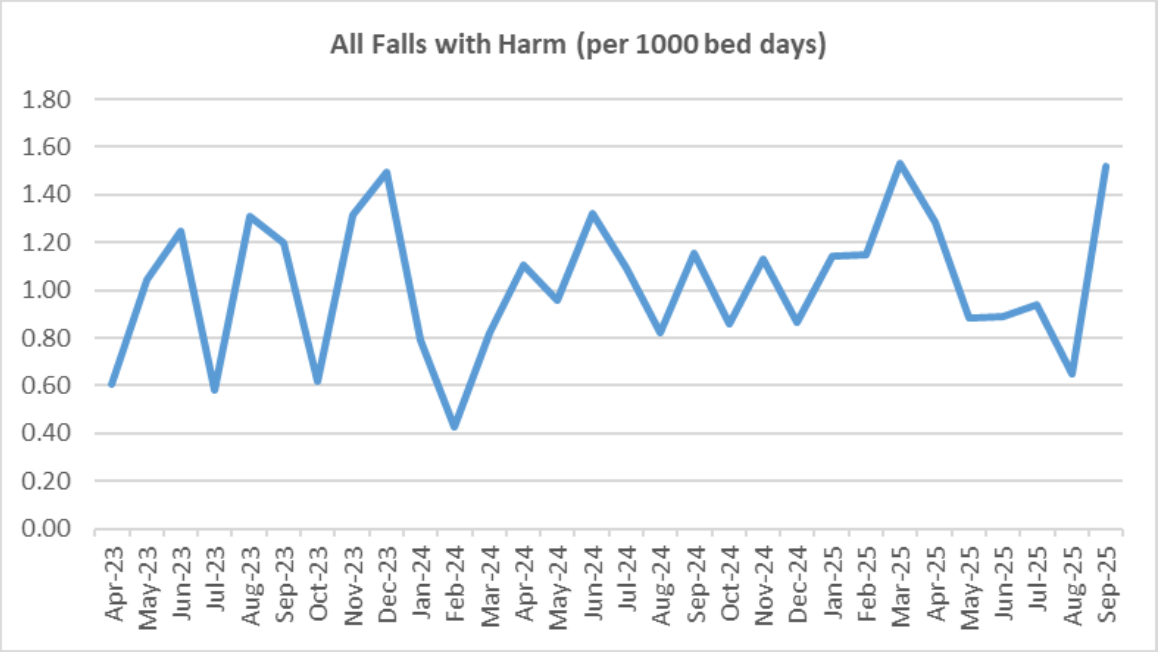
**Subject to change following review at Falls Incident Oversight Group*

October's data sees a minor increase in total falls from 75 to 78, an increase of unwitnessed falls from 55 to 57 and decrease of falls with harm from 20 to 14.

Training compliance remains over 97% across the trust and work is still ongoing in Kingsmoor and Harold wards to support targeted training in the clinical areas.

Falls Rate per 1000 bed days September 2025 data





Pressure Ulcers

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

There was an increase in October for reportable HAPUs (24 to 30) and non-reportable skin changes (43 to 75) compared to last month and a significant increase in category 3 HAPUs (14 from 4). All 8 category 3 are deemed moderate harms – this will be validated with PS&Q discussion once all investigations are complete.

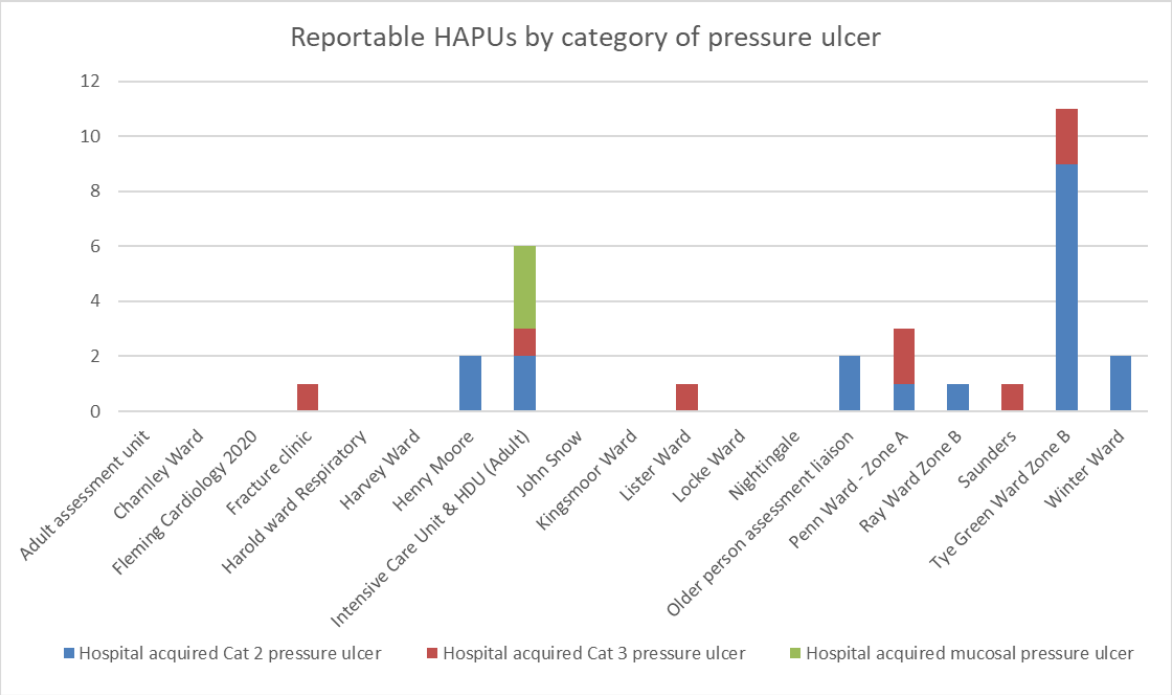
2 wards remain under quality surveillance (Tye Green and Kingsmoor) and improvements noted in Kingsmoor. However, 9 wards reported no HAPUs in October, which is commendable.

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 (Table 2b).

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.

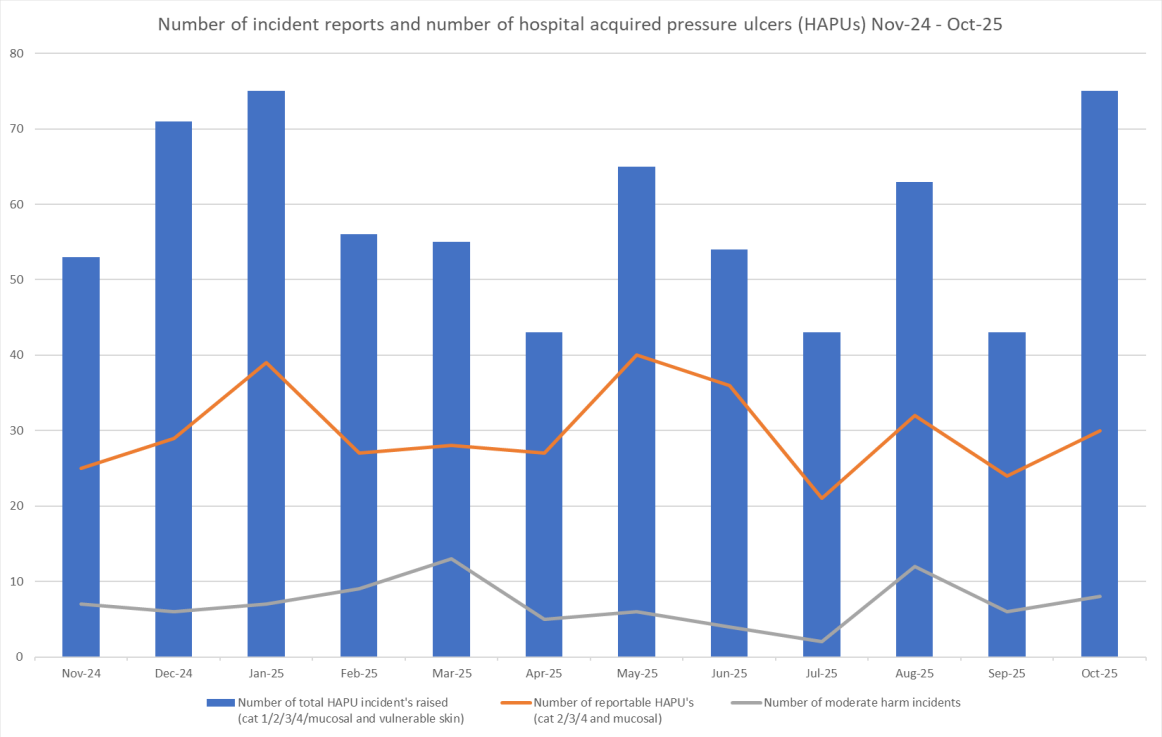
Tissue viability will soon be introducing a system to monitor all category 1s and vulnerable skin ensuring pressure care is in place and capturing any resolved skin damage.

From October the trust will be implementing the ‘All you have to do is ASK’ campaign which will form the theme for ‘Stop the Pressure Day’ in November. All Trusts in the ICB will be participating this year with a patient questionnaire to raise awareness of pressure ulcers, we will be engaging with in-patients and visitors to complete questionnaires.



Total in month	Top 3 wards		
30	Tye Green – 11	ITU/HDU – 6	Penn – 3

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



Complaints, PALS and Compliments Trend Data January 2025 – October 2025

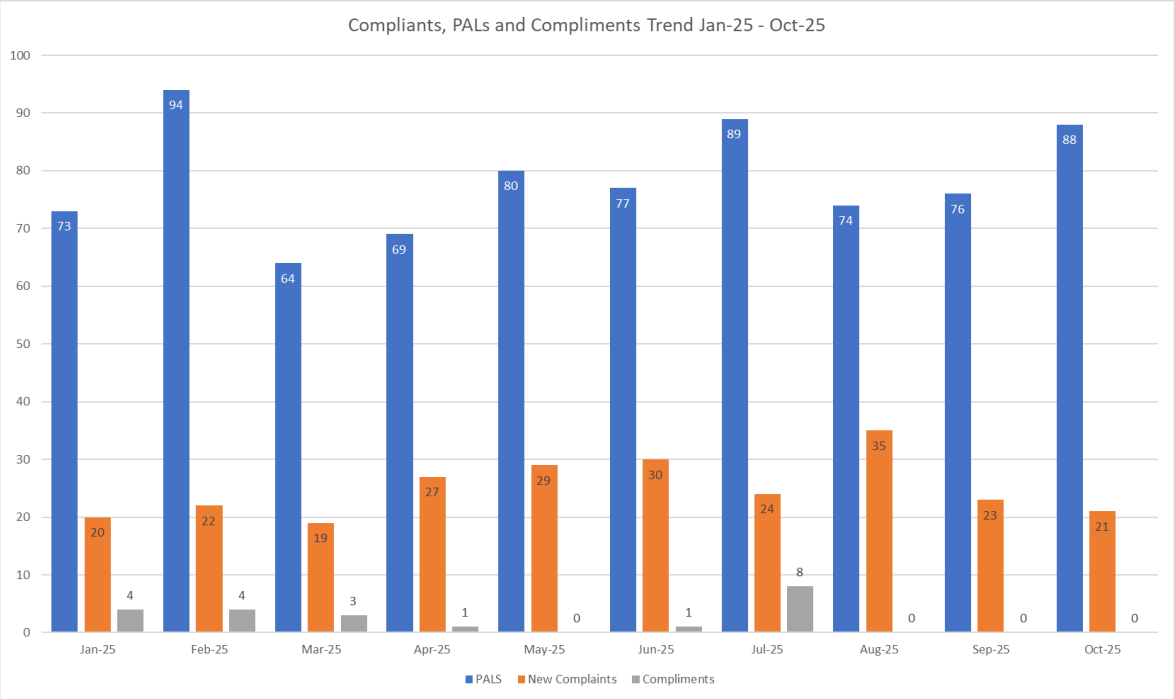


Table 3. Number of new Complaints, PALS and Compliments in October 2025 with top three wards highlighted

	Total in month	Top Departments		
New complaints	21	P.ED – 5	Kingsmoor, Henry Moore and ITU/HDU – 3	
PALs	88	A&E – 15	Charnley – 9	Fleming, Lister, Saunders and Winter – 6
Compliments	None recorded			

The main themes for PALS concerns received in October 2025 are as follows:

- Delay – 38.43%
- Communication – 24.16%
- Cancellations – 9.77%

The main themes for Complaints received in October 2025 are as follows:

- Communication – 25.61%
- Medical care – 17.07%
- Delay – 15.85%

The main themes for Compliments received in October 2025 are as follows:

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

APPENDIX 5

September–October Workforce, Falls and Patient Safety Correlation Report

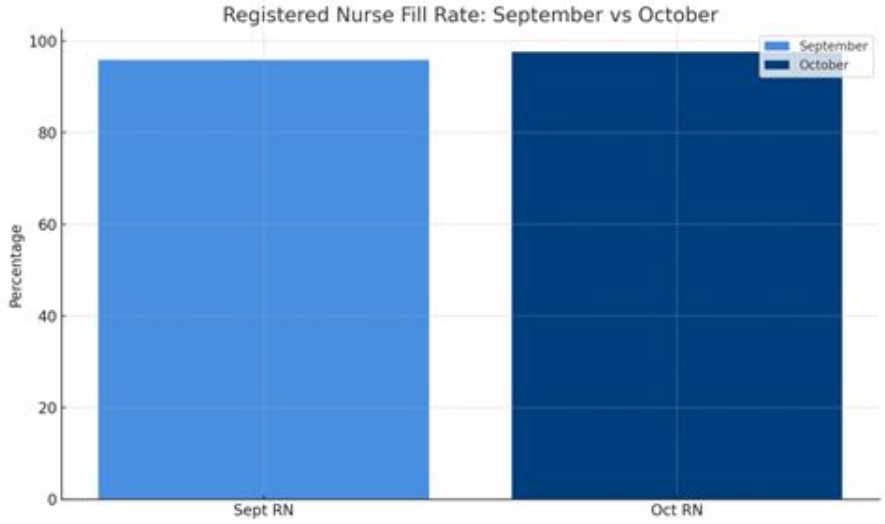
This paper brings together four datasets for September and October – actual staffing fill rates, staffing shortage incident reports, unwitnessed falls and reportable hospital-acquired pressure ulcers (HAPUs) – to provide Board-level assurance on the relationship between workforce pressures and patient safety. The analysis covers a two-month period, which offers an early indication of emerging patterns but is not sufficient on its own to draw long-term conclusions. The findings should therefore be viewed as indicative and monitored over a longer trend period.

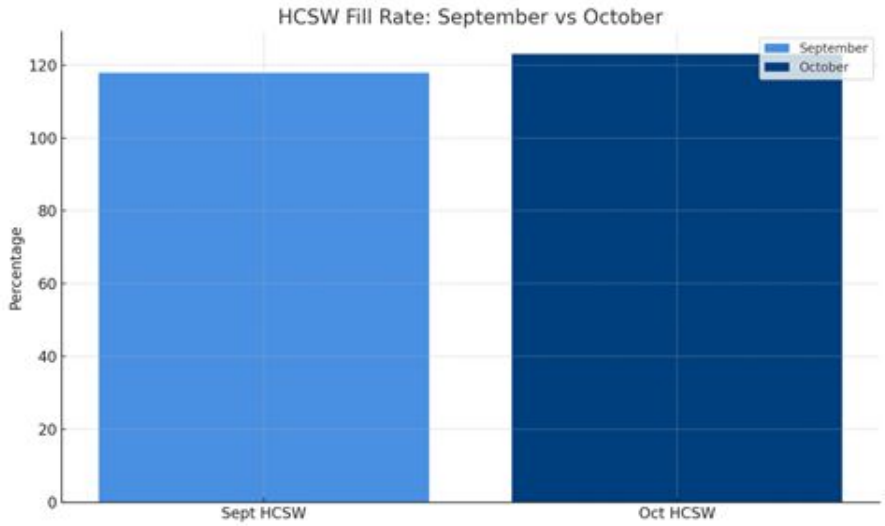
1. Trust-Wide Summary (September vs October)

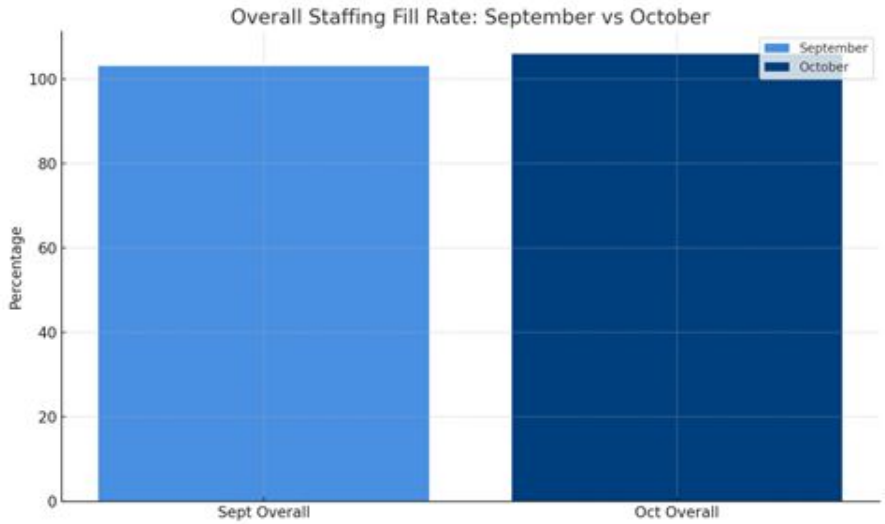
- Registered Nurse (RN) fill rate: September 95.9% vs October 97.7%
- Health Care Support Worker (HCSW) fill rate: September 117.9% vs October 123.1%
- Overall staffing fill: September 103.1% vs October 106.0%
- Staffing incident reports: September 47 vs October 77
- Reportable HAPUs: September 24 vs October 30
- Unwitnessed falls: September 55 vs October 57

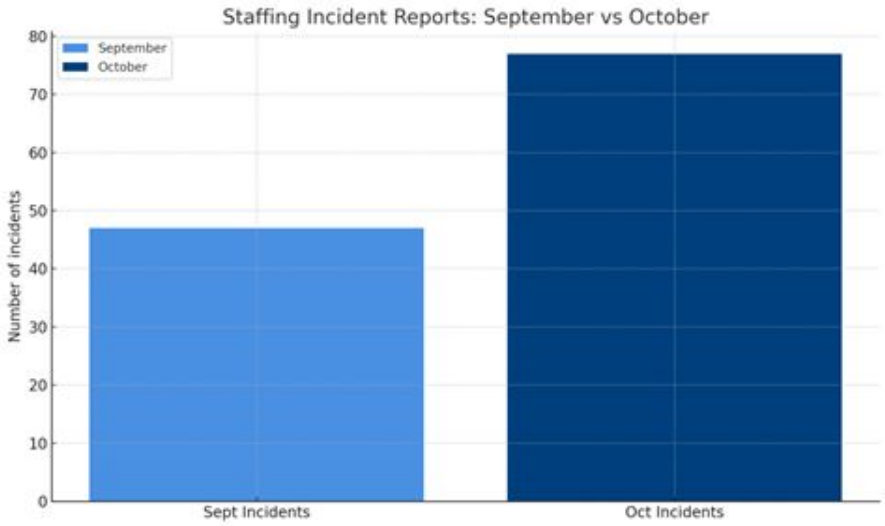
Across the Trust, October showed slightly higher staffing fill rates than September for both RNs and HCSWs, with overall fill rising from 103.1% to 106.0%. Reported staffing incidents increased from 47 to 77, and unwitnessed falls were broadly stable (55 to 57). Encouragingly, the number of reportable HAPUs rose only slightly from 24 to 30, suggesting that the quality of pressure-area care may be improving even as workforce pressures and falls risk remain evident.

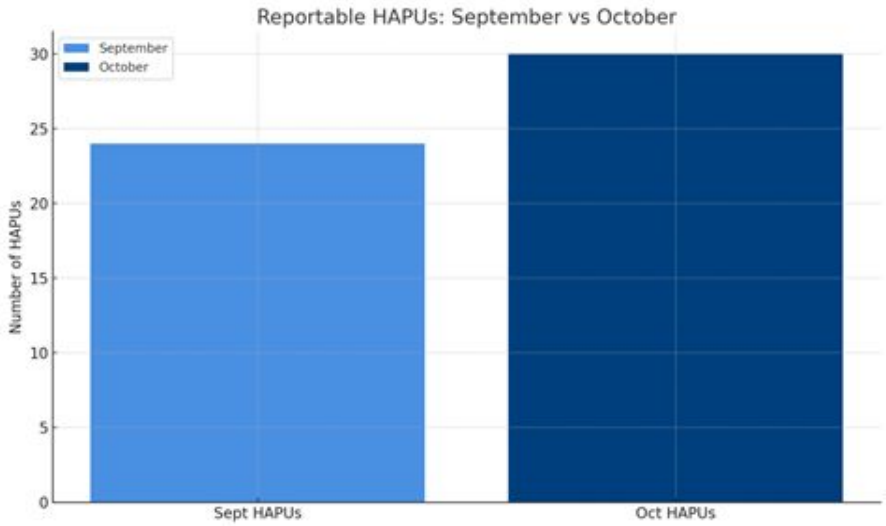
2. Graphical Overview

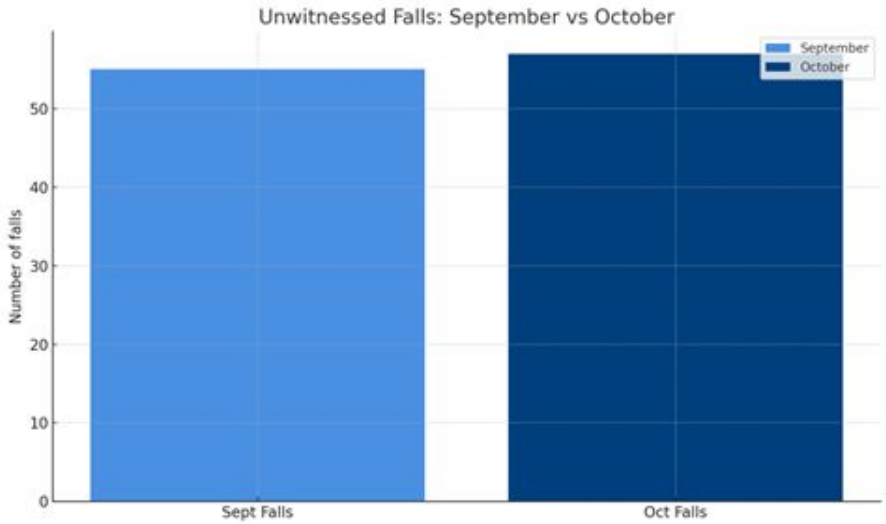



HCSW Fill Rate: September vs October
September
October
Percentage
0
20
40
60
80
100
120
Sept HCSW
Oct HCSW


Overall Staffing Fill Rate: September vs October
September
October
Percentage
0
20
40
60
80
100
Sept Overall
Oct Overall


Staffing Incident Reports: September vs October
September
October
Number of incidents
0
10
20
30
40
50
60
70
80
Sept Incidents
Oct Incidents





The graphs illustrate modest improvements in staffing fill rates alongside rising staffing incident reports, broadly stable unwitnessed falls and a relatively small change in HAPUs between September and October. September is shown in a lighter blue and October in a darker blue to highlight the month-on-month comparison.

3. Key Wards – Staffing, HAPUs, Falls and Fill Rates

The table below focuses on wards that appear in all relevant datasets – staffing incidents, HAPUs, unwitnessed falls and fill rates – and therefore provides the most robust comparison. It highlights areas of higher activity and those subject to targeted improvement work.

Ward	Sept incidents	Sept HAPUs	Sept falls	Sept RN fill %	Sept HCSW fill %	Oct incidents	Oct HAPUs	Oct falls	Oct RN fill %	Oct HCSW fill %

Tye Green Ward Zone B	6	4	5	89.4	130.5	9	11	1	94.2	143.3
Kingsmoor Ward	1	0	5	91.5	134.7	1	0	8	93.7	155.4
Winter Ward	1	6	4	98.1	144.4	10	2	5	97.5	149.5
Accident & Emergency	2	0	6	90.7	142.9	4	0	5	94.2	144.8
Fleming Cardiology	8	0	1	90.9	104.3	0	0	2	91.5	115.6
ICU (Adult)	2	0	1	95.3	115.6	1	0	1	97.2	94.5
Harold Ward Respiratory	0	3	3	94.6	115.0	0	0	2	96.5	125.5
Harvey Ward	0	0	2	90.3	123.5	0	0	2	92.8	153.8
Lister Ward	1	1	3	95.8	135.5	0	1	4	95.4	135.3
Locke Ward	1	0	1	92.6	125.5	0	0	0	92.0	115.8
Penn Ward – Zone A	1	1	0	94.9	149.1	1	3	1	96.9	139.8
Ray Ward Zone B	0	0	5	115.0	140.4	1	1	6	100.5	130.8
Charnley Ward	1	0	3	90.5	149.2	0	0	3	97.5	152.2
Saunders Ward	0	1	4	103.7	146.7	1	1	1	101.9	134.0
AAU	0	0	2	90.9	136.7	0	0	4	92.0	137.3

4. Interpretation of Findings

The two-month comparison suggests a continued relationship between staffing pressures and patient safety outcomes, but not a simple one-to-one correlation. October recorded more staffing

incidents than September, and unwitnessed falls were similar across the two months. Despite this, the number of HAPUs increased only slightly. This indicates that local improvement work and strengthened processes can mitigate some risks even when operational pressures remain high.

Tye Green Ward Zone B stands out as a key area of activity, with higher numbers of staffing incidents, falls and HAPUs in both months and RN fill remaining slightly below other wards, despite strong HCSW cover. By contrast, Kingsmoor Ward reports similar or improved staffing fill rates and very low levels of both incidents, falls and HAPUs, reflecting the impact of focused improvement efforts. Winter Ward shows a different pattern, with a marked rise in staffing incidents between September and October but a reduction in HAPUs and relatively stable falls, suggesting that enhanced pressure-area care may be offsetting the effects of increased demand.

Across many wards, HCSW fill is consistently above 100%, indicating good availability of staff to support fundamental care. RN fill, while close to plan overall, remains slightly below 100% on several wards. Rather than focusing solely on deficits, the Trust continues to emphasise how teams are using the available workforce to best effect through allocation, safety huddles and education.

5. Ongoing Improvement Work and Establishment Review

Tye Green Ward Zone B and Kingsmoor Ward have both undertaken focused improvement projects. These include reviewing staff allocation processes, strengthening the content and follow-through of safety huddles, and enhancing education and competency in pressure-area care and falls prevention. The early data from September and October suggests that this work is beginning to support greater consistency and earlier identification of risk.

Alongside ward-level initiatives, the full-year staffing establishment review is in progress. This review will include recommendations to adjust the skill mix on Tye Green Ward, increasing the number of Health Care Support Workers relative to Registered Nurses where appropriate to better match the profile of patient need. These changes are intended to support sustainable delivery of fundamental care tasks such as repositioning, comfort rounding, enhanced observation and falls prevention.

Trust-wide recruitment activity, including successful events for newly qualified nurses, is expected to further improve RN availability over the coming months. New staff will be prioritised to wards with the greatest workforce and safety pressures, including those highlighted in this report.

6. Conclusion and Next Steps

In summary, the September–October comparison demonstrates that, although staffing pressures remain and are reflected in rising incident reports and a stable level of unwitnessed falls, the number of reportable HAPUs has not increased to the same extent. This suggests that targeted ward-level work, particularly on Tye Green and Kingsmoor, together with the wider establishment review, is beginning to support safer care. Continued monitoring over a longer period, coupled with implementation of the review's recommendations, will be important to confirm and build on these early signs of improvement across falls and pressure-area harm.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – December 2025

4.4

Agenda item:	4.4
Presented by:	Andrew Kelso | Chief Medical Officer
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Andrew Kelso | Chief Medical Officer
Date prepared:	2nd December 2025
Subject / title:	Learning from Deaths and Mortality Paper

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

Key issues:	Standardised Mortality Ratio is above expected range but stable and not deteriorating. HSMR+ ratio for weekend admissions is above expected range but improving. Other indices are within expected range. Reasons for this position are discussed in the paper.
Recommendation:	To note the progress being made on learning from death processes 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 & Quality & Safety Committee
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.*
Appendices:	Appendix A: Mortality Data Explained

The Princess Alexandra Hospital NHS Trust

4.4

1.0 Purpose

The purpose of this paper is to provide monthly assurance on the learning from death process. 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 21st October 2025. The risks associated with this are captured on the learning from death risk register.

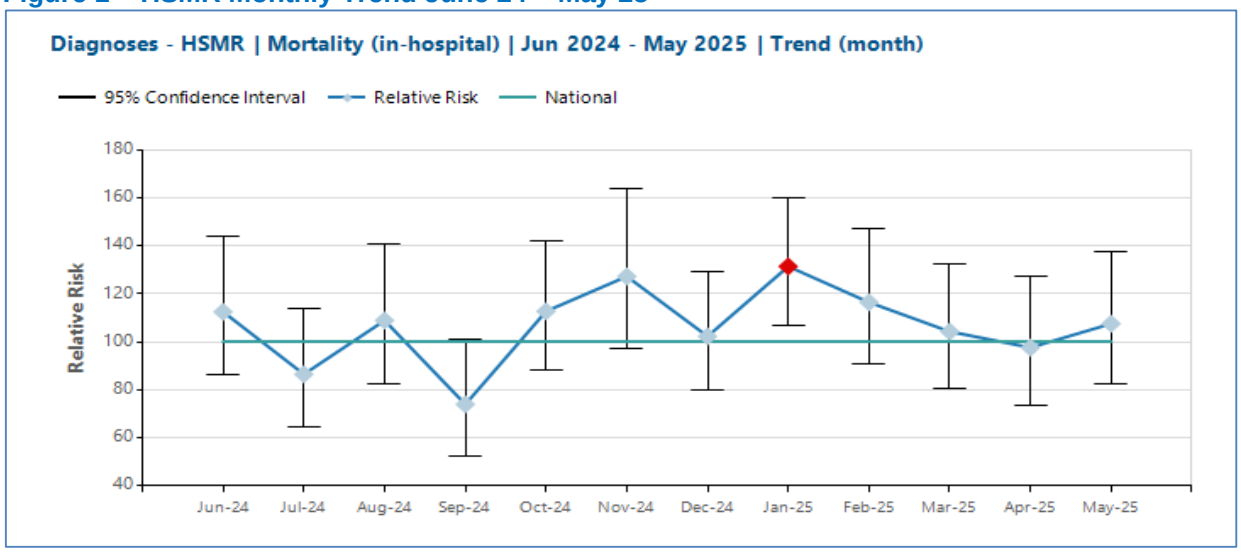
3.0 Current Telstra update on mortality indices for Princess Alexandra Hospital

Telstra provide an in-hospital mortality report for all inpatient admissions. This report covers the 12-month time period Jun 2024 - May 2025.

3.1 Analysis

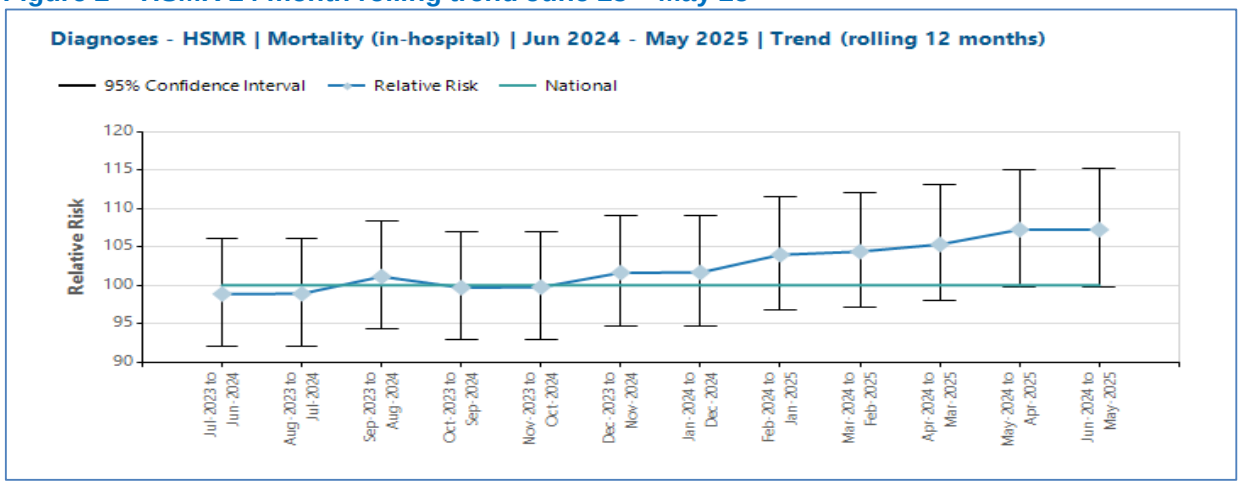
Hospital standardised mortality ratio (HSMR) overview

Figure 1 – HSMR Monthly Trend June 24 – May 25



HSMR+ for the period Jun-24 to May-25 is 107.24 and "within expected", based on 19,436 superspells and 763 deaths (crude rate 4.03%).

Figure 2 – HSMR 24 month rolling trend June 23 – May 25



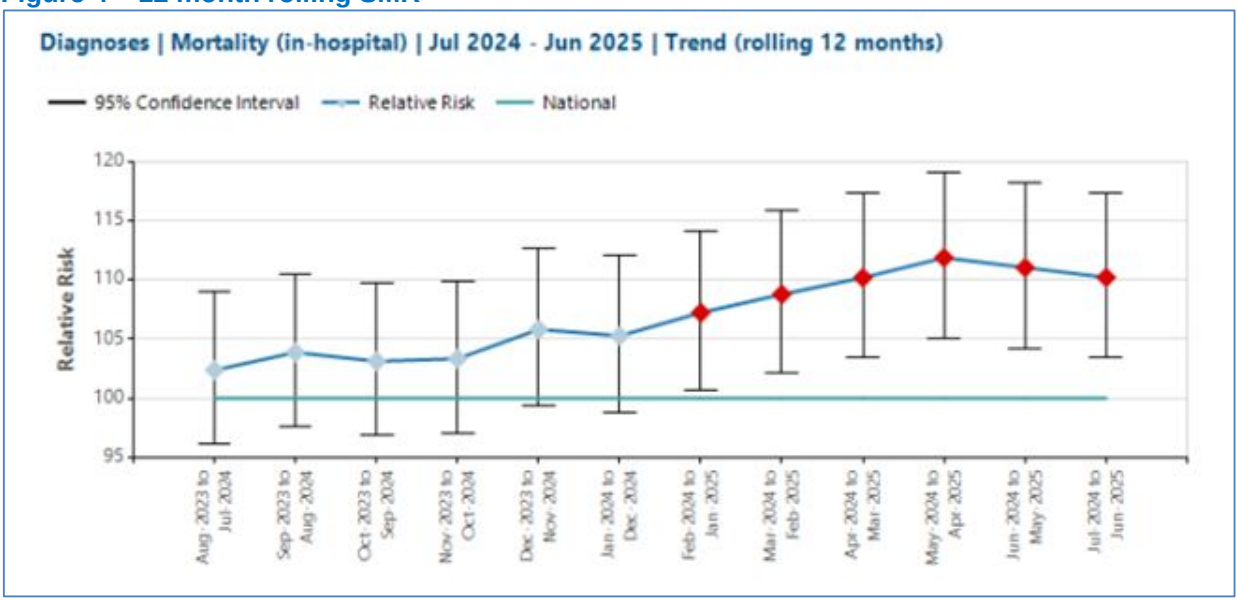
HSMR+ for May-25 is 107.52 and "within expected", based on 1566 superspells and 63 deaths (crude rate 4.02%).

Standardised Mortality Ratio (SMR) overview

Figure 3 – SMR for Monthly Trend

SMR for Jun-25 is 96.8 and “within expected”, based on 5865 superspells and 72 deaths (crude rate 1.2%).

Figure 4 – 12 month rolling SMR



SMR for the period Jul-24 to Jun-25 is 110.21 and “higher-than-expected”, based on 67,432 superspells and 972 deaths
(crude rate 1.44%).

3.2 Relative Risk and CUSUM Alerts July 2024 - June 2025

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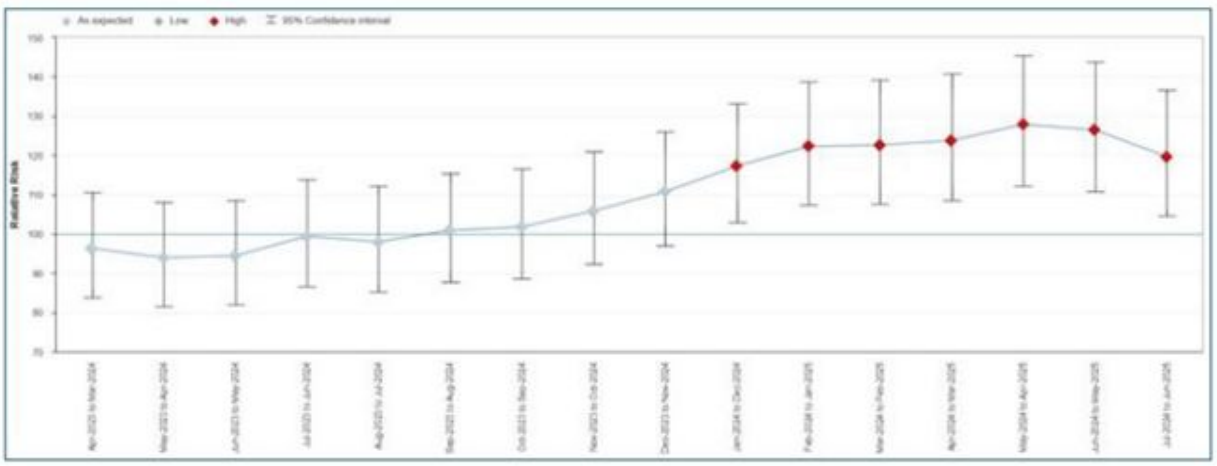
Title	CUSUM	Vol	Obs
All Diagnoses	1 16	67432	972
HSMR (41 diagnosis groups)	2	19392	758
Cardiac dysrhythmias	1	778	19
Fluid and electrolyte disorders	1	303	17
Hodgkin's disease	2	46	2
Immunizations and screening for infectious disease	1	14	1
Medical examination/evaluation	1	156	4
Other circulatory disease	1	222	8
Other diseases of kidney and ureters	1	251	5
Other endocrine disorders	1	151	5
Other injuries and conditions due to external causes	1	107	9
Other liver diseases	1	158	9
Other psychoses	2	70	4
Other upper respiratory disease	2	433	7
Respiratory failure, insufficiency, arrest (adult)	1	83	25
Senility and organic mental disorders	1	257	24
Syncope	1	239	3
Systemic lupus erythematosus and connective tissue disorders	1	14	1

There are no new CUSUM alerts.

3.3 PAH Emergency Weekend HSMR+

Emergency Weekend HSMR+ (Apr-23 to Mar-24 | Jun-24 to May-25)



Emergency Weekend HSMR+ remains “higher-than-expected”. A deep dive analysis is being repeated. Emergency Weekday HSMR+ is consistent report-to-report, and continues to perform “within expected”.

3.4 Summary

SMR for Jun-25 is 96.8 and "within expected", based on 5865 superspells and 72 deaths (crude rate 1.2%).

SMR for the period Jul-24 to Jun-25 is 110.21 and "higher-than-expected", based on 67,432 superspells and 972 deaths (crude rate 1.44%). This is an +0.83pt improvement on last month, and marks two consecutive months of SMR improvement. Historic high in month positions are contributing to the rolling 12 month position.

This month, there are 4 HSMR+ outliers, 7 non-HSMR+ outliers, and 6 discharge-only outliers to report to the Trust. Of these, only 2 groups are consistent outliers from admission-to-discharge ("senility and organic mental disorders" and "Hodgkin's disease"). Crucially there are also a number of outliers which have ceased to flag this month, including groups such as "biliary tract disease".

Emergency Weekend HSMR+:
While the Trust are "higher-than-expected", the outcomes are not found statistically significantly higher than national peers and is simlarto the national HSMR+ for the same cohort of patients. The models are designed for risk-adjusted benchmarking and suggests that any differences in the Trust outcomes might be explained by differences in patient case mix.

The most recent Emergency Weekend HSMR+ reports improvement – should this be sustained, then the metric may cease to flag in future months. An exercise has been commissioned by the CMO to review deaths in this group for assurance on standards of care and treatment, over and above the Trust's standard mortality review processes.

3.5 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 continue to be further understood and addressed by a dedicated working group.

The rise in weekend admission, deaths is being investigated a case review and will be presented at the SLfDG by relevant specialty clinicians.

The outlier 'senility and organic mental disorders' will undertake a clinical coding review, which is likely to find the same themes as before; whereby clinical documentation of 'confusion' and 'delirium' is coded as the primary diagnosis, rather than the patients' conditions that are causing these symptoms, such as infection. Training is being undertaken across all specialties to raise awareness and priority of the importance of accurate clinical documentation and how this affects coding.

Despite these conclusions, the Trust remains alert to deficiencies in standards of care or treatment contributing to excess deaths and has standard and enhanced review processes (section 4.0) in place to provide assurance.

4.0 Mortality Programme Updates

4.1 Mortality Narrative

There were 84 deaths in October 2025. 18 cases referred for Structured Judgement Review (SJR)

4.2 Deaths Investigated Under the Patient Safety Incident Response Framework

There are 2 deaths currently under investigation

4.3 Cases awaiting the second review panel

There is 1 case awaiting the second review panel

4.4 Themes and Issues Identified from Reviews and Investigation

- Timely interventions are crucial in improving patient outcomes.
- Multidisciplinary care coordination enhances comprehensive patient management.
- Proactive nursing monitoring can prevent adverse events.
- Family involvement is essential for informed decision-making and support.
- Early recognition of complications allows for prompt treatment adjustments.
- Structured teaching for pain management increases confidence among ward doctors.
- Regular observations and early warning scores are vital in post-operative care to identify deteriorating patients.
- Transparent communication about irreversible conditions is necessary for setting realistic expectations.

These themes are shared widely amongst clinical staff to inform improvement.

4.5 Actions Taken in Response to Avoidable Deaths

None required

5.0 Medical Examiner (ME) Headlines

100% of deaths were scrutinised. 24 cases were referred to the Coroner.

6.0 Medical Certificate of Causes of Death (MCCD) issued within 72 hours

93.3% of MCCDs being issued within 72 hours in October 2025 (National Target 95%)

7.0 Project and Working Group Updates

7.1 PAHT Deterioration in HSMR position since the introduction of Alex Health

- Telstra have produced a video to improve understanding of HSMR for clinician to be used across the trust.
- Mortality Improvement team have set up a programme of engagement at educational, audit and team meeting to improve understanding of clinical documentation and how it affects clinical coding. Training session started in October 2025.
- Clinical Coding team are working with the Clinical Digital Fellow team to complete a baseline audit measuring concordance between the entry of structured data compared to repeated manual data and review associated

7.2 MCCD 72h Improvement Project

Pilot Project to commence in the Emergency Department. Trial on Harold Ward to commence to improve the time Doctors, attend the Bereavement Office to complete MCCD.

8.0 Recommendation

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

9.0 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.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

Agenda item:	4.5							
Presented by:	Andrew Kelso							
Prepared by:	Andrew Kelso							
Date prepared:	18 November 2025							
Subject / title:	Health Inequalities							
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	NHS Providers have recommended 80 objectives that trusts should work towards to meet regulatory standards and guidance on reducing health inequalities. At a recent Executive Away Day, a self-assessment was completed to check organisational maturity with respect to health inequalities. Also, the recommended actions were reviewed and prioritised. This exercise is summarised in this paper, and recommendations made to appropriate governance of the work necessary.							
Recommendation:	The Board is invited to approve the proposals to reduce health inequalities.							

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

Previously considered by:	Executive Board
Risk / links with the BAF:	BAF 1.1 There is a risk that there are variations in outcomes caused by unwarranted variation in care, constraints with system wide flow and workforce gaps resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	NHS England - NHS England » National Healthcare Inequalities Improvement Programme
Appendices:	Health Inequalities Self-Assessment – November 2025

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.5

1.0 Purpose

To describe our requirements towards health inequalities and set out some recommendations.

2.0 Background

2.1 NHS Providers - Reducing health inequalities: a guide for NHS trust board members

2.2 NHS England - NHS England » National Healthcare Inequalities Improvement Programme

2.3 Self assessment outcome - Health Inequalities Self-Assessment Tool

2.4 NHS Providers Tool - Health Inequalities Leadership Framework: board assurance tool | NHS Confederation

3.0 Analysis

3.1 A self-assessment exercise towards the NHS Providers recommendations on Health Inequalities was completed by Trust Directors on 3 November 2025. The following results were achieved:

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	4	50%	Maturing
2 - Data, insight, evidence and evaluation	6	43%	Developing
3 - Strategic leadership & accountability	8	44%	Developing
4 - System partnerships	9	90%	Thriving

3.2 The recommendations set out by NHS Providers were reviewed and grouped into three segments: Do Now, Do Later, Don't Forget. These have been collated, and a governance route and owning director recommended for each. Recommendations in **BOLD** are suggested as priorities by NHS Providers for every NHS Trust.

Forty six recommendations have been identified as being compete, or immediately achievable:

Actions	When	Where (how)
Chair – Darshana Bawa		
1.1 Assure themselves that there is adequate strategic intent, relevant oversight (including clear governance approach and senior accountability) for addressing health inequalities.	Do now	Board (annual report)
1.2 Working alongside the chief executive, set specific health inequalities objective(s) for the chief executive.	Do now	Appraisal
Non-Executive Directors – Darshana Bawa		

2.2 All NEDs to undertake baseline training on health inequalities, which is refreshed as needed and provided within the induction process for new NEDs.	Do now	Board (annual report)
2.3 All NEDs to seek opportunities for personal development on health inequalities	Do now	Appraisal
CEO – Thom Lafferty		
3.1 Establish health inequality oversight within the trust governance structure.	Do now	Executive Board
3.2 Work with the strategy director and executive lead for health inequalities to include a commitment to reducing health inequalities in the trust's organisational strategy.	Do now	Executive Board (Trust Strategy)
3.3 Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these.	Do now	Executive Board
3.4 Identify an executive lead for health inequalities on the board.	**Do now**	**Executive Board**
3.5 Ensure the board receives annual training on health inequalities, with priority for the board member appointed as executive lead for health inequalities. Training should be refreshed, as relevant, and provided in induction processes.	**Do now**	**Board**
3.6 Set health inequalities objectives in annual objectives for all executive board members.	Do now	(Appraisal)
3.8 Ensure that executive board members, senior leaders (Band 9 and very senior managers) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities – this could include through appraisal processes.	Do now	Executive Board
3.10 Include equality and health inequalities related impacts and risks in board and committee papers (including minutes), alongside actions for how they will be mitigated and managed.	Do now	Executive Board
3.11 Engage the company secretary to ensure that the board agenda framework includes regular oversight on health inequalities.	Do now	Executive Board
3.12 Identify a trust lead for digital inclusion and provide supporting governance.	Do now	Executive Board
Executive Lead – Andrew Kelso		
4.1 Provide strategic oversight of organisational health inequalities work and encourage other executive board members to embed an equity lens to their work programmes.	Do now	Executive Board; WE HCP Board
4.2 Ensure integrated working with HR and equality, diversity and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality.	Do now	People Committee (Head of EDI)
4.3 Publish an annual health inequalities report and/or update for the board.	Do now	Board (HI annual report)
4.6 Provide executive oversight of external reporting on the trust's health inequalities work.	Do now	Executive Board
4.7 Develop in-house public health capacity and capability to support the delivery health inequalities work.	Do now	WE HCP Board
4.10 Ensure there are systems in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities of interest for health inequalities.	Do now	Executive Board

4.11 Work collaboratively with executive board members leading on the organisation's anchor institutions work, to ensure alignment with the health inequalities agenda.	Do now	Executive Board
People – Gio Leeks		
5.3 Establish programmes to improve access to employment for those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups in your trust.	Do now	People Committee
5.4 Maximise use of the apprenticeship levy to improve pathways into employment, either internally for existing staff or externally targeting groups from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.	Do now	People Committee
5.8 Work in collaboration with the executive lead for health inequalities to understand and address health inequalities experienced by staff.	Do now	People Committee (Head of EDI)
5.9 Consult with staff to provide appropriate support initiatives to address health inequalities in the workforce. This could include offering access to staff networks and peer support opportunities, employee wellbeing assistance, financial support services and/or food banks for staff.	Do now	People Committee (Head of EDI)
Strategy – Michael Meredith		
6.1 Work with the chief executive and executive lead for health inequalities to include a commitment to reducing health inequalities in the trust's organisational strategy, which reflects national and system requirements alongside local need.	Do now	Executive Board (Strategy)
6.2 Embed an equity lens across all organisational priorities, strategic documents and annual planning processes.	Do now	Executive Board
6.4 Develop a strategic focus on the trust's role as an anchor institution, considering employment opportunities, organisational supply chains, supporting local housing and access to green spaces.	Do now	Executive Board; People Committee; WE HCP Board
6.5 Work in collaboration with the executive lead for health inequalities, people and estates teams, amongst others, to deliver anchor institutions work.	Do now	WE HCP Board
Finance – Tom Burton		
7.1 Embed health inequalities as part of financial decision making in the trust - including pathway review and design, business case approval and cost improvement programmes.	Do now	Performance and Finance (PaF) Committee
7.3 Ensure opportunities are identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits.	Do now	WE HCP Board
Operations – Anna Jebb		
8.3 Establish a culture of data reporting among staff on health inequalities outcomes, and on the impact of health inequality initiatives.	Do now	Operations Board; Quality and Safety Committee
8.4 Consider staff training to enable staff to feel confident in asking questions around demographic characteristics, such as ethnicity. Training should be refreshed, as relevant.	Do now	People Committee
8.5 Ensure that care pathways are reviewed to consider the extent to which they enable equitable access, experience, and outcomes. Transformation and quality improvement approaches should aim to reduce inequalities.	Do now	Operations Board

8.6 Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms.	Do now	Operations Board; Divisional Review Meetings
8.8 Work with the communications lead to review trust communications with patients (such as leaflets and letters) in response to the health literacy and digital literacy levels of your patient population. Refresh and update communications accordingly.	Do now	Executive Board
8.9 Integrate equality impact assessment tools across clinical delivery.	Do now	Operations Board; Divisional Review Meetings
Data and Digital – Jim McLeish and Anna Jebb		
9.1 Respond to the data indicators set out in the statement on information on health inequalities within annual reports, ideally setting out plans on how to improve outcomes in areas identified (NHS England, 2023a).	Do now	Digital Board
9.2 Datasets (including patient experience, patient safety, operational and clinical measures) to be broken down as a minimum by ethnicity, deprivation, age and sex. Where available, data on other protected characteristics and inclusion health groups could be considered.	Do now	Digital Board; Operations Board
9.5 Build in-house capacity and capability for analytical work, including investment in digital, data and technology teams.	Do now	Digital Board; Operations Board
9.6 Consider how digital technology, such as electronic patient record systems, could be used to support health inequalities decision making.	Do now	Digital Board
9.8 Engage with regional/ICS population health analytics teams, and local authority public health teams to make use of existing population health data and support whole system approaches to tackling health inequalities. Where possible consider data sharing agreements and interoperability with local systems.	Do now	WE HCP Board
9.9 Collect qualitative data through engagement with population groups to incorporate patient's views into health inequalities work (such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups).	Do later	WE HCP Board
Clinical, Quality and Research – Andrew Kelso and Jo Ward		
10.1 Support the delivery of quality improvement work or change programmes related to health inequalities.	Do later	Quality First Review Meetings
10.2 Apply a health inequalities framework across quality improvement and research work, to ensure that systems and programmes do not exacerbate or perpetuate inequalities.	Do now	Quality First Review Meetings; Clinical Effectiveness Committee
10.4 Include reference to health inequalities within all pillars of clinical governance (e.g. patient safety, audit), including learning for individual cases and overarching themes relating to health inequalities.	Do now	Patient Safety Group; Quality and Safety Committee

Thirty-Four recommendations will be deferred until a later time point for completion. Further planning on completion of these deferred items will be recommended by the Executive Board after one year, following another self-assessment exercise. Two recommendations were not felt to be necessary to achieve high performance in reducing health inequalities and will not be pursued.

Actions	When
2.1 NED membership and representation on relevant oversight committees within the trust governance structure with oversight for health inequalities work.	Do later
3.7 Ensure trust representation on appropriate Integrated Care System (ICS) group(s) (and other system level groups) to contribute to system wide decision making on population health and tackling health inequalities.	Do later
3.9 Set an expectation on executive board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivation.	**Do later**
4.4 Lead development of a trust level strategy or delivery plan for health inequalities, working with the strategy director, which sets out a workplan and measures of success.	Don't forget
4.5 Establish a working group(s), steering group(s) or committee(s) to coordinate the organisation's work on health inequalities.	*Don't do*
4.8 Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems.	Don't forget
4.9 Embed the use of tools such as the health equity assessment tool across your organisation when making decisions about service delivery.	Don't forget
4.12 Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations.	Don't forget
4.13 Ensure the equality impact assessment process takes into account existing health inequalities in the population and provides assurance that service developments will not exacerbate these, and where possible they will aim to reduce them. There should be specific consideration to those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.	Don't forget
5.1 Ensure all staff have training and development opportunities in health inequalities, with priority for induction programmes and leadership and development programmes. Training should be refreshed, as relevant.	Don't forget
5.2 Ensure all frontline staff have training and development opportunities in 'Making Every Contact Count'. Training should be refreshed, as relevant.	Don't forget
5.5 Establish mechanisms to support staff from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups with leadership development opportunities to ensure adequate representation across the organisation.	Don't forget
5.6 Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles.	*Don't do*
5.7 Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant.	Don't forget
6.3 Ensure the trust's work programme for reducing health inequalities includes engagement and co-production with local communities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms.	Do later
7.2 Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives.	Don't forget

7.4 Purchase supplies and services from organisations that embed social value to make positive environmental, social and economic impacts.	Don't forget
7.5 Procure goods and services locally (within the catchment area of the trust) to boost local economies and reduce inequalities.	Don't forget
8.1 Identify divisional, below-board level, health inequalities lead(s) to drive the agenda at site and/or service level.	Don't forget
8.2 Ensure a trust wide focus on inclusive recovery and operational improvement through an equity lens.	Do later
8.7 Ensure that services prioritise equity of access, experience and outcomes for the most deprived 20% of the population, inclusion health groups, those with protected characteristics (and other relevant 'PLUS' groups) as per 'Core20PLUS5' (NHS England, 2021b; NHS England, 2022a).	Do later
9.3 Assess the baseline and set targets to improve data reporting by ethnicity, deprivation and protected characteristics.	Do later
9.4 Set local metrics to monitor progress over time and ensure these are available in a timely manner to monitor services and support timely decision-making to ensure equity.	Don't forget
9.7 Review relevant data sources to inform the strategic development of health inequalities measures, such as Joint Strategic Needs Assessments (JSNA), OHID's fingertips and trust catchment area tools.	Do later
9.9 Collect qualitative data through engagement with population groups to incorporate patient's views into health inequalities work (such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups).	Do later
10.1 Support the delivery of quality improvement work or change programmes related to health inequalities.	Do later
10.3 Maximise research assets and expertise to develop programmes of work which have the potential to reduce health inequalities.	Don't forget
10.5 Work with research partners and in partnership with other NHS organisations to ensure participation in relevant research related to health inequalities, to develop an evidence-base on the effectiveness of provider led interventions to tackle inequalities.	Don't forget
10.6 Build in-house capacity and capability for health inequalities research work.	Don't forget
10.7 Review trust data on the five clinical priorities from 'Core20PLUS5' to inform the development of specific work programmes in these areas (NHS England, 2021b; NHS England, 2022a).	Do later
10.8 Use available data and insights to identify the most deprived 20% of the population and agree 'PLUS' groups within the 'Core20PLUS5' framework on which the trust will focus (NHS England, 2021b; NHS England, 2022a).	Do later
10.9 Consider active case finding approaches to reduce health inequalities, such as hypertension case finding and early cancer diagnosis.	Do later
10.10 Evaluate the impact of trust initiatives to address health inequalities.	Do later
10.11 Engage with groups that may not be traditionally involved in research or quality improvement, such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.	Don't forget

3.3 The Trust is Host Provider for the West Essex Health and Care Partnership, who lead on reducing health inequalities aligned to the core objectives of Integrated Care Systems. The work of the trust will closely follow and augment these existing workstreams. Population Health management resource will initially be accessed through this route, although the trust is investigating options for developing its own PHM resource, to help develop this and other transformation work.

4.0 Risks

This work directly supports mitigation of BAF 1.1 “There is a risk that there are variations in outcomes caused by unwarranted variation in care, constraints with system wide flow and workforce gaps resulting in poor clinical quality, safety and patient experience.”

5.0 Resources required

This proposal has been designed to work alongside existing boards and committees in the trust, and although executive leadership sits with the Chair, CEO and Executive Lead (CMO), roles are clearly identified for other executive directors. A degree of project management resource will be required to coordinate and report on this work. It is proposed that this comes from the Trust Programme Management Office.

6.0 Next steps or timeline

Progress towards these recommendations will be reported to the board annually through a Health Inequalities Annual Report. The Executive Directors will monitor progress 6 monthly through the trust Executive Board. Individual actions will also be carried through other groups and committees as indicated.

7.0 Recommendation

To approve this approach to reducing health inequalities.

Author: Andrew Kelso, Chief Medical Officer, Executive Lead for Health Inequalities
Date: 18 November 2025

Health Inequalities Self Assessment Tool

Use the following link to regenerate the tool with your answers: https://health-inequality-tool.net/reload/Rz0UR31Yy

Scoring

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	4	50%	Maturing
2 - Data, insight, evidence and evaluation	6	43%	Developing
3 - Strategic leadership & accountability	8	44%	Developing
4 - System partnerships	9	90%	Thriving

Recommended Objectives

1 - Building public health capacity & capability	Maturing
2.3	NEDs: All NEDs to seek opportunities for personal development on health inequalities
3.3	Chief executive: Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these
3.8	Chief executive: Ensure that board members, senior leaders (Band 9 and Very Senior Managers) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
4.10	Executive lead for health inequalities: Ensure there are systems

	in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities of interest for health inequalities
5.6	People: Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles
5.7	People: Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant
10.6	Clinical, quality and research: Build in-house capacity and capability for health inequalities research work

2 - Data, insight, evidence and evaluation **Developing**

3.9	Chief executive: Set an expectation on board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivation
3.12	Chief executive: Identify a trust lead for digital inclusion and provide supporting governance
8.8	Operations/delivery: Work with the communications lead to review trust communications with patients (such as leaflets and letters) in response to the health literacy and digital literacy levels of your patient population. Refresh and update communications accordingly
9.2	Data, digital and information: Datasets (including patient experience, patient safety, operational and clinical measures) to be broken down as a minimum by ethnicity, deprivation, age and sex. Where available, data on other protected characteristics and inclusion health groups could be considered

9.4	Data, digital and information: Set local metrics to monitor progress over time and ensure these are available in a timely manner to monitor services and support timely decision-making to ensure equity
10.3	Clinical, quality and research: Maximise research assets and expertise to develop programmes of work which have the potential to reduce health inequalities
10.4	Clinical, quality and research: Include reference to health inequalities within all pillars of clinical governance (eg patient safety, audit), including learning for individual cases and overarching themes relating to health inequalities

3 - Strategic leadership & accountability	**Developing**
1.1	Chair: Assure themselves that there is adequate strategic intent, relevant oversight (including clear governance approach and senior accountability) for addressing health inequalities
2.1	NEDs: NED membership and representation on relevant groups or committees within the trust governance structure with oversight for health inequalities work
3.1	Chief executive: Establish health inequality oversight within the trust governance structure
4.4	Executive lead for health inequalities: Lead development of a trust level strategy or delivery plan for health inequalities, working with the Strategy Director, which sets out a workplan and measures of success
4.6	Executive lead for health inequalities: Provide oversight of external reporting on the trust’s health inequalities work
4.9	Executive lead for health inequalities: Embed the use of tools such as the health equity assessment tool across your organisation when making decisions about service delivery

5.10	People: Consult with staff to provide appropriate support initiatives to address inequalities in the workforce. This could include offering access to employee wellbeing assistance, financial support services or food banks for staff
7.3	Finance: Ensure opportunities are identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits
8.7	Operations/delivery: Ensure that services prioritise equity of access, experience and outcomes for the most deprived 20% of the population, inclusion health groups, those with protected characteristics (and other relevant 'PLUS' groups) as per 'Core20PLUS5'
8.9	Operations/delivery: Integrate equality impact assessment tools across clinical delivery

4 - System partnerships **Thriving**

4.8	Executive lead for health inequalities: Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems
4.11	Executive lead for health inequalities: Work collaboratively with executive board members leading on the organisation’s anchor institutions work, to ensure alignment with the health inequalities agenda
4.12	Executive lead for health inequalities: Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations
8.6	Operations/delivery: Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups,

	engagement events, or similar mechanisms

Your Answers

1 - Building public health capacity & capability

1	Has your board received training and/or development on health inequalities?	Yes
2	Does your trust deliver regular training to all staff groups on health inequalities?	No
3	Has your trust delivered any quality improvement work or change programmes related to health inequalities?	Yes
4	Does your trust employ public health specialist staff and is the wider workforce encouraged to develop public health expertise?	No

2 - Data, insight, evidence and evaluation

1	Is your trust's data on patient ethnicity accurate and comprehensive?	Partial
2	Does your trust board routinely receive performance data broken down by ethnicity and deprivation?	No
3	Does your trust use existing population health data (e.g. population demographics and index of multiple deprivation) in your analysis of trust-level data?	No
4	Has your trust taken part in any research related to health inequalities?	Partial
5	Has your trust carried out engagement with communities to inform work on health inequalities?	Partial
6	Has your trust reviewed any care pathways to consider the extent to which they enable equitable access, experience, and outcomes?	Yes

7	Has your trust reviewed the accessibility of your services in relation to the digital and health literacy rates of your local population?	Partial

3 - Strategic leadership & accountability

1	Does your trust have commitments to reducing health inequalities within its strategy documents?	Partial
2	Does your trust have a named board-level Executive Lead for health inequalities?	Yes
3	Does your board have health inequalities objectives set in your annual review process?	No
4	Is your Executive lead for health inequalities providing strategic leadership and embedding an equity lens into cross-organisational work?	Yes
5	Is there a clear governance structure for the trust's health inequalities work within your trust, including a group or committee that provides oversight?	No
6	Does your trust/board use a health inequalities impact assessment tool in your business case process?	Yes
7	In allocating trust resources, are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits?	No
8	Does your trust have a programme of work aimed at reducing health inequalities experienced by staff members?	No
9	Does your trust use and implement NHS England's 'Core20PLUS5' framework to guide the organisation's approach to reducing health inequalities?	Partial

4 - System partnerships

1	Is your trust represented on appropriate Integrated Care System group(s) to contribute to population health decision making in your region?	Yes
2	Is your trust contributing to anchor institution working?	Yes
3	Does your trust have programmes in place to improve access to employment to underrepresented groups in your organisation?	Yes
4	Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities?	Partial
5	Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives?	Yes

BOARD OF DIRECTORS: Trust Board - Public 11 December 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa, Acting Trust Chair

DATE OF COMMITTEE MEETING: 24 November 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Medical Staffing Review Proposal	Yes	Yes	No	The Committee supported the proposal to establish a Medical Workforce Group. This will strengthen oversight of medical staffing, aligning with safer staffing principles. Risks around lack of validated tools for medical staffing were acknowledged; this would be mitigated by the multidisciplinary group formation.
2.2 NHS England Self-assessment	Yes	No	No	The Self-assessment for educational placements had been completed and submitted under delegated authority from the Board. The Trust achieved full compliance with NHS England requirements. Areas for improvement included training space and placement management with action plans in place for improvement.
2.3 Safe Learning Environment Charter	Yes	No	No	The Committee supported the adoption of the Charter. There is ongoing work to embed principles of safety, inclusion, and support for trainees.
2.4 Freedom to Speak Up Report and update on self-assessment	Yes	Yes	No	The FTSU self-assessment was undertaken in July 2025; no scores below 3 had been identified. There is an action plan which addresses the areas for improvement (identifying and addressing detriment, enhancing training, improving communications).
2.5 Guardian of Safer Working Hours Report	Yes	Yes	No	There were 76 exception reports received between July and September 2025, mainly related to working hours and high workloads in Acute Medicine, Care of the Elderly, and Gastroenterology. There was an increase in reports from

BOARD OF DIRECTORS: Trust Board - Public 11 December 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa, Acting Trust Chair

DATE OF COMMITTEE MEETING: 24 November 2025

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				senior doctors, reflecting greater normalisation of reporting and inclusion of Locally Employed Doctors. Immediate patient safety concerns were noted but linked to staffing shortages rather than specific patent safety incidents
2.6 People Report	Yes	Yes	No	Workforce KPIs were reviewed and good progress was noted. Vacancy and sickness rates are above target, but turnover is at a historic low. Rostering improvements and bank/agency usage are under review. Diversity in senior roles is steadily improving. There are action plans in place for underperforming areas.
2.7 Internal Audit - 25/26 - Final Report - People Deployment Recommendations	Yes	Yes	No	Internal Audit recommendations were noted. There are actions underway to improve KPI monitoring, hours tracking, and consistency in rostering practices. Accountability and training are being strengthened.
2.8 Violence and Aggression Plans	Yes	Yes	No	The proposal to establish a working group with refreshed priorities was acknowledged. This included a focus on training, escalation processes, and policy oversight. Actions to improve staff and patient safety are being implemented.
2.9 Learning & OD Update including: • Staff Survey Update • Appraisal Deep Dive • Sexual Safety Training Update	Yes	Yes	No	Staff survey response rate was improving at 55%. Appraisal compliance is below target but there is an action plan in place. Statutory training compliance is at 89% (improved from previous year). The suggestion to move sexual safety training to mandatory status was discussed and agreed it required further discussion by the Executive.

BOARD OF DIRECTORS: Trust Board - Public 11 December 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa, Acting Trust Chair

DATE OF COMMITTEE MEETING: 24 November 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.10 People Strategy - Update on Progress	Yes	Yes	No	A verbal update was provided. Several milestones had transitioned to business-as-usual. There was ongoing oversight to ensure sustained cultural improvements.
2.11 PAHT2030 Culture Update	Yes	Yes	No	Our Culture" programme milestones had been completed and embedded. EDI strategy, leadership framework, and recruitment system improvements were now part of routine operations. This would be embedded n the new Trust strategy.
2.12 Safer Nurse Staffing Report	Yes	No	No	Registered nurse fill rates sustained above 95%. No wards below 75%. Enhanced care needs and redeployment were managed appropriately. Quality indicators (falls, pressure ulcers) are monitored with targeted interventions.
2.13 Gender Pay Gap Report	Yes	Yes	No	The gender pay gap persists, mainly due to senior role distribution. Action plans are in place to address structural barriers and support women's progression. The Committee recommended the report to Board. *On the Board agenda*
2.14 Ethnicity Pay Gap Report	Yes	Yes	No	The overall pay gap is in favour of BME staff, but underrepresentation in senior non-clinical roles and pay gap in medical roles was noted. Actions focus on fair recruitment, development, and monitoring. The Committee recommended the report to Board. *On the Board agenda*
2.15 Disability Pay Gap Report	Yes	Yes	No	This is the first annual report. A pay gap has been identified; however, declaration rates are low. Action plan in place to encourage disclosure, support disabled staff, and ensure fair recruitment and progression. The Committee recommended the report to Board. *On the Board agenda*

BOARD OF DIRECTORS: Trust Board - Public 11 December 2025 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa, Acting Trust Chair

DATE OF COMMITTEE MEETING: 24 November 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.16 BAF Risk 2.1 Staff Engagement and Morale	Yes	Yes	No	The score was reviewed and remained at 12
2.17 Horizon Scanning	Yes	No	No	Highlights included: • **Strikes and further disruptions-** Further strikes are possible as the mandate is lasting until early 2026. • **Divisional restructure-** Aim to be delivering the new structures and new ways of working by December. • **CQC Well led-** Recent CQC inspections were discussed and that the well led interviews will close the 'live window' on the 27/28/29 January 2026.
3.1 Communications Update	Yes	Yes	No	A brief update on recent communications initiatives was received. There had been a delay in progressing future plans due to editing software restrictions.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

5.2

Agenda item:	5.2
Presented by:	Giovanna Leeks, Chief People officer
Prepared by:	Lindsay Hanmore – Lead Freedom to Speak Up Guardian
Date prepared:	August 2025 – updated 8th October 2025
Subject:	Freedom to Speak up Trust (FTSU) Self-Assessment

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	A self-assessment was undertaken in July 2025 on the Trust's freedom to speak up arrangements which identifies areas of strength and areas of opportunity for further strengthening the service and culture. PAHT demonstrates strong foundations and commitment to FTSU, with clear governance, leadership engagement, and cultural integration. Yet, several principles require formalisation of processes, improved training coverage, and stronger evidence of impact to achieve full maturity. Overall Rating: Developing to Strong – Positive trajectory with targeted actions needed to embed excellence across all principles.								
Recommendation:	Board is asked to agree the self-assessment and to have assurance that the actions close the gaps identified on the self-assessment								

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:	Executive Cabinet – October 2025 People Committee – November 2025
Risk / links with the BAF:	2.1 Staff engagement and morale
Legislation, regulatory, equality, diversity and dignity implications:	Freedom to speak up principles are contained with the NHS Contract Public Interest disclosure act 1998 and Employment Rights Act 1996 Regulation 10/12/17 CQC Well led
Appendices:	1 -Scoring tool for self-assessment of our speaking up arrangements 2- High level improvement plan 3. Completed self-assessment tool

1.0 Purpose

1.1 The primarily purpose of this paper is to provide the Board with assurance and oversight of our latest self-assessment, and to provide a strategic direction regarding the organisation's approach to speaking up and raising concerns. Specifically, it aims to give:

- Assurance of compliance and culture;
- Reporting and Accountability;
- Risk Management;
- Learning and Improvement;
- Support for Freedom to Speak Up Guardians and Ambassadors;
- Alignment with Strategic Objectives.

2.0 Background

2.1 The reason of FTSU is to create an environment where all staff feel safe and supported to raise concerns, confident that these will be listened to and acted upon appropriately. This is essential for safeguarding patient safety, improving staff wellbeing, and maintaining public trust in healthcare services. Speaking up is not limited to clinical concerns; it also encompasses issues such as bullying, discrimination, and organisational practices that may compromise care or staff experience.

2.2 All NHS organisations are required to comply with national guidance, including the NHS England Freedom to Speak Up Policy, and report annually on FTSU activity. The Board has a statutory responsibility to ensure that the organisation promotes a culture of openness, provides accessible routes for raising concerns, and monitors the effectiveness of these processes. Regular reporting to the Board enables oversight of trends, themes, and actions taken, ensuring accountability and continuous improvement.

2.3 Embedding FTSU within the organisational strategy aligns with the NHS People Plan, the PAHT People Strategy and the Equality, Diversity and Inclusion Improvement Plan, reinforcing the commitment to a just and learning culture. It also mitigates risks associated with staff silence, which can lead to patient harm, reputational damage, and regulatory non-compliance.

2.4 The executive lead, responsible for FTSU in the organisation, has responsibility for ensuring the National Guardians' Office reflection tool is completed at least bi-annually. The Executive lead responsibility changed in October 2025 from the Chief Nurse / Deputy Chief Executive to the Chief People Officer.

3.0 Self-Assessment Tool

3.1 The previous Executive Lead for FTSU and the Lead Guardian undertook the self-assessment during the months of June and July 2025.

3.2 within the tool there are eight principles to be reviewed, and each have several statements to score using a Likert scale (survey tool that measures how strongly people agree or disagree with a statement, typically using a 5- or 7-point scale), requiring summarisation of the information that supports the scores. Appendix 1 has the scoring range.

3.3 All elements scoring <4 (less than 4) requires plans for improvement. Individual principles are not scored, instead individual statements are scored to support identifying the key elements to be included in improvement plans. Please review Appendix 2 for the high-level improvement plan.

4.0 Principles

4.1 Principle 1 – Value Speaking Up

4.1.1 PAHT demonstrates a strong commitment to fostering a speaking-up culture, with leadership engagement evident across key areas. The senior lead responsible for FTSU scored consistently at 4 out of 5 across all reflective statements, indicating a high level of knowledge and active involvement in promoting openness.

4.1.2 Key strengths include:

- **Knowledge and Oversight:** The senior lead is well-informed about Freedom to Speak Up and has led a review of speaking-up arrangements within the last two years.
- **Guardian Support:** Assurance is provided that the Freedom to Speak Up Guardian was recruited through a fair and transparent process and has sufficient ring-fenced time to fulfil their role.
- **Regular Engagement:** Monthly meetings between the lead guardian and executive lead enable discussion of emerging themes, concerns, and support needs.
- **Collaborative Approach:** the self-assessment was completed in June 2025 in partnership with the executive lead, Non-Executive Director, Chief People Officer, and lead guardian, reinforcing shared accountability.

4.1.3 The overall self-assessment is that PAHT is performing well against Principle 1, with clear evidence of leadership commitment and structured engagement. Continued focus on maintaining regular reviews and strengthening visibility of speaking-up initiatives will further embed a culture of openness.

4.2 Principle 2 – Role-model speaking up and set a health Freedom to Speak up Culture

4.2.1 PAHT demonstrates a developing but positive approach to embedding a speaking-up culture through leadership role-modelling. Scores indicate that while there are clear commitment and progress in several areas, further work is required to strengthen consistency and visibility across the leadership team.

4.2.2 Key Strengths include

- **Vision and Communication:** The organisation regularly articulates its vision for speaking up, supported by CEO and executive communications, including videos and staff briefings.
- **Cultural Integration:** FTSU principles are embedded within the new People Strategy and wider culture improvement plans, with active promotion during initiatives such as *People Week – This is Us*.
- **Staff Feedback:** Staff survey results show that 66% of employees feel comfortable raising concerns, reflecting progress toward an open and transparent culture.
- **Network Engagement:** Guardians maintain strong links with staff networks, ensuring awareness and advocacy for speaking up across diverse groups.
- **Use of Intelligence:** FTSU data and insights are actively used to influence cultural improvements and inform leadership decisions.

4.2.3 The overall self-assessment is that PAHT is performing ok against Principle 2 showing positive progress but areas for improvement. While the vision for speaking up is well communicated and embedded in the People Strategy, scores of 3 in key areas—such as leadership buy-in, evidencing no detriment, and financial investment—highlight gaps in consistency and assurance.

4.3 Principle 3 – Make sure workers know how to speak up and feel safe and encouraged to do so

4.3.1 PAHT demonstrates a strong foundation in ensuring staff know how to speak up, supported by clear policies and accessible information. The speaking-up policy reflects the 2022 national update (score 5), and staff feedback confirms that details of guardians and contact routes are easy to find. Independent assurance from the 2024 BDO (internal) audit further validates that the intranet (Alex.net) provides comprehensive guidance.

4.3.2 Communication efforts are evident through posters, internal articles, screen savers, and dedicated campaigns such as *This Is Us Week* and Schwartz Rounds, which share positive stories of speaking up. However, scores of 3 in areas such as annual planning and storytelling indicate that while communication is effective, it lacks consistency and strategic depth. The current annual plan for raising the profile of Freedom to Speak Up requires refinement, and there is an opportunity to share more detailed, anonymised success stories to inspire confidence and demonstrate impact.

4.3.3 Key strengths include:

- **Policy compliance and accessibility**
- **Multi-channel communication strategy with collaboration between FTSU and Communications teams.**
- **Evidence of staff awareness and positive feedback**.

4.3.4 The overall assessment of Principle 3 is strong but requires targeted improvements to achieve excellence in communication and cultural reinforcement.

4.4 Principle 4 - When someone speaks up, thank them, listen and follow up

4.4.1 PAHT demonstrates partial progress in ensuring that staff who speak up feel valued, heard, and supported. While Freedom to Speak Up is embedded in corporate and local inductions (score 4) and guardians provide timely support to managers, several areas require significant improvement.

4.4.2 Key strengths include:

- **Induction Coverage:** Freedom to Speak Up is consistently included in Trust-wide induction, preceptorship programmes, and local team sessions.
- **Manager Support:** Guardians and executives actively assist managers in handling concerns compassionately and fairly, with minimal delays reported by staff.
- **Reporting and Oversight:** High-level overview reports are shared with divisional leadership and the Chief People Officer, ensuring visibility of themes and trends.

4.4.3 The overall assessment of Principle 4 is that needs further development. While foundational elements are in place, significant improvements in training, measurement, and leadership capability is required to fully meet the principle.

4.5 Principle 5 - Use Speaking up as an opportunity to learn and improve

4.5.1 PAHT demonstrates a strong commitment to learning from speaking up, with clear processes for identifying concerns and integrating insights into improvement initiatives. Scores of 4 for supporting guardians and using triangulated data indicate that the organisation

is effectively leveraging intelligence to inform cultural and safety improvements. The establishment of a Staff Feedback Group, chaired by the executive lead for speaking up, and regular collaboration between the Lead Guardian and Associate Director for Quality and Governance to link themes with Datix and whistleblowing data are notable strengths.

4.5.2 However, areas scoring 3—such as identifying good practice externally, incorporating this into improvement plans, and sharing learning internally and externally—highlight opportunities for greater formalisation and visibility. While examples of good practice are shared verbally within ICS and NGO networks, this is not yet embedded in a structured improvement plan.

4.5.3 Key strengths include:

- **Effective triangulation of data** through the Staff Feedback Group.
- **Regular sharing of themes and concerns** with relevant colleagues and governance forums.
- **Integration of speaking-up intelligence into cultural and safety programmes**.

4.5.4 The overall assessment of Principle 5 is string but requires formalisation. PAHT is effectively using speaking-up intelligence for improvement but needs to embed learning and sharing into structured plans to achieve excellence.

4.6 Principle 6- Support guardians to fulfil their role in a way that meets workers' needs and NGO requirements

4.6.1 PAHT demonstrates strong compliance and support for Freedom to Speak Up guardians, with several areas of excellence and some opportunities for improvement. Guardians were appointed through a fair and transparent process (score 5) and have completed training and registration with the National Guardian's Office (score 5). There is clear evidence of robust governance, including documented case-handling procedures (score 4) and assurance that confidentiality is maintained effectively.

4.6.2 Guardians receive regular one-to-one support from senior leads (score 4) and have access to emotional support and/or supervision. The organisation has an effective plan for covering absences and ensures quarterly data submissions to the National Guardian's Office (score 5). These measures reflect strong structural support and compliance with national standards.

4.6.3 However, areas scoring 3—such as performance and development objectives, stakeholder engagement, and consistency of positive staff experience—highlight the need for further development. While feedback from referrers is generally positive, response rates are low, limiting the ability to monitor experience comprehensively. Additionally, engagement with managers on their role in handling speaking-up cases requires strengthening.

4.6.4 Key strengths include:

- **Transparent recruitment**
- **Full NGO compliance for training and registration.**
- **Effective cover arrangements**
- **Quarterly reporting**.
- **Strong confidentiality**
- **Assurance and timely case progression.**

4.6.5 The overall assessment of Principle 6 is strong with targeted improvements needed. PAHT meets most requirements and provides robust support but should

focus on formalising development objectives and strengthening feedback and engagement processes.

4.7 Principle 7 Identify and tackle barriers to speaking up

4.7.1 PAHT demonstrates moderate progress in identifying and addressing barriers to speaking up, with clear evidence of data collection and monitoring but gaps in formal processes and evaluation. A score of 4 for identifying barriers reflects strong awareness of organisational challenges, supported by data analysis showing trends such as an increase in clinical staff speaking up over the past two years. Ambassadors have defined roles and responsibilities and represent a diverse range of roles and ethnic backgrounds, which strengthens accessibility and trust.

4.7.2 However, scores of 3 in key areas—such as understanding who isn't speaking up and why, evaluating the impact of actions, and ensuring champions are fully confident in their role—highlight opportunities for improvement. While feedback forms capture detriment and monitoring is in place (score 4), the process for investigating and addressing detriment is not yet fully formalised. Limited data on protected characteristics of those who speak up also restricts the ability to identify and address equality-related barriers.

4.7.3 Key strengths include:

- **Barriers identified through staff feedback and trend analysis.**
- **Monitoring of detriment and involvement of the Non-Executive Director in oversight.**
- **Diverse ambassador network with bi-monthly meetings to reinforce role clarity.**

4.7.4 The overall assessment of Principle 7 is ok. PAHT has a clear understanding of barriers and some effective monitoring but requires formalisation of processes and improved data analysis to fully meet this principle.

4.8 Principle 8 – Continually improve our speaking up culture

4.8.1 PAHT demonstrates a strong commitment to continuous improvement, with a comprehensive strategy and evaluation processes in place. Scores of 4 and 5 across most areas indicate that the FTSU strategy is well-aligned with the organisation's cultural improvement plans and follows a recognised quality improvement approach (Plan-Do-Study-Act). Speaking-up arrangements have been evaluated within the last two years, supported by external assurance through the 2024 BDO (internal) audit and regular reporting to the People Committee and Trust Board.

4.8.2 However, the improvement plan is currently rated 3, reflecting the need for an updated and fully implemented plan for 2025–2026. While the strategy is up to date and monitored bi-annually, actions from the recent self-assessment have not yet been formalised into the improvement plan. Additionally, assurance that speaking up results in learning and improvement requires strengthening (score 3), with clearer evidence needed to demonstrate impact on staff confidence and cultural change.

4.8.3 Key strengths include:

- **Comprehensive and current strategy aligned with organisational priorities.**
- **Regular evaluation using qualitative and quantitative measures.**
- **Use of PDSA methodology to drive improvement.**
- **Guardian reporting structured to provide assurance and reviewed by executives and NEDs**

4.8.4 The overall assessment of Principle 8 is strong but requires formalisation and impact evidence. PAHT has a robust strategy and evaluation framework but needs to ensure improvement actions are fully implemented and linked to measurable outcomes

5.0 Overall Position

5.1 PAHT demonstrates strong foundations and commitment to FTSU, with clear governance, leadership engagement, and cultural integration. Yet, several principles require formalisation of processes, improved training coverage, and stronger evidence of impact to achieve full maturity.

5.2 Overall Rating: Developing to Strong – Positive trajectory with targeted actions needed to embed excellence across all principles.

6.0 Update on Actions

6.1 Appendix 2 shows the high-level plans for 6-24 months from when the plan was originally written since then, the following actions have been undertaken that relate to the development areas in the last 6-12 months:

- **Mandatory FTSU e-learning**

Application has been made through the Trusts internal gateway process for the FTSU e-learning videos to become mandatory training

- **Diversity of FTSU Team**

Recruitment has been undertaken and there is now a more diverse support with the guardians.

- **Communications Plan**

Communication team supporting with regular updates Trust wide to raise profile of service. The lead FTSU guardian and Head of People are developing an communications plan for the next quarter.

- **Experience of referrers**

All guardians request feedback quarterly from all those people who have raised a concern with them. Feedback is voluntary but endeavours to explore their experience of using the service. It now also now asks for details of any protected characteristics to try and identify any gaps in those who are not comfortable to speak up. The experience of referrers will be reported from quarter 3.

7.0 Recommendation

Board is asked to agree the self-assessment and to have assurance that the actions close the gaps identified on the self-assessment

Author: Lindsay Hanmore – Lead Freedom to Speak Up Guardian
Date August 2025 – updated 8th October 2025

The Princess Alexandra Hospital NHS Trust

Appendix 1

Scoring for set reflections within each principle

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

The Princess Alexandra Hospital NHS Trust

5.2

Appendix 2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Collaboration with OD team to review need to ensure three NGO FTSU videos are mandated for all staff and explore if these can be linked to sexual safety training. Explore other training options with OD for managers that includes the importance of speaking up, listening up and following up Collaborate with OD team to explore the need for "behaviours" expectations in staff training.	Sept 2025	Lead Guardian and Lead for OD
2. Increase the diversity of the guardian team and leadership support	Sept 2025	Lead Guardian and Executive Lead
3. FTSU budget to be realigned so that it is pooled in one place under Executive lead for Speaking Up	Sept 2025	Executive Lead and Finance
4. Refine and update annual communications plan for speaking up that includes detailed anonymous stories of speaking up, the benefits and what has changed because of speaking up	October 2025	Lead Guardian and Communications
5. Monitor the experience of increased numbers of referrers by increasing number of people who respond. Develop supporting email to be sent with link to promote numbers. Analyse feedback data on who is and who isn't speaking up to identify gaps for improvement	October 2025	Lead Guardian
6. Produce, share and implement these actions as part of speaking up improvement plan for 2025-2026 Learning and improvement to be captured as part of improvement plan with aim to improve to 60% in staff survey results	January 2026	Lead Guardian

Development areas to address in the next 12–24 months	Target date	Action owner
1. Update Freedom to Speak Up Strategy for 2026-202029. Include details of the process for identifying and addressing potential or actual detriment following speaking up.	April 2026	Lead Guardian
1. Develop a process for exploring and dealing with detriment following speaking up in collaboration with People Team including the role of the NED	January 2026	Lead Guardian and People Team

Appendix 3 Completed self assessment tool

Final Self Assessment completed June-July 2

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I have led a review of our speaking-up arrangements at least every two years	4
I am assured that our guardian(s) was recruited through fair and open competition	4
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	4
I am regularly briefed by our guardian(s)	4
I provide effective support to our guardian(s)	4

Enter summarised commentary to support your score.

Monthly meetings with lead guardian and executive lead to explore themes, concerns and need for support. Self assessment tool completed in June 2025 in collaboration with executive lead, NED, Chief People Office and lead guardian.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	3
I am confident that the board displays behaviours that help, rather than hinder, speaking up	4
I effectively monitor progress in board-level engagement with the speaking-up agenda	3
I challenge the board to develop and improve its speaking-up arrangements	4
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	4
I am involved in overseeing investigations that relate to the board	3
I provide effective support to our guardian(s)	3
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3
We regularly and clearly articulate our vision for speaking up	4
We can evidence how we demonstrate that we welcome speaking up	3
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
We regular discuss speaking-up matters in detail	4

Enter summarised evidence to support your score.

Speaking up vision is shared by CEO and other executives within staff communications including videos on Youtube and staff briefs.
Many of the senior leadership team have received briefings from lead guardian or have accessed listen up and follow up NGP videos but this is not captured in numbers.
We have shared anonymously one example of when it would appear that detriment could have happened but was addressed proactively and dealt with by senior executive director for that division.
We request feedback quarterly from everyone who raises a concern and majority very positive but only approximately 25% respond

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1. Revisit need to ensure three NGO FTSU videos are mandated for all staff and explore if these can be linked to sexual safety training. Also to explore content of freedom to speak up training for all managers of staff
2. Need to be explicit in new strategy the process for identifying and addressing potential or actual detriment following speaking up.

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes 5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes 4
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes 4
We support our guardian(s) to make effective links with our staff networks	Yes 4
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes 4

Enter summarised evidence to support your score.

We are reviewing all our ER policies to add just culture to it and in practice we have been applying the principles. We champion an open and transparent culture across the organisation and this is evidenced by our documentation. On our staff survey 66% of our people feel comfortable raising concerns. On our 'People week – This is Us' we have promoted our 'Freedom to Speak Up' guardians and work delivered by them. Our networks are fully aware of the programme of work delivered by our Guardians and actively promote speaking up. New People Strategy fully committed to Speaking Up principles

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 delivery to a transformational culture to improve awareness and application of principles
2

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	4
We have reviewed the ringfenced time our Guardian has in light of any significant events	4
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	4
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	3
Enter summarised evidence to support your score. Review of speaking up paper shared at People Committee early 2025 which included leadership requirements and time required	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 budget needs to be realigned so that it is pooled in one place,	
2 Increase the diversity of the guardian team and leadership support	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	4
Enter summarised evidence to support your score. Feedback from staff states that easy to find details of guardians and how to contact them. BDO audit 2024 confirms Alex.net provides detail information for staff	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	3
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	4

Enter summarised evidence to support your score.

The communications team work in collaboration with the FTSU team to share all aspects of speaking up. This includes posters, articles in Trust communications, screen savers, This Is Us Week focus June 2025.
Swhartz round sharing stories of when “they were heard” focusing on the benefits of speaking up

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Share more detailed anonymous stories of speaking up, the benefits and what has changed because of speaking up

2 Refine and update annual communications plan for speaking up

3. Collaborate with OD team to explore the need for “behaviours” expectations in staff training

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	2
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	2
Enter summarised evidence to support your score. Freedom to speak up delivered at all Trust Inductions, Preceptorship and ad hoc to local teams	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1. Revisit need to ensure three NGO FTSU videos are mandated for all staff and explore if these can be linked to sexual safety training. Also to explore content of freedom to speak up training for all managers of staff	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3
All managers and senior leaders have received training on Freedom to Speak Up	2
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

The guardians and executive team support managers as required when speaking up concerns are raised to ensure dealt with in a compassionate, timely and fair manner.

Minimal delays reported, in feedback from referrers, about delays from their managers in dealing with concerns that have been brought to their attention.

High level overview reports are shared with all Divisional Triumvirates and With the CPO for corporate functions outline numbers and themes from their Divisions.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Continue to develop leadership training for managers that includes the importance of speaking up, listening up and following up
2

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	4
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

Themes and areas of concerned are shared with appropriate colleagues and included in reports. Data is triangulated in newly established Staff Feedback group chaired by Executive lead for speaking up.
Lead Guardian and Associate Director for Quality and Governance shared details of themes and explore links to datix and whistleblowing monthly.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	3
We share the good practice we have generated both internally and externally to enable others to learn	3
Enter summarised evidence to support your score. Practice examples are shared verbally with ICS FTSU lead and at NGO network meetings We have used strategy as improvement plan previously	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 to formalise all actions included in self assessment with other speaking up requirements into Trust Improvement Plan for 2025-2026	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. Evidenced through expressions of interest and appointments and training records with NGO	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	3
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	4
Our guardian(s) has access to a confidential source of emotional support or supervision	4
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

Although currently no local development objectives these are set by the NGO and are reviewed annually as part of refresher NGO training for all guardians. Lead Guardian offers support to other guardians and ambassadors, all ambassadors also have a link guardian. With 5 guardians they cover each other's absence and staff can contact any one of the five guardians, details of how to contact other guardians in Lead's out of office message.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	4
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	3
Enter summarised evidence to support your score. Handling process described in NGO policy, feedback from staff captures confidentiality and no reported cases of breaches. Guardians liaise directly with appropriate managers to support the process and to ensure staff are not waiting excessive periods for feedback. Feedback captures experience of referrers and if there are any concerns this is explored with the managers.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 - Monitor the experience of more referrers but increasing number of people who respond. Work with other guardians to ensure this is progressed.	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	4
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	3
We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

We have data on most aspects of the groups that do and don't speak up. This has shown over last two years increase in number of clinical staff who speak up.
Ambassadors have defined role and responsibilities and these are supported at bi monthly ambassador meetings.
We have minimal data on protected characteristics of those who speak up but are addressing this through new feedback forms and will work with this data to identify where improvement needs to happen.
We have ambassadors from a wide range of roles and ethnic backgrounds.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 encourage more feedback and analyse data on who is and who isn't speaking up to identify gaps for improvement

2

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	3
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	4

Enter summarised evidence to support your score.

The feedback forms capture if there has been any detriment received following speaking up.

Previous NED have always discussed detriment with Lead guardian, and this will continue to be an arrangement with new NED

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 – Develop a process for exploring and dealing with detriment following speaking up in collaboration with People Team
2 meet with NED to ensure aware of any cases of detriment reported

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	4
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	4
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	4
Our improvement plan is up to date and on track	3

Enter summarised evidence to support your score.
Strategy is up to date and will be reviewed and updated by 2026. It was developed in collaboration with the organisations quality and improvement strategy.
The strategy aims and objectives are monitored and details shared in the Freedom To Speak up bi-annual reports shared at People Committee and Trust Board
Updated improvement plan to be developed following outcomes of self assessment

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Produce, share and implement speaking up improvement plan for 2025-2026
2

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	5
Enter summarised evidence to support your score. Evaluated and evidenced in FTSU reports. PDSA approach to improvement including impact of communications and role of ambassadors to increase number of referrals. Self evaluation 6 months out of date but BDO audit undertaken in 2024 has evidence of evaluation of our service	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
We have we evaluated the content of our guardian report against the suggestions in the guide	4
Our guardian(s) provides us with a report in person at least twice a year	4
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3
Enter summarised evidence to support your score. FTSU reports are evaluated by the executive and non-executive colleagues. Oversight and development of report with Executive lead for FTSU. Although Lead Guardian can not always present at these committees they are presented by the executive lead. Assurance on speaking up captured in staff survey – identified questions.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 – Learning and improvement to be captured as part of improvement plan with aim to improve staff survey results to 60%	
2	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Collaboration with OD team to review need to ensure three NGO FTSU videos are mandated for all staff and explore if these can be linked to sexual safety training. Explore other training options with OD for managers that includes the importance of speaking up, listening up and following up Collaborate with OD team to explore the need for "behaviours" expectations in staff training.	Sept 2025	Lead Guardian and Lead for OD
2. Increase the diversity of the guardian team and leadership support	Sept 2025	Lead Guardian and Executive Lead
3. FTSU budget to be realigned so that it is pooled in one place under Executive lead for Speaking Up	Sept 2025	Executive Lead and Finance
4. Refine and update annual communications plan for speaking up that includes detailed anonymous stories of speaking up, the benefits and what has changed because of speaking up	October 2025	Lead Guardian and Communications
5. Monitor the experience of increased numbers of referrers by increasing number of people who respond. Develop supporting email to be sent with link to promote numbers. Analyse feedback data on who is and who isn't speaking up to identify gaps for improvement	October 2025	Lead Guardian
6. Produce, share and implement these actions as part of speaking up improvement plan for 2025-2026 Learning and improvement to be captured as part of improvement plan with aim to improve to 60% in staff survey results	January 2026	Lead Guardian
7		
8		

Development areas to address in the next 12–24 months	Target date	Action owner
1. Update Freedom to Speak Up Strategy for 2026-202029. Include details of the process for identifying and addressing potential or actual detriment following speaking up.	April 2026	Lead Guardian
2. Develop a process for exploring and dealing with detriment following speaking up in collaboration with People Team including the role of the NED	January 2026	Lead Guardian and People Team
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Commitment to speaking up culture from executive lead		
2. We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them		
3. We use triangulated data to inform our overall cultural and safety improvement programmes		
4		
5		
6		
7		
8		

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

5.3

Agenda item:	5.3
Presented by:	Giovanna Leeks, Chief People Officer
Prepared by:	Nathaniel Williams, People Information and Systems Lead, and Arleen brown, Head of Equality Diversity and Inclusion
Date prepared:	14 October 2025
Subject:	Gender Pay Gap Reporting 2024/25

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	**Workforce Composition**: Women: **75%;** Men: **25%** **Overall Gender Pay Gap:** **Mean gap**: **23%** (in favor of men, approx. £6.58) **Median gap**: **16%** (in favor of men, approx. £3.69) The gender pay gap within the Trust is not due to unequal pay for the same role but is driven by role distribution and progression disparities. Women dominate lower-paid AfC bands, while men hold a greater share of senior clinical and managerial positions. Closing the gap requires targeted action on career progression, leadership development, and flexible working opportunities, particularly for women in mid-bands and medical grades.
Recommendation:	For discussion and approval for publication

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

Previously considered by:	People Committee – November 2025
Risk / links with the BAF:	2.1 Staff engagement and morale
Legislation, regulatory, equality, diversity and dignity implications:	NHSE EDI Improvement Plan Equality Act 2010 -Specific Duties and Public Authorities - Regulations 2017.
Appendices:	Appendix 1 - Disability pay Gap Action Plan

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1. Introduction

1.1 The purpose of this paper is to provide the Board with a comprehensive overview of the gender pay gap within the National Health Service (NHS). The gender pay gap represents the difference in average earnings between men and women across the workforce, expressed as a percentage of earnings. It is not a measure of equal pay for equal work, but rather an indicator of broader structural imbalances in representation, career progression, and access to senior roles.

1.2 Addressing the gender pay gap is a matter of fairness, compliance, and organisational effectiveness. As one of the largest employers in the United Kingdom, the NHS has a responsibility to lead by example in promoting equity and inclusivity.

1.3 This paper sets out the current position of PAHT in relation to the gender pay gap, explores the data, and outlines actions being taken to reduce inequalities. It aims to support the Board in understanding the scale of the challenge, evaluating progress to date, and considering further measures to ensure that PAHT continues to foster a diverse, equitable, and high-performing workforce.

2. Background & context

2.1 The gender pay gap has been a persistent feature of the UK labour market and remains a challenge within the NHS. Legislation introduced under the Equality Act 2010 requires all organisations with more than 250 employees to publish annual gender pay gap data. For NHS Trusts, this obligation is reinforced by the public sector equality duty, ensuring transparency and accountability in how pay disparities are monitored and addressed. The publication of this data provides both a legal requirement and an opportunity for organisations to reflect on their workforce composition and take action to promote fairness.

2.2 Despite women comprising the majority of the NHS workforce, men are disproportionately represented in higher-paid roles, particularly within medical, managerial, and executive positions. Women, by contrast, are more likely to be concentrated in lower-paid roles such as nursing, administrative, and support functions. This occupational segregation, combined with barriers to career progression and the impact of part-time work or caring responsibilities, contributes to the persistence of the pay gap.

2.3 The issue is not only one of compliance but also of organisational effectiveness. Pay disparities can undermine staff morale, hinder retention, and damage the NHS's reputation as an equitable employer. Conversely, tackling the gender pay gap supports the NHS's values of inclusivity and fairness, strengthens public trust, and contributes to building a workforce that is motivated, diverse, and capable of delivering high-quality patient care.

2.4 This context underscores the importance of sustained action. Addressing the gender pay gap requires a multifaceted approach, including targeted recruitment, leadership development, flexible working arrangements, and cultural change. For PAHT, progress in this area is not only a matter of equity but also a strategic imperative for the future resilience and success of the organisation.

2.5 PAHT's composition of workforce is 75% women and 25% men as at 31 March 2025.

3. Terminology and how to read the data

- **Mean pay gap** – the difference between the mean (average hourly earnings, excluding overtime) of men and women staff.
- **Median pay gap** – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of men and women staff.
- **Mean bonus gap** – the difference between the mean bonus paid to men and women staff (bonus pay exclusively made up of local and national consultant clinical excellence awards (CEA), discretionary points and the welcome bonus for our international Nurses).
- **Pay distribution by gender** – the proportion of men and women staff in the lower, lower middle, upper middle and upper quartile pay bands.

4. Gender profile of the Trust

4.1 Table 1 provides a breakdown of staff who works full and part time by gender.

	2024				2025			
Gender	**Full Time**	**%**	**Part Time**	**%**	**Full Time**	**%**	**Part Time**	**%**
Female	2129	67%	1049	**33%**	2082	66%	1055	**34%**
Male	880	89%	105	**11%**	899	88%	121	**12%**
Grand Total	**3009**	**72%**	**1154**	**28%**	**2981**	**72%**	**1176**	**28%**

Table 1

5. Mean and median pay by gender

5.1 Graph 1 demonstrates across all three years that men consistently earn more than women on average. The narrowing of the gap in 2023/24 reflects the targeted interventions aimed at improving gender equity. The slight increase in 2024/25 indicates that those measures were insufficiently sustained and offset by other structural factors such as part-time workers and medical and dental staff being the highest paid staff group with more men staff in this reporting period compared 23/24.

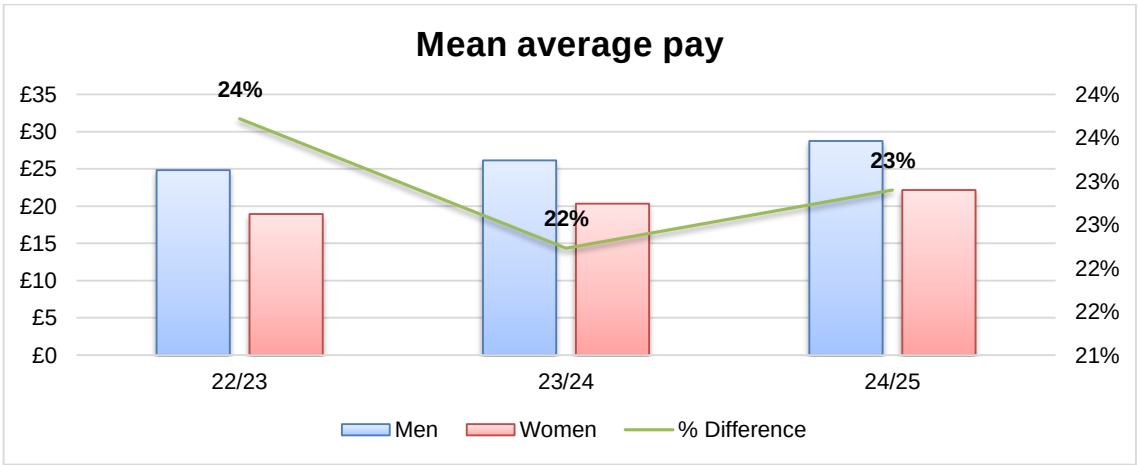


Chart 1

5.2 Graph 2 shows that both men and women saw pay increases, but men's grew faster, causing the gap to increase. The gap was stable at 13% for two years, but then jumped to 16%, indicating a structural concern as per previous paragraph.

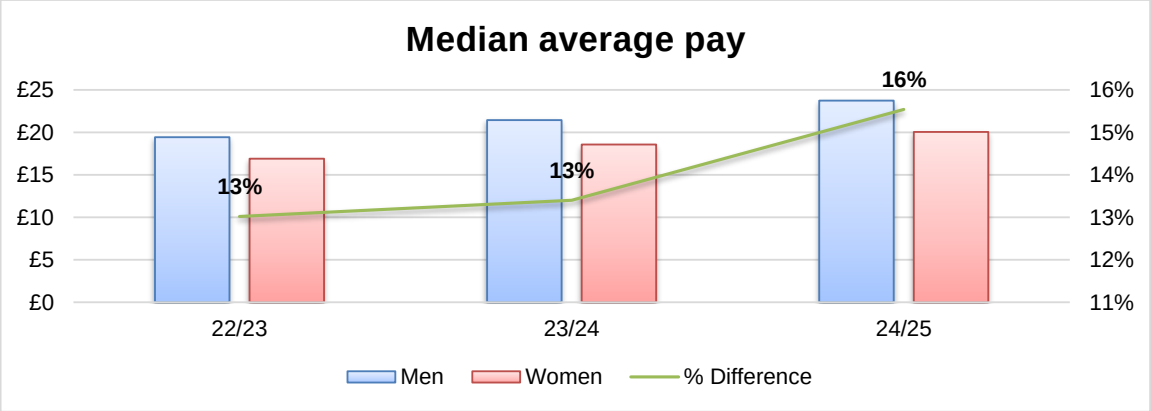


Chart 2

5.3 Tables 2, 3 and 4 give a clear separation of medical and dental staff group when compared to Agenda for Change (AFC) pay bands (including very senior managers - VSM) for this reporting period as at 31st March 2025.

AFC &VSM	Mean Hourly Rate	Median Hourly Rate
Men	£20.68	£17.98
Women	£20.56	£19.59

Table 2

M&D only	Mean Hourly Rate	Median Hourly Rate
Men	£43.44	£40.41
Women	£39.14	£34.95

Table 3

Summary of Overall Pay Gap		
Gender	**Mean Hourly Rate**	**Median Hourly Rate**
Male	£28.74	£23.74
Female	£22.16	£20.05
Difference	£6.58	£3.69
Pay Gap %	**23%**	**16%**

Table 4

6. Mean and median bonus pay gap

6.1 For the purposes of this report, bonuses are exclusively made up of local and national consultant clinical excellence awards (CEA), discretionary points and welcome bonus payment for our international nurses and allied health professionals.

6.2 Charts 2 and 3 show the mean and median bonus pay amount as a percentage between men and women, while charts 4 and 5 show welcome bonus and CEA by headcount. Whilst reviewing the data the decrease in median bonus pay to women and increase in median bonus to men, is due to the reduced number of welcome bonus paid to women staff from 149 in the last reporting

to 18 in this reporting period. In addition the NHS has a structural concern in relation to CEA's being mostly granted to men, due to the nature of the process. The pattern indicates a participation and size inequality. Women's bonus distribution remains highly skewed – more small awards, fewer mid-large awards – even though a subset received significantly higher bonus in 24/25.

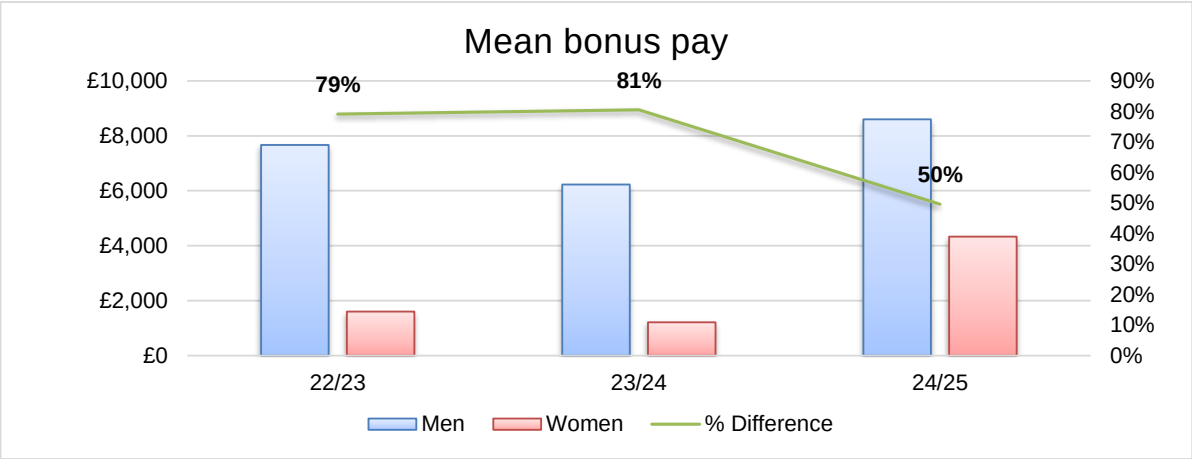
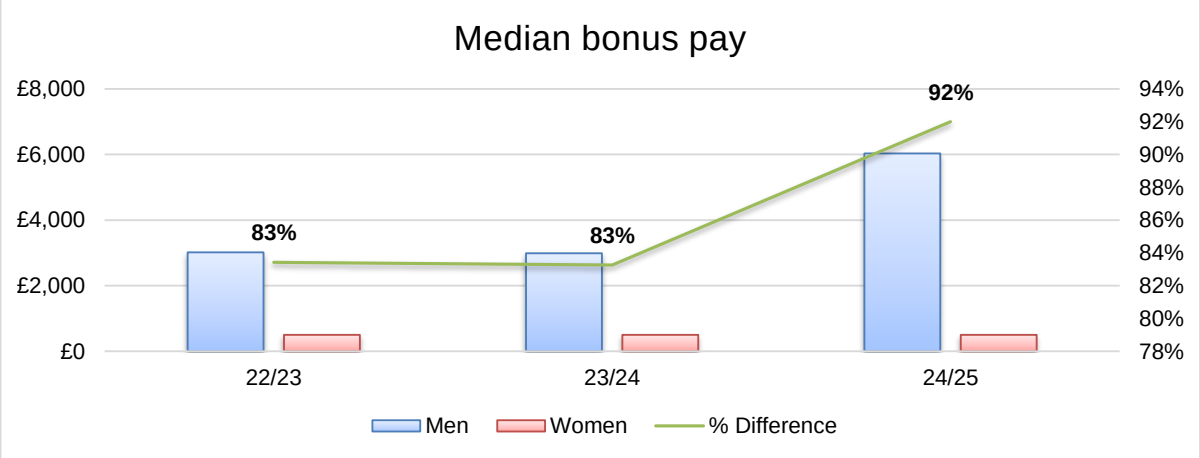


Chart 2



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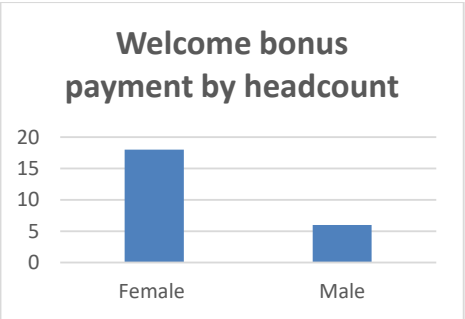


. Chart 4.

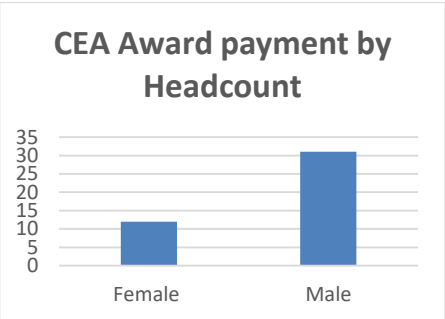


Chart 5

7. Pay distribution by quartiles

7.1 Chart 6 shows the proportion of employees by disability status in each quartile, this is calculated based on total pay and not banding or grade.

7.2 Staff are allocated into each quartile based on their hourly rate of pay and does not differentiate full time from part-time hours – it only considers salary paid and banding.

7.3 Lower quartile is our lowest pay quartile, and upper quartile is our highest pay quartile as per the requirement. Job roles included in each quartile are as follows:

- Lower quartile – roles include domestics porters, HCA and clerical staff
- Lower middle quartile – roles included staff nurse
- Upper middle quartile – roles include manager, F1, F2 doctors and specialists
- Upper quartile – consultants, senior managers, heads of service and directors

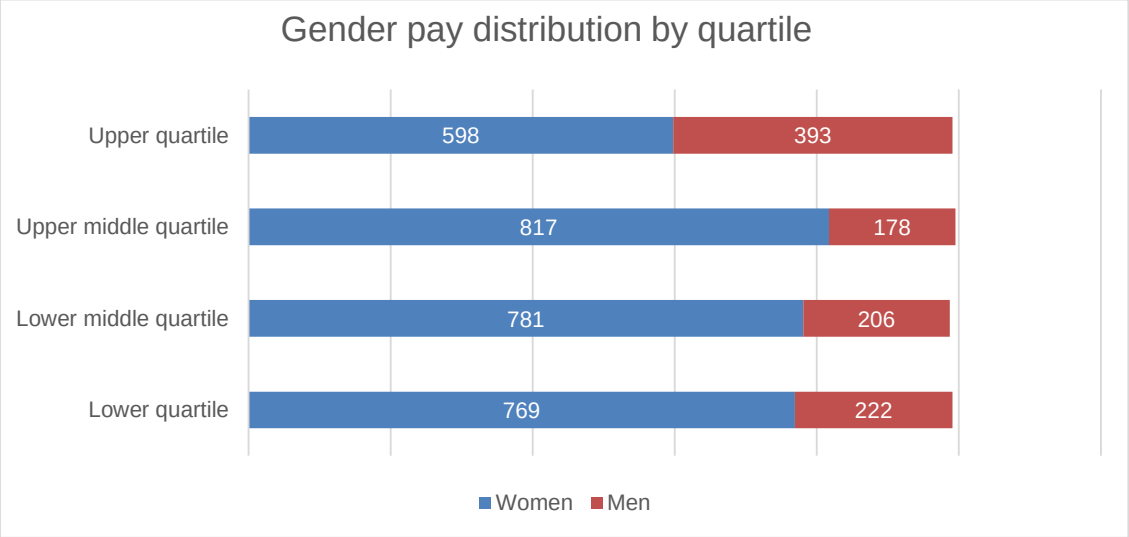


Chart 6

7.4 Table 5 provides the corresponding number of staff on each category according to their banding – Agenda for Change and Very Senior Manager framework and Table 6 provides the corresponding number of staff on each category for Medical and Dental terms and conditions.

Pay Bands	Female	%	Male	%
Band 1	12	86%	2	14%
Band 2	404	72%	154	28%
Band 3	503	83%	106	17%
Band 4	228	85%	40	15%
Band 5	658	84%	125	16%
Band 6	489	85%	84	15%
Band 7	328	82%	72	18%
Band 8 - Range A	149	81%	34	19%
Band 8 - Range B	51	76%	16	24%
Band 8 - Range C	14	64%	8	36%
Band 8 - Range D	14	67%	7	33%
Band 9	9	64%	5	36%
NED	5	50%	5	50%
VSM	3	38%	5	63%
Grand Total	**2867**	81%	**663**	19%

Table 5

Grade	Female	%	Male	%
Foundation Year 1	27	49%	28	51%
Foundation Year 2	30	58%	22	42%
Specialty Registrar	66	55%	55	45%
Trust Grade	33	38%	55	63%
Career Grade Doctor	31	33%	64	67%
Consultant	83	38%	133	62%
Grand Total	**270**	43%	**357**	57%

Table 6

8. Conclusion

8.1 The gender pay gap within the Trust is not due to unequal pay for the same role but is driven by role distribution and progression disparities. Women dominate lower-paid AfC bands, while men hold a greater share of senior clinical and managerial positions. Closing the gap requires targeted action on career progression, leadership development, and flexible working opportunities, particularly for women in mid-bands and medical grades.

8.2 Our vision is to close the gender pay gap between women and men. It's important to note the gender profile of men in our trust has increased from 23% in March 2024 to 25% in March 2025.

8.3 Whilst we are committed to flexible working and this is an opportunity we continue to promote, this trend highlights the need to address career progression for part-time staff. The bonus pay gap is driven by recruitment trends (fewer welcome bonuses for women). AfC pay bands show narrow gaps, suggesting structural pay equality within standard roles, but leadership roles skew the overall picture.

8.4 In our EDI Strategy & Delivery Plan we have set out our ambition to close the gender pay gap. The activity to address the mean and median gender pay gap for women in the senior roles within medical and dental is the action plan. As the gap is driven by senior leadership concentration of men, not by AfC pay structure, we are implementing the recommendations from the Mend the Pay Gap report. Our aim is to create equality of opportunity for women at PAHT, this commitment is not just about compliance as it reflects our vision for women at every level.

9. Recommendations

9.1 Board is requested to discuss this paper and approve for publication.

9.0 Action Plan

Area and Objective	Action	Outcome and impact	Lead	Timescales	Where will this be reported / monitored
To Reduce the Gender Pay Gap	Rollout de-biased recruitment tool kit to line managers at the beginning of the recruitment process.	Recruiting managers are more aware of gender biases Toolkit available on Alex net	Head of People – Recruitment & Retention	Dec-25	People Committee
	Develop coaching /mentoring schemes for women to build skills and encourage development in line with NHS programmes	Female employees are confident to explore and apply for more senior roles	Head of OD & Learning	Dec-25	People Committee
	Introduce women's networks to develop peer support across the organisation	Employees are confident they can receive guidance on progressing within their careers	Head of EDI	Dec-25	People Committee
	Leadership pipeline development for women working full and part-time through succession planning and talent management	To increase the number of senior women in the upper quartile	Head of OD & Learning	Sept-26	People Committee
	Promote talent development programmes to ensure that we have a pipeline of qualified and skilled female employees who feel confident and motivated to apply for promotion and be successful when applying for more senior roles.	Increase the proportion of female staff in upper pay quartile.	Head of OD & Learning	Dec-25	People Committee
	Review the Mend the Gap recommendations and assess which ones are applicable to our Trust:	Address the gender pay gap and bonus in medical.	Chief medical Officer & Head of EDI	Dec- 2026	People Committee

	Theme 1 - Address structural barriers to the career and pay progression of women Theme 2 - Make senior jobs more accessible to more women Theme 3 - Introduce increased transparency on gender pay gaps Theme 4 - Mandate changes to policy on gender pay gaps Theme 5 - Promote behaviour and cultural change – national conversation Theme 6 - Review clinical excellence and performance payments and change accordingly Theme 7- Implement a programme for continued and robust analysis of gender pay gaps				

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

5.4

Agenda item:	5.4
Presented by:	Giovanna Leeks, Chief People Officer
Prepared by:	Nathaniel Williams, People Information and Systems Lead, and Arleen brown, Head of Equality Diversity and Inclusion
Date prepared:	9 October 2025
Subject:	Ethnicity Pay Gap Reporting 2024 – 2025

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	**Workforce Composition**: Minority Ethnic (ME) staff: **46%**; White staff: **51%;** Not stated: **3%** **Overall Ethnicity Pay Gap**; **Mean gap**: **-14.69%** (in favor of ME, approx. £3.26) **Median gap**: **-20.32%** (in favor of ME, approx. £3.71) • Overrepresentation of ME on B5s with data suggestion a possible concern around promotion and progression • Under representation at entry level suggesting a possible labor market dynamic • Overrepresentation of ME under Medical and Dental terms and conditions
Recommendation:	For discussion and approval for publication

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

Previously considered by:	People Committee – November 2025
Risk / links with the BAF:	2.1 Staff engagement and morale
Legislation, regulatory, equality, diversity and dignity implications:	NHSE EDI Improvement Plan
Appendices:	Appendix 1 - Ethnicity Pay Gap Actions 2025- 2026

1.0 Introduction

1.1 The National Health Service (NHS) is one of the largest employers in the United Kingdom, with a workforce that reflects the diversity of the nation it serves. Despite this diversity, evidence suggests that disparities in pay persist across ethnic groups within the NHS. The ethnicity pay gap—defined as the difference in average hourly pay between employees from different ethnic backgrounds—has become an increasingly important issue in the context of equality, diversity, and inclusion. Addressing this gap is not only a matter of fairness but also critical for fostering trust, improving staff morale, and ensuring the NHS remains an exemplar of equitable employment practices.

1.2 This paper explores the current state of the ethnicity pay gap within The Princess Alexandra Trust (PAHT), examining the data, implications for workforce equality, and the steps being taken to address it. By analysing available data and policy initiatives, the discussion aims to highlight both progress and challenges, while considering the broader social and organizational impact of pay disparities. Ultimately, understanding and closing the ethnicity pay gap is essential for achieving the NHS's commitment to equality and for delivering high-quality care in a truly inclusive environment.

2.0 Background and Context

2.1 The NHS was founded on principles of universal access and equality, but workforce equality has evolved over decades. Early diversity initiatives focused on recruitment and pay equity became a formal agenda much later, influenced by the Equality Act 2010, which provided the legal basis for tackling discrimination, including race and ethnicity.

2.2 The ethnicity pay gap reporting remains voluntary, creating inconsistencies in transparency. At PAHT we understand the value of transparency, and we aim to reduce inequality across the board, through all our policies and practical steps. It is also included in our plan for the NHS High Actions Improvement Plan 2023.

2.3 NHS People Plan and Workforce Race Equality Standard (WRES) are key initiatives aimed at improving representation and reducing disparities. Pay gaps impact morale, retention, and progression opportunities, it undermines the NHS's commitment to equality and can affect patient care indirectly through workforce dissatisfaction.

3.0 Terminology and how to read the data

- **Mean ethnicity pay gap** – the difference between the mean (average hourly earnings, excluding overtime) of relevant staff from different ethnic backgrounds
- **Median ethnicity pay gap** – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of relevant staff from different ethnic backgrounds
- **Mean bonus gap** – the difference between the mean bonus paid to staff from different ethnic backgrounds (bonus pay exclusively made up of local and national consultant clinical excellence awards, discretionary points and the welcome bonus for our international Nurses)

- **Pay distribution by ethnicity**– the proportion of relevant staff in the lower, lower middle, upper middle and upper quartile pay bands by ethnicity

3.1 How to read the data:

- A positive percentage (e.g. 1.0%) indicates that white employees have higher ordinary pay or bonuses than ethnic minority employees.
- A negative percentage (e.g. -1.0%) indicates that ME employees have higher ordinary pay or bonuses than white employees.

4.0 Ethnicity Profile of the Trust

4.1 The table and chart shows the ethnicty profile for all staff employed at PAHT as at March 2025.

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

Ethnicity	Headcount	%
BME	1901	46%
Not Stated	115	3%
White – British & white other	2141	51%
Grand Total	**4157**	

Table 1

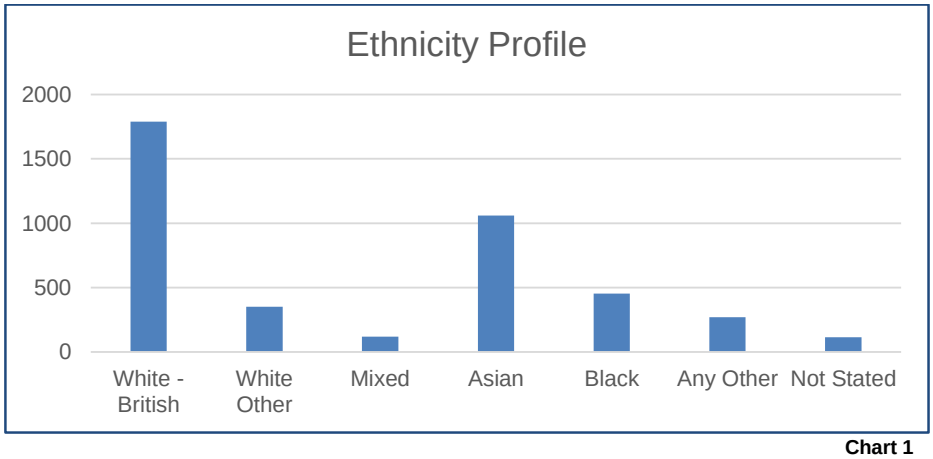


Chart 1

5.0 Mean and Median Basic Pay by Ethnicity

5.1 Table 2 provides the overall mean ethnicity pay gap between ME and white staff is -14.69% (in favour of ME) and median pay gap is -20.32% (in favour of ME).

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	25.42	21.94
Not Known	28.4	23.07
White	22.16	18.23
Diff White - BME Gap	-14.69%	-20.32%
Diff White - BME Gap	-£3.26	-£3.71

Table 2

5.2 Table 3 provides the corresponding number of staff within each ethnic group by pay band or grade excluding medical and dental staff.

Band/Grade	BME	White	Not Stated	Grand Total
Band 1	2	10	2	14
Band 2	175	366	17	558
Band 3	192	404	13	609
Band 4	39	226	3	268
Band 5	573	200	10	783
Band 6	259	300	14	573
Band 7	129	259	12	400
Band 8 - Range A	55	124	4	183
Band 8 - Range B	20	45	2	67
Band 8 - Range C	4	17	1	22
Band 8 - Range D	3	17	1	21
Band 9	3	11	0	14
VSM	1	7	0	8
NED	4	5	1	10
Grand Total	1459	1991	80	3530

Table 3

5.3 Table 4 illustrates the ethnicity pay gap breakdown for medical and dental staff only. Mean gap: 7.75% (in favor of White) Median gap 11.15% (in favour of white).

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	40.55	36.53
Not Known	44.24	45.29
White	43.96	41.12
Diff White - BME Gap	7.75%	11.15%
Diff White - BME Gap	£3.41	£4.59

Table 4

5.4 Table 5 provides the corresponding number of staff under medical and dental only within each ethnic group by pay grade.

Band/Grade	BME	White	Not Stated	Grand Total
Foundation Year 1	40	12	3	55
Foundation Year 2	38	12	2	52
Specialty Registrar	80	38	3	121
Trust Grade	71	10	7	88
Career Grade Doctor	78	13	4	95
Consultant	135	65	16	216
Grand Total	442	150	35	627

Table 5

6.0 Mean and median bonus pay by ethnicity (Medical and Dental Terms and conditions and international nurses)

7.1 Chart 3 illustrates the international nursing scheme that PAHT run during the last year, which was only applicable to ME staff.

7.2 Chart 4 illustrates the CEA payments, demonstrating that ME staff had favourable payments when compared to white staff.

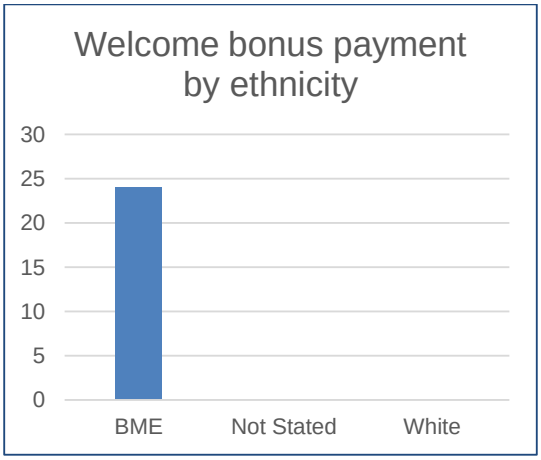


Chart 3

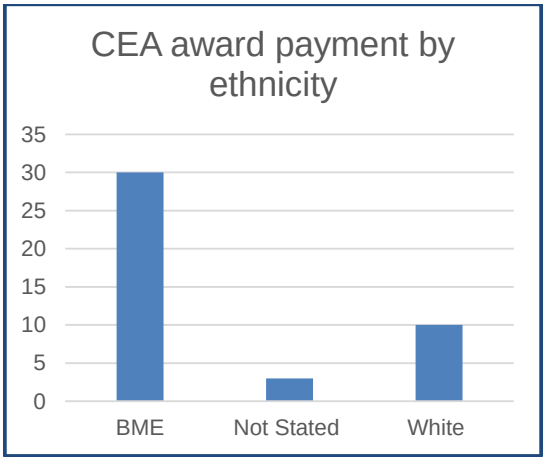


Chart 4

7.0 Pay distribution by ethnicity

6.1 Chart 2 shows the proportion of ethnic staff in each quartile.

6.2 Staff are allocated into each quartile based on their hourly rate of pay and does not differentiate full time from part-time hours – it only considers salary paid and banding.

6.3 Lower quartile is our lowest pay quartile, and upper quartile is our highest pay quartile as per the requirement. Job roles included in each quartile are as follows:

- Lower quartile – roles include domestics porters, HCA and clerical staff
- Lower middle quartile – roles included staff nurse
- Upper middle quartile – roles include manager, F1, F2 doctors and specialists
- Upper quartile – consultants, senior managers, heads of service and directors

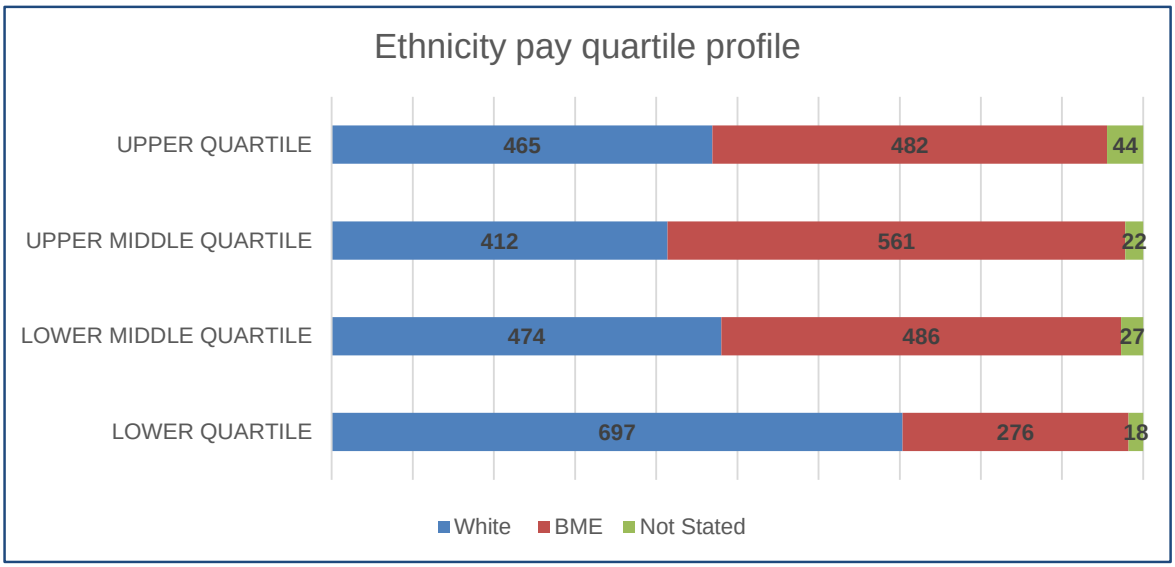


Chart 2

8.0 Patterns and insights

8.1 The data from PAHT clearly shows a concentration of ME representation at Band 5 roles at 73.2% which far exceeds Trust average (41.3%). That indicates a strong presence of ME in roles such as nursing, which is not surprising given the international recruitment drive for the past few years.

8.2 However, what the data also points out to is that without proportionate progression into Bands 6-7 and beyond, this concentration may signal a progression bottleneck.

8.3 Analysing ME concentration at Band 6 (45.2%), which is slightly above overall average, suggest partial progression from Band 5.

8.4 However when looking at Band 7 (32.3%) the data dips below average, pointing to the limited transition into first-line leadership or specialist posts.

8.5 at Higher bands (8A-9) the representation ranges between 12-30% and at VSM is 12.5% which indicates structural barriers to senior leadership roles for our ME staff.

8.6 We also may have a possible concern around our entry-level (Band 1-4) as it ranges around 14-15% suggesting that either, role-type allocation, or labour market/recruitment dynamics are affecting entry level representation. Considering most of our staff are Harlow home-based, and the composition of the population/community around Harlow is 83% white, it may be labour market dynamics around the postcode.

8.7 There is also a clear over representation of ME under medical and dental terms and conditions driven by the labour market. However, despite over representation, there is still a pay gap favouring white staff.

9.0 Conclusion

9.1 Our efforts to address the ethnicity pay gap will require a focus on a few factors. The role of bias shapes on who gets promoted, training opportunities and career outcomes.

9.2 To ensure equality of opportunity for ME staff and increasing representation in the upper quartiles, we will:

- Review our current practices;
- Monitor opportunities for promotion;
- Promote career progression routes;
- Provide leadership training and targeted professional development;
- Target succession planning;
- Implement the NHS debias recruitment programme targeting ME staff;
- Introduce mentorship programmes.

9.3 Appreciating that there is still work to be done to eliminate those systemic barriers and ensure that pay and career advancement are fair for all ME groups.

9.4 Our EDI Strategy & Delivery Plan features the East of England (EoE) Anti -racism Strategy, that sets out the work we are doing to address the activity mentioned above in tackling discrimination, to create equity and equality of opportunity for ME staff.

9.5 Our ambition is to create an inclusive culture that fosters diversity of thought and experience**.**

9.6 To achieve equity, ME staff must have opportunities to progress to senior posts**,** proportionate to their representation in the Trust and we will aim to achieve that through our policies and action plan (Appendix 1)

10.0 Recommendation

10.1 Board is requested to discuss this paper and approve for publication.

Appendix 1
Ethnicity Pay Gap Actions 2025- 2026

Area and Objective	Action	Outcome and impact	Lead	Timescales	Where will this be reported / monitored
To improve the underrepresentation of BME staff in non-clinical senior managers posts band C to VSM.	Provide a clear brief to recruitment consultants and executive search firms	More diverse candidate shortlists to improve representation of BME staff in the non-clinical roles.	Head of People – Recruitment & Retention	On going	Divisional Resourcing meetings
	Implementing fair and inclusive practices across all HR employee relation processes and	Ensure a fair recruitment process for BME Staff.	Head of People – Recruitment & Retention	On going	

	implement NHSE De bias Recruitment practices.				
	Enhance communications to Staff for Trust's Ready-to-Manage, Coaching, ICB and NHS Leadership Academy Programmes.	Employees are given equal access to development programmes for career progression. Promotion of NHS development programmes that are tailored to minority groups.	Head of OD & Learning	On going	People Committee
	Monitor the outcomes of WRES Action Plan – recruitment, training, promotion discrimination, bullying and harassment.	WRES actions are having a positive improvement on the progression of BME Staff.	Head of EDI	On going	People Committee
	Monitor outcomes form the from the EoE Anti- racism Strategy	Activity to address systemic racism is having a positive effect in addressing barriers for BME staff.	Head of EDI	On going	People Committee
	Through the REACH staff networks run focus groups to monitor feedback on perceptions of career progression and promotion amongst BME staff.	Increase employee knowledge and confidence with regards to access to development programmes, career paths and opportunities.	Head of EDI Chair of the REACH Staff Network	April 2026	People Committee

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

5.5

Agenda item:	5.5
Presented by:	Giovanna Leeks, Chief People Officer
Prepared by:	Nathaniel Williams, People Information and Systems Lead, and Arleen brown, Head of Equality Diversity and Inclusion
Date prepared:	9 October 2025
Subject:	Disability Pay Gap Reporting 2024 – 2025

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

Key issues:	**Workforce Composition**: Disable staff: **4%**; Non-disable staff: **75%;** Not stated/not declared: **21%** **Overall Disability Pay Gap:** **Mean gap**: **9%** (in favor of non-disable, approx. £2.17) **Median gap**: **4%** (in favor of non-disable, approx. £0.94) Our Electronic Staff Record (ESR) data indicates that 4% of staff have formally declared a disability. In contrast, findings from the 2024 Staff Survey suggest a significantly higher proportion, with 23% of respondents (based on a 49% response rate) identifying as having a disability or long-term condition.
Recommendation:	For discussion and approval for publication

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

Previously considered by:	People Committee – November 2025
Risk / links with the BAF:	2.1 Staff engagement and morale
Legislation, regulatory, equality, diversity and dignity	NHSE EDI Improvement Plan
Appendices:	Appendix 1 - Disability pay Gap Action Plan

1.0 Introduction

1.1 The National Health Service (NHS) is committed to fostering equality, diversity, and inclusion across its workforce. However, persistent disparities in pay among employees with disabilities remain a significant challenge. The disability pay gap refers to the difference in average earnings between staff who identify as disabled and those who do not. This gap is not only a matter of financial inequality but also reflects broader systemic issues related to accessibility, career progression, and workplace culture within healthcare settings.

1.2 Recent analyses have highlighted that disabled employees often face barriers to advancement, limited opportunities for flexible working, and underrepresentation in senior roles. These factors contribute to a structural imbalance that perpetuates income disparities. Addressing the disability pay gap is essential for ensuring fairness, improving staff morale, and meeting the NHS's statutory obligations under the Equality Act 2010. Furthermore, closing this gap aligns with the NHS People Plan's vision of creating an inclusive environment where all staff can thrive and contribute fully to patient care.

1.3 This paper explores the extent of the disability pay gap within The Princess Alexandra Trust (PAHT), examines the data, and considers strategies for meaningful change. By understanding these dynamics, PAHT can take informed steps toward eliminating inequality and promoting a truly inclusive workforce.

2.0 Background and Context

2.1 Unlike equal pay—which is a legal requirement under the Equality Act 2010 ensuring individuals performing the same role receive the same remuneration—the pay gap reflects structural inequalities across job roles, career progression, and access to opportunities. In the NHS, this issue is particularly significant given its status as the UK's largest employer, with over 1.3 million staff and a statutory duty to promote equality and inclusion.

2.2 Nationally, the disability pay gap in the UK stood at 12.7% in 2023, meaning disabled employees earned on average £13.69 per hour compared to £15.69 for non-disabled employees. Within the NHS, early reporting suggests that while some trusts report relatively small gaps—such as a median gap of 0.49% in favour of non-disabled staff—others show significant disparities across pay bands, particularly in senior roles and specialist positions. Occupational segregation is a key driver: disabled staff are disproportionately represented in lower-banded roles, while underrepresented in leadership and clinical consultant positions.

2.3 Several factors contribute to the disability pay gap in healthcare settings:

- **Career Progression Barriers:** Disabled employees often face limited access to development opportunities and leadership roles.
- **Occupational Segregation:** Concentration in lower-paid, less secure roles due to assumptions about capability and flexibility needs.
- **Disclosure Challenges:** Many staff choose not to declare a disability, leading to incomplete data and underestimation of disparities.
- **Workplace Adjustments:** While initiatives like the NHS Workplace Adjustment Passport have improved consistency, gaps remain in implementation across trusts.

2.4 The Equality Act 2010 provides protection against discrimination and imposes a duty on employers to make reasonable adjustments for disabled staff. A person is considered disabled under the Act if they have a physical or mental impairment with a substantial and long-term adverse effect on daily activities. Although disability pay gap reporting is not yet mandatory, the NHS has committed to voluntary reporting through the Workforce Disability Equality Standard (WDES) and the Equality, Diversity and Inclusion Improvement Plan (EDI IP), which sets out actions to eliminate pay gaps by 2025.

2.5 Addressing the disability pay gap is not only a compliance issue but a strategic imperative for PAHT. Pay disparities can negatively impact staff morale, retention, and recruitment, undermining the People Plan's ambition to create a culture of belonging and inclusion. Furthermore, reducing the gap aligns with broader goals of health equity, as workforce diversity directly influences patient care quality and organisational performance.

3.0 Terminology and how to read the data

- **Mean disability pay gap** – the difference between the mean (average hourly earnings, excluding overtime) of relevant staff by disability status.
- **Median disability pay gap** – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of relevant staff by disability status.

3.1 How to read the data:

- A positive percentage (e.g. 1.0%) indicates that white employees have higher ordinary pay or bonuses than ethnic minority employees.
- A negative percentage (e.g. -1.0%) indicates that ME employees have higher ordinary pay or bonuses than white employees.

4.0 Disability Profile of the Trust

4.1 Table 1 and Chart 1 illustrate the profile of staff who have recorded their disability status within the ESR. Nevertheless, analysis undertaken as part of this year's Workforce Disability Equality Standard, supported by findings from the 2024 Staff Survey, reveals that 23% (Staff survey data based on 49% rate of responses) of our workforce self-identify as having a disability or long-term health condition.

4.2 To addresss the gap in disability status reporting we are working with the communications team and staff networks, to build a campaign to encourage staff to declare and update their disdability status. Within that campaign we aim to hear the views from satff, as to why they are reluctant to declare their status and seek to understand what would make a difference, for them to declare.

Disability status	Headcount	%
No. of non-disabled employees	3132	75%
Not declared	346	8%
Prefer not to answer	24	1%
No. of employees whose disability status is unknown	485	12%
No. of disabled employees	170	4%
Total	**4157**	100%

Table 1

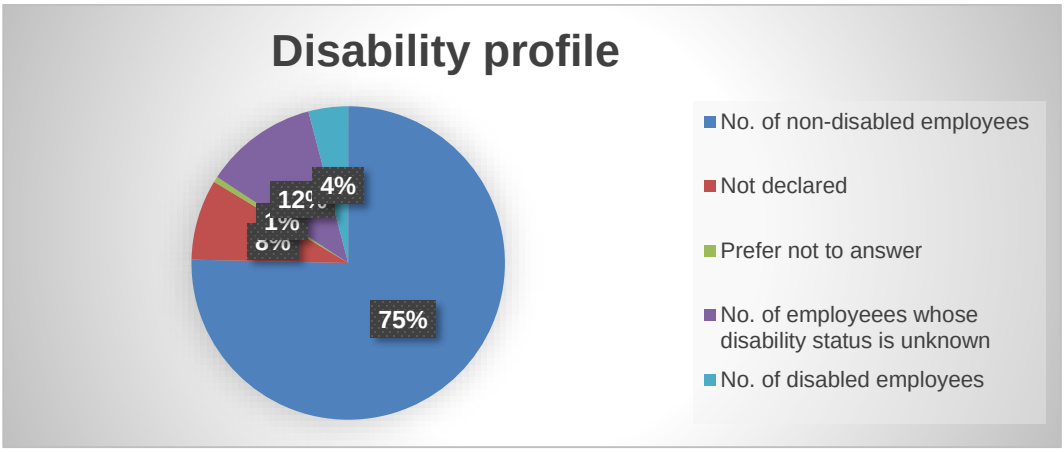


Chart 1

5.0 Mean and Median basic pay by disability profile

5.1 Table 2 illustrates the comparison of both mean and median hourly pay of staff, based on their disability status focusing on the percentage pay difference between staff that have disability and those that have declared that they do not have a disability.

5.2 An examination of hourly pay rates by disability status reveals notable disparities within our People. Staff who identify as disabled have the lowest mean hourly rate at £21.25, compared to £23.42 for non-disabled staff, representing a 9% difference.

5.3 The median hourly rate for disabled staff is £22.33, which is 4% lower than that of non-disabled colleagues.

5.4 Staff who have not declared their disability status or whose status is recorded as “unspecified” exhibit the highest pay levels, with mean rates of £25.07 and £26.40, and median rates of £26.15 and £26.96, respectively.

5.5 The mean gap is £2.17 in favour to non-disable staff, while the gap in median rates is £0.94, also in favour to white staff

Disability Grouping	Mean Hourly Rate	Median Hourly Rate
Non-disabled	£23.42	£23.27
Not Declared	£25.07	£26.15
Prefer Not to Answer	£21.38	£21.30
Unspecified	£26.40	£26.96
Yes	£21.25	£22.33
% Diff No - Yes	9.26%	4.02%

Table 2

5.6 Table 3 provides the corresponding number of staff on each category according to their banding – Agenda for Change and Very Senior Manager framework

Pay Band	Non Disabled	%	Not Declared	%	Prefer Not To Answer	%	Unspecified	%	Disabled	%
Band 1	5	36%	8	57%		0%	1	7%		0%
Band 2	412	74%	63	11%	1	0%	50	9%	32	6%
Band 3	470	77%	51	8%	4	1%	58	10%	26	4%
Band 4	181	68%	33	12%	3	1%	34	13%	17	6%
Band 5	643	82%	43	5%	2	0%	71	9%	24	3%
Band 6	409	71%	39	7%	4	1%	95	17%	26	5%
Band 7	288	72%	34	9%	2	1%	62	16%	14	4%
Band 8 - Range A	116	63%	23	13%	1	1%	29	16%	14	8%
Band 8 - Range B	54	81%	8	12%		0%	3	4%	2	3%
Band 8 - Range C	20	91%	1	5%		0%		0%	1	5%
Band 8 - Range D	16	76%	2	10%		0%	2	10%	1	5%
Band 9	12	86%	1	7%		0%	1	7%		0%
VSM	7	88%	0	0%		0%		0%	1	13%
NED	9	90%	0	0%		0%		0%	1	10%
Total	**2642**	**75%**	**306**	**9%**	**17**	0%	**406**	**12%**	**159**	**5%**

Table 3

5.7 Table 4 illustrates the analysis of pay bands for all categories, by grades, for medical and dental staff only.

Grade	Non Disabled	%	Not Declared	%	Prefer Not To Answer	%	Unspecified	%	Disabled	%
Foundation Year 1	49	89%	0	0%	3	5%		0%	3	5%
Foundation Year 2	44	85%	1	2%		0%	5	10%	2	4%
Specialty Registrar	103	85%	2	2%	3	2%	12	10%	1	1%
Trust Grade	83	94%	1	1%	1	1%	2	2%	1	1%
Career Grade Doctor	73	77%	9	9%		0%	13	14%		0%
Consultant	138	60%	27	13%		0%	47	22%	4	2%
Total	**490**	**78%**	**40**	**6%**	**7**	1%	**79**	13%	**11**	**2%**

Table 4

6.0 Pay distribution by quartiles

6.1 Chart 2 shows the proportion of employees by disability status in each quartile, this is calculated based on total pay and not banding or grade.

6.2 Staff are allocated into each quartile based on their hourly rate of pay and does not differentiate full time from part-time hours – it only considers salary paid and banding.

6.3 Lower quartile is our lowest pay quartile, and upper quartile is our highest pay quartile as per the requirement. Job roles included in each quartile are as follows:

- Lower quartile – roles include domestics porters, HCA and clerical staff
- Lower middle quartile – roles included staff nurse
- Upper middle quartile – roles include manager, F1, F2 doctors and specialists
- Upper quartile – consultants, senior managers, heads of service and directors

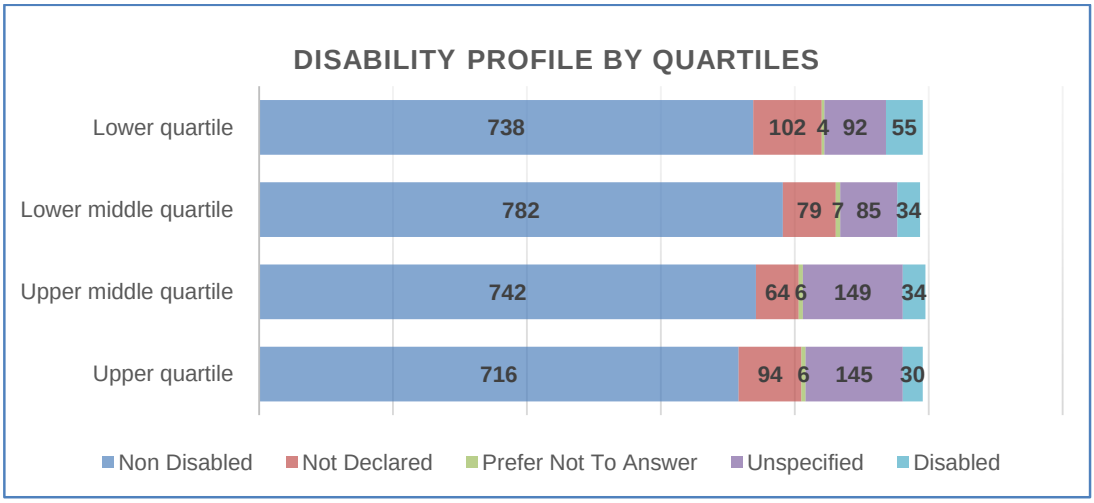


Chart 2

7.0 Conclusion

7.1 The data suggests that staff who have not declared their disability status or whose status is recorded as “unspecified” exhibit the highest pay levels, which may include individuals in senior or specialist roles, or that incomplete data may obscure the true distribution of pay.

7.2 With both median and mean pay gap being favour to non-disable staff indicate that staff who disclose a disability are concentrated in lower-paid roles, reinforcing the structural nature of the disability pay gap. While median differences are smaller than mean differences, the latter suggests that higher-paid positions disproportionately belong to staff who do not declare a disability.

7.3 These findings underscore the need for targeted interventions to improve disclosure rates, address occupational segregation, and create equitable opportunities for career advancement. Closing the disability pay gap is essential to fostering an inclusive workforce and delivering on the organisation’s commitment to equality, diversity, and fairness.

7.4 We are fully committed to the recruitment and retention of disabled staff and a full campaign to increase the disability declaration rates is in development. It is not just simply asking our staff to complete their status, but it’s about creating a psychological safe space for staff to feel confident that their individual talents will be recognised, and equality of opportunity would be afforded to them regardless of their disability.

7.5 Our aim is to deliver the ambitions in our EDI Strategy, ensuring an inclusive culture where disabled staff can express themselves and flourish. It is paramount that we engage with our disabled staff to understand their lived experience and for us to have a real understanding of our disability pay gap and the experience of disabled staff. To shift the dial and bridge the gap for disabled staff, we need to move with intent and compassion, ensuring actions are effective and measurable.

8.0 Recommendation

8.1 Board is requested to discuss this paper and approve for publication.

The Princess Alexandra Hospital NHS Trust

Appendix 1 - Disability pay Gap Action Plan

Area and Objective	Action	Outcome and impact	Lead	Timescales	Where will this be reported / monitored
To reduce the Disability Pay Gap	Implementing fair and inclusive practices across all HR employee relation processes and implement NHSE De bias Recruitment practices.	Ensure a fair recruitment process for disabled applicants.	Head of People – Recruitment & Retention	On going	Divisional Resourcing meetings
	Develop pathways for disabled staff to access senior roles.	Aid career progression to senior management.	Head of OD Learning	On going	People Committee
	Implement the recommendations in the Disabled NHS Directors Network (DNDN) Good Practice Toolkit	Recruitment and Retention of Disabled People in the NHS.	Head of People – Recruitment & Retention	On going	People Committee
	EDI training covering disability awareness and our responsibilities, including the role out of our new Reasonable Adjustment Policy. (WDES)	To create a more inclusive culture and support staff with disabilities to take up training, promotion and future job opportunities.	Head of EDI and Employee relations Manager	On going	People Committee
	Undertake a campaign with the Communications team to encourage staff to declare their disability status.	Increase employee knowledge and confidence in declaring their disability status	Head of EDI & Dawn Staff Network Chairs	December 2026 – on going	EDI Steering Group
	DAWN staff Network to encourage staff to declare their disability status and seek to understand what would make the difference to declare.	Increase employee knowledge and confidence in declaring their disability status	Head of EDI & DAWN Staff Network Chairs	March 2026	People Committee
	Launch an online resource library to further educate staff on belonging and inclusion	Improve employee engagement and retention.	Head of OD Learning	March 2026	People Committee

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27.11.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 M7 Finance Update	Y	Y	N	The Trust declared a surplus of £1.4m in M7 against a planned surplus of £1.4m and is on plan year to date. Temporary staffing spend, especially bank, remains high and is not reducing in line with NHSE targets for 25/26 with bank returning to April 24 levels. Though we are making substantive appointments, we are not seeing the drop off in bank spend and will need to focus on this for 2025/26 on. Capital is on plan with expenditure to date of £13m against a full year plan of £35.8m with anticipated increased activity in the last half of 2025/26. Cash at the end of October was £17.7m. Work was underway in relation to reducing some elements of historic debt and the risk around the Trust's share of the system planning gap was hoped to be confirmed by calendar year-end.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Operational Planning Update	Y	Y	N	Submission for first draft plans is 17.12.25 with final submission on 12.02.26. Capital allocations for the period 26/27 to 29/30 are projected to be lower by £2.4m for 26/27 than received in 25/26 but potential opportunity to bid against national funds for constitutional standards and estates safety. Next steps before submission are to prioritise schemes to remain within the allocation. The first draft revenue position is a deficit plan of £32m. This includes a PQP programme of c.5% at £21.5m.
2.3 Capital Update	Y	Y	N	PAF was taken through a slide deck relating to mid-term enablers which includes current live works. Work had commenced on the Paediatric ED upgrade and works had been agreed for the EM-SDEC corridor. The CDC was still on plan for mid-March (phased approach) and leases had been exchanged for the Phlebotomy move to the Harvey Centre. Discussions continued around the proposed site/plan for the new hospital.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27.11.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.4 PQP Update	Y	Y	N	The £26.1m PQP target for 2025/26 represented a significant delivery challenge but YTD to M7 the Trust had achieved its PQP target of £13.42m. In M7 there was a partial over-delivery which was an improvement on M6.

2.5 Quarterly Procurement Update				The report covered Q2 of FY25/26 and key headlines were: • Baseline savings target for HWE ICS is £7.6m. Savings forecast in Q2 FY25/26 is £9.76m across the ICS with PAHT Q2 savings forecast at £2.27m against baseline target of £1.59m. • FY25/26 budget approved 14th March 2025 and overall operational performance continues to be strong. • IMS roll out plan for wards developed with an aim to start of January 26; noting that Endoscopy, Radiology and Theatres were already completed. • Commercial Strategy developed and embedded by April 26. • Compassionate Leadership session held with Senior Leadership Team to share practices across the department. • ICS wide Surgical Procurement Group Terms of Reference developed with go-live in December 25. • Cluster ICB workplans shared and projects for collaboration being considered. • Team shortlisted for two National awards at HCSA. It was agreed to focus on the benefits of the rollout of the new Inventory Management System in the next Capital Update to PAF and to also focus on contract renewals/wider procurement as PAHT moves to the wider Essex ICB – this will be discussed in January 2026 .
2.6 BAF Risk 5.1 (Finance)				In line with the recommendation, it was agreed that the risk score would remain at 16.
3.1 Health & Safety Update	Y	Y	N	The team is working on many initiatives around improving the H&S infrastructure including recruitment and investment in new installations such as new fire panels. A reduction in the fire risk score of 15 has been discussed but a final call will need to be held with the Authorising Engineer who is on leave until mid-December. A senior fire safety officer has recently been appointed and due to start around February.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27.11.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				Water safety on Winter Ward is being monitored and pipework replacement is required. Ventilation system improvements have also been identified and there is a programme of works to ensure upgrades are achieved. Collaborative work with Harlow College to secure new colleagues/apprentices was commended and is being showcased more widely.
3.2 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 for the estate given the condition of the building and on-going pressures; however it was noted that there are significant improvement works that are being undertaken.
4.1 M7 Integrated Performance Report	Y	Y	N	PAF received an update on the plans for the revised IPR format. Key headlines were a large increase in complaints, (linked to long waits) and a worsening trend in ambulance handovers. In contrast there had been an improvement in ED 4-hour performance. The Trust's position nationally in terms of performance against the 28 day faster diagnosis standard had improved (and was now middle of the pack). The Trust remained an outlier for RTT (18 week) performance.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27.11.25**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
4.2 Access Performance Report	Y	Y	N	Key headlines were: **Alert Measures:** • DM01 and RTT 65+ weeks / 52+ 1st OPA booked off forecast, requiring 1) Urgent validation of reporting output 2) Specialty-level recovery planning and 3) Accelerated booking activity. • Endoscopy DM01 data accuracy is a critical dependency for performance recovery. **Advise Measures:** • Cancer 62-day and RTT incomplete pathways show improvement due to 1) Additional capacity 2) Validation resource and 3) Strengthened PTL governance. • Urgent and Emergency Care performance is stabilising with 1) Winter actions underway 2) EMSDEC redesignation and 3) GP streaming implementation **Assured Measures:** • Improved performance across 1) Cancer 31-day and 28-day FDS standards 2) A&E 4-hour performance and 3) Diagnostics (MRI, CT, Echocardiography). All showing consistent improvement and on-track compliance trajectory.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 2025**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27.11.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.3 BI/Informatics Team Resourcing Update	Y	Y	N	The current backlog and resource constraints in the Informatics team are limiting the team's ability to provide timely and comprehensive support to the organisation. Without intervention, the backlog will continue to grow and delay critical reporting delivery. The current list has been prioritised with the services focussing on clinical needs and the risk is being mitigated and managed. Given the ongoing difficulty in recruiting and retaining staff with Qlik Sense expertise, it was proposed that the organisation transitions to a different business intelligence and reporting platform. A business case will be presented to PAF in due course.
4.4 Dark Trace 6 Monthly Update	Y	Y	N	Over the past six months Darktrace has continued to deliver substantial security benefits to the organisation.
4.5 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.
4.6 BAF Risk 1.4 (EHR)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
4.7 BAF Risk 1.5 (Cyber)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.

The Princess Alexandra Hospital NHS Trust

Trust Board – 11 December 2025

Agenda item:	6.2								
Presented by:	Tom Burton, Chief Finance and Infrastructure Officer and Interim Deputy Chief Executive Officer								
Prepared by:	Beth Potton, Interim Operational Director of Finance								
Date prepared:	24 November 2025								
Subject / title:	Month 7 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 surplus of £1.4m in month 7 of 25/26 against a planned surplus of £1.4m. The Trust is on plan year to date at £0.9m deficit. Temporary staffing especially bank remains high and not reducing in line with NHSE targets for 25/26 with bank returning to April 24 levels. The Trust had a PQP target of £2.2m in month 7 which was fully delivered, the PQP plan is therefore on plan at £13.4m YTD. Capital is on plan with expenditure to date of £13m against a full year plan of £35.8m. Cash at the end of October was £17.7m .								
Recommendation:	The Board is asked to note the month 7 financial position.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	X	**X**	**X**	**X**	**X**				

Previously considered by:	n/a
Risk / links with the BAF:	BAF risks 5.1.
Legislation, regulatory, equality, diversity, and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

October - Month 7

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a surplus of £1.4m in month 7 of 25/26 against a planned surplus of £1.4m, this is a positive continuation of achievement of the plan from the start of the financial year, with PQP delivering in month and YTD.

- MARS payments were made in month of £0.4m which were mitigated by the release of a central provision. There are still MARS payments of £0.1m to be made of which will be partially offset from savings on the vacant posts in future months. The overall impact of MARS by the year end will be a cost pressure of £0.2m.

- Non-pay costs remain high, £2.0m overspent in month, £0.8m of this is offset by income with the remainder relating to high engineering, building and maintenance costs, front door ED pilot and winter test costs and unachieved PQP delivery (which is being offset by additional savings on pay).

- 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 M7 this has not been achieved so far, this financial year. Agency costs have also increased in the last three months.

- The Trust had a PQP target of £2.2m in month 7 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.

- The capital plan for 25/26 is £33.1m with expenditure to date of £13m. The current capital forecast is for an overspend of £2.8m due to schemes including Phlebotomy Services and EHR. Work is ongoing to mitigate the overspend by the year end. The Trust continues to bid for new capital funding throughout the year with success in securing funding for additional clinical equipment and diagnostic equipment.

Summary financial results

The Princess Alexandra Hospital NHS Trust

	FY Budget £'m	Oct-25 Budget £'m	Oct-25 Actual £'m	Oct-25 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	411.1	35.5	36.8	1.3	240.2	243.0	2.8
Pass through Income	20.3	1.7	1.8	0.1	11.8	11.6	(0.2)
Income Total	**431.4**	**37.2**	**38.6**	**1.3**	**252.0**	**254.6**	**2.6**
Pay							
Substantive	(276.0)	(22.9)	(20.4)	2.5	(161.3)	(145.1)	16.2
Bank	(7.1)	(0.6)	(2.3)	(1.7)	(4.1)	(17.1)	(12.9)
Agency	(3.3)	(0.5)	(0.5)	(0.1)	(2.0)	(2.6)	(0.5)
Pay Total	**(286.4)**	**(24.0)**	**(23.2)**	**0.8**	**(167.4)**	**(164.7)**	**2.7**
Non-Pay							
Drugs & Medical Gases	(11.5)	(0.9)	(0.8)	0.1	(6.4)	(5.8)	0.6
Pass through expenditure	(20.7)	(1.7)	(2.0)	(0.2)	(12.1)	(11.9)	0.2
Supplies & Services - Clinical	(14.3)	(1.1)	(1.5)	(0.4)	(8.3)	(10.7)	(2.3)
Supplies & Services - General	(6.3)	(0.5)	(0.4)	0.1	(3.6)	(3.0)	0.7
All other non pay costs	(69.3)	(5.6)	(7.1)	(1.5)	(41.6)	(46.0)	(4.4)
Non-Pay Total	**(122.0)**	**(9.9)**	**(11.8)**	**(1.9)**	**(72.0)**	**(77.3)**	**(5.4)**
Financing & Depn							
Depreciation	(17.8)	(1.5)	(1.7)	(0.2)	(10.4)	(10.8)	(0.4)
PDC & Interest	(5.5)	(0.5)	(0.4)	0.0	(3.2)	(2.9)	0.3
Financing & Depn Total	**(23.3)**	**(1.9)**	**(2.2)**	**(0.2)**	**(13.6)**	**(13.6)**	**(0.0)**
Total	**(0.3)**	**1.4**	**1.4**	**(0.0)**	**(1.0)**	**(1.1)**	**(0.0)**
Technical Adjustment	0.3	0.0	0.0	(0.0)	0.2	0.2	(0.0)
Grand Total	**0.0**	**1.4**	**1.4**	**(0.0)**	**(0.9)**	**(0.9)**	**(0.0)**
Non recurrent system transformation funding	(15.1)	(1.3)	(1.3)	0.0	(8.8)	(8.8)	0.0
Non recurrent deficit support funding	(5.3)	(0.4)	(0.4)	0.0	(3.1)	(3.1)	0.0
Non recurrent efficiency	(6.9)	(0.6)	(0.6)	0.0	(4.0)	(4.0)	0.0
25/26 Underlying position	**(27.2)**	**(0.8)**	**(0.8)**	**(0.0)**	**(16.7)**	**(16.8)**	**(0.0)**

The income plan for the year includes deficit support funding of £5.3m. There is a further £15m income assumption based on delivery of system efficiency and required to achieve break-even which is included within the plan.

For M7 £11.8m (7/12th of the total) has been included in the budget along with assumed income to match whilst system efficiencies are identified.

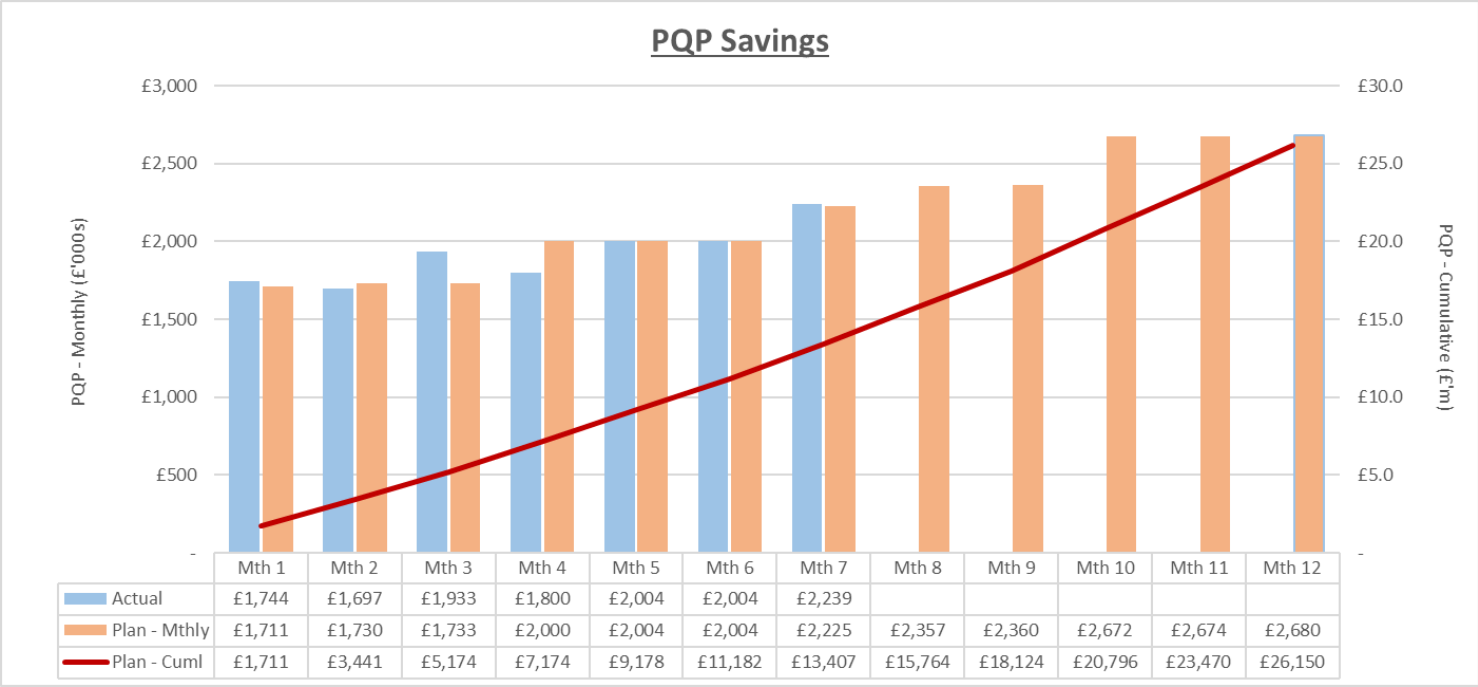
The 25/26 plan includes a high proportion of non recurrent income and benefits. Although we are planning for a breakeven position in 25/26 and on track to deliver this, the underlying recurrent position is a £27.2m deficit.

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 7, the Trust delivered £2.2m PQP against a plan of £2.2m, 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. There is still an element of PQP not yet identified. 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	£2,004	£2,239					
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

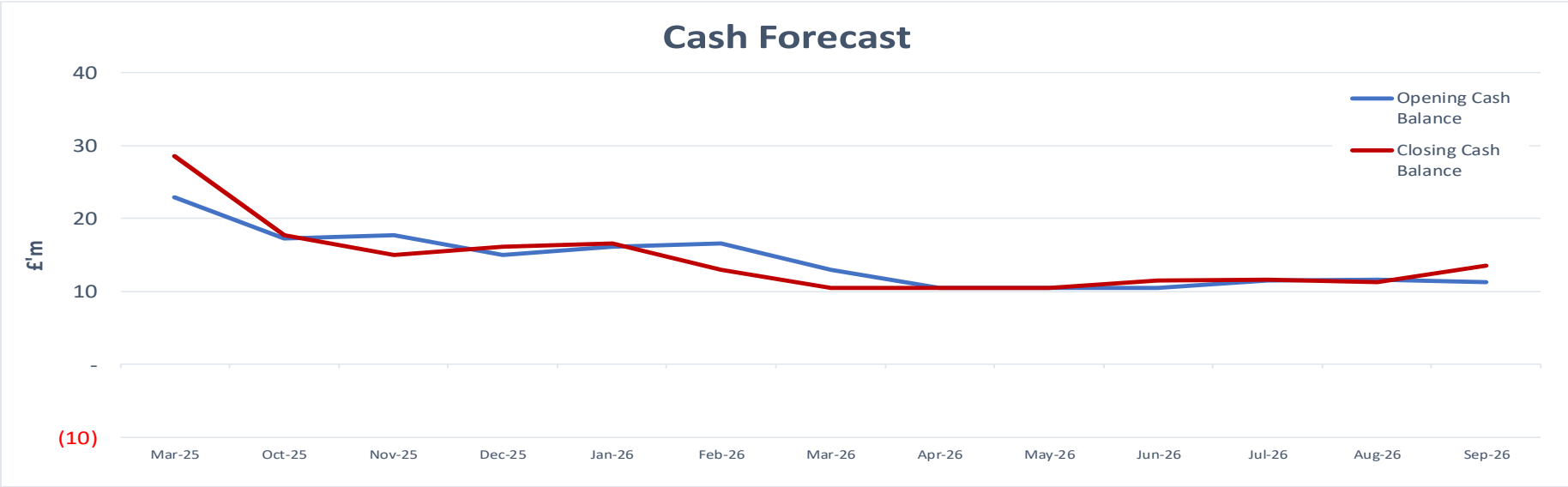
Statement of Financial Position	Mar-25	Sep-25	Oct-25	Movement In Month	Movement YTD
	£'m	£'m	£'m	£'m	£'m
Non-current assets					
Property, plant & equipment	189.1	193.7	194.1	0.5	5.1
Right of use assets	43.1	41.7	41.5	(0.2)	(1.6)
Intangible assets	32.1	30.8	31.0	0.2	(1.1)
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**265.4**	**267.2**	**267.7**	**0.5**	**2.3**
Current assets					
Inventories	4.2	4.2	4.2	-	-
Trade & other receivables	10.5	22.1	25.3	3.2	14.8
Cash & cash equivalents	28.6	17.3	17.7	0.4	(10.9)
Current assets	**43.3**	**43.6**	**47.2**	**3.6**	**3.9**
Total assets	**308.7**	**310.8**	**314.9**	**4.0**	**6.2**
Current liabilities					
Trade & other payables	(46.1)	(51.9)	(52.0)	(0.1)	(5.9)
Provisions	(1.2)	(1.2)	(1.2)	-	-
Borrowings	(2.7)	(3.2)	(3.2)	-	-
Current liabilities	**(50.0)**	**(56.3)**	**(56.4)**	**(0.1)**	**(5.9)**
Net current assets/ (liabilities)	**(6.6)**	**(12.7)**	**(9.2)**	**3.5**	**(2.1)**
Total assets less current liabilities	**258.7**	**254.5**	**258.5**	**4.0**	**0.2**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.0)	(0.9)	(0.9)	0	-
Borrowings	(40.2)	(38.9)	(38.7)	0.2	1.5
Total non-current liabilities	**(41.2)**	**(39.8)**	**(39.6)**	**0.2**	**1.5**
Total assets employed	**217.5**	**214.7**	**218.9**	**4.2**	**1.7**
Financed by:					
Public dividend capital	384.6	384.2	387.2	3	3
Income and expenditure reserve	(172.6)	(183.3)	(182.1)	-	(9.5)
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**	**214.7**	**218.9**	**3.0**	**1.4**

- Non-Current Assets PPE has increased by £0.5m and is due to Non-Residential & P&M AUC additions. A decrease of £0.2m in ROU assets is mainly due to ROU depreciation charge during the year. An increase of £0.2m in intangible assets relates to additions to the development expenditure.
- Trade and Other Receivables have increased by £3.2m and this is mainly driven by invoices raised to ICB of £0.8m, an increase in accrual for System support and Deficit support income of £1.2m and increase in accrual for patient income of £1.2m.
- Cash balance has increased by £0.4m due to the excess of supplier receipts from HSL of £0.6m, HCT of £0.1m and Compass of £0.1m, over payments made to Carlisle Ltd of £0.4m.
- Trade and Other Payables have decreased by £0.1m largely due to payments made to NHS Professionals of £2.1m, Morgan Sindall of £1.2m, offset by receipt of invoices from West Herts of £1.9m, Supply Chain of £0.8m, Vanguard of £0.4m and others £0.1m.
- Borrowings decrease represent payment of ROU lease repayment & Interest charge

Cashflow

The Princess Alexandra Hospital NHS Trust

	<----Actual---->		<----------Forecast---------->										
	Mar-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Opening Cash Balance	22,934	17,333	17,705	15,050	16,111	16,634	13,035	10,464	10,532	10,498	11,498	11,572	11,300
Closing Cash Balance	28,628	17,705	15,050	16,111	16,634	13,035	10,464	10,532	10,498	11,498	11,572	11,300	13,560



Cash balance has increased by £0.4m due to the excess of supplier receipts from HSL of £0.6m, HCT of £0.1m and Compass of £0.1m, over payments made to Carlisle Ltd of £0.4m.

Capital Analysis 25/26

	Month 7			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 Schemes	143	143	0	583	583	-	1,436	1,458	(22)
Estates BLM Schemes	249	249	0	883	883	-	1,561	1,561	-
HDU Works	-	-	-	-	-	-	-	200	(200)
Phlebotomy to Harvey refurb	-	-	-	-	-	-	-	554	(554)
CDC									
CDC	(1,734)	(1,734)	-	5,637	5,637	-	11,029	11,029	-
EHR, ICT & Info									
ICT & Information Schemes	-	(4)	4	368	364	4	-	568	(568)
EHR	182	182	-	939	939	-	770	1,867	(1,097)
Corporate									
IFRS16 Leased Assets	-	-	-	-	-	-	3,300	3,300	-
Medical									
Medical Equipment (Surgery)	9	3	5	26	20	5	-	26	(26)
Medical Software (Medicine)	-	-	-	-	-	-	21	66	(45)
Refurbishment - UTC Works Phase 1 (Medicine)	-	-	-	77	77	-	-	77	(77)
Refurbishment - SMH (CSS)	-	-	-	91	91	-	-	91	(91)
Medical Equipment (Medicine & UEC)	-	-	-	-	-	-	-	-	-
Medical Equipment (CHAWS)	-	-	-	66	66	-	-	66	(66)
Dispensing Robot (Pharmacy)	-	7	(7)	-	7	(7)	-	-	-
CRL to be allocated to plan	-	-	-	-	-	-	-	-	-
YTD Total	**(1,151)**	**(1,153)**	**2**	**8,669**	**8,667**	**2**	**18,117**	**20,864**	**(2,747)**
Externally Funded Schemes									
Fire-CIR- Compartmentation & Fire Doors	102	102	-	102	102	-	1,500	1,500	-
Electrical CIR IPS/UPS and Distribution	7	7	-	102	102	-	1,083	1,083	-
Chidrens ED	65	65	-	85	85	-	1,750	1,750	-
Phase 2 UTC Corridor Refurbishment	2	2	-	465	465	-	2,000	2,000	-
CDC	3,000	3,000	-	3,000	3,000	-	3,000	3,000	-
CDC Pathways Funding	-	-	-	-	-	-	1,883	1,883	-
NHP	35	35	-	345	345	-	2,470	2,470	-
Gamma Probe - Surgery	-	-	-	36	36	-	36	36	-
Image Intensifier - Surgery	-	-	-	65	65	-	65	65	-
Olympus Keymed CF-Q260DL ADU Endoscopy	-	-	-	-	-	-	920	920	-
Flexible Nasal Endoscopy	-	-	-	-	-	-	86	86	-
Redirooms, canopies and Proxide HPV systems	-	-	-	208	208	-	211	211	-
Wayfinder PEP NHS App - ICT	-	-	-	-	-	-	200	200	-
Estates Safety Fund	-	-	-	-	-	-	2,492	2,492	-
YTD spend on External Schemes	**3,211**	**3,211**	**-**	**4,410**	**4,410**	**-**	**17,696**	**17,696**	**-**
Total - Internal and External	**2,060**	**2,058**	**2**	**13,079**	**13,077**	**2**	**35,813**	**38,560**	**(2,747)**

Plan
Total capital funding approved by the ICS is £35.8m. Included within this is £17.7m of external funding.

Actual and Forecast
Year-to-date capital expenditure totals £13.1m, in line with the approved financial plan.

Top 5 issues:
1. Overspend - the current forecast for EHR indicates a potential budget overrun by £1.1m. This is continually been monitored to ensure there is no additional overrun.

2. The following schemes have been progressed at financial risk, pending formal funding confirmation:
- **ICT**: New Boardroom Technology and PACS Storage – £363k
- **Estates**: Refurbishment of St Margaret's – £91k
- **CHAWS**: Vapotherm System – £66k
- **Medicine**: DAWN Software- £45k
- **Surgery**: Cryotherapy Equipment – £26k
- **Estates**: Dishwasher Replacement – £22k

3. Year-to-date, £0.7m of capital invoices primarily for subscriptions, licenses, and similar items have been reclassified to revenue, offset by £0.2 in revenue transfers, resulting in a net adjustment of £0.5m.

4. The Capital Team is finalising the 2025/26 forecast and exploring IFRS 16 funding to mitigate potential overspend.

5. FOT reduction of £0.05m from prior month is due to a reduction in Phlebotomy works.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 11 December 2025

Agenda item:	6.3							
Presented by:	Anna Jebb – Chief Operating Officer							
Prepared by:	Informatics Team							
Date prepared:	20th November 2025							
Subject / title:	Integrated Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**
Key Issues:	The metrics falling into the concerning variations at month 7 are: • Complaints – new • Appraisal – non-medical • Statutory & Mandatory Training • Proportion of Ambulance Handovers Between 15 & 30 minutes The metrics which are showing an improving variation are: • Domestic Services (Cleaning) High Risk • Proportion of Patient treated within 4 hours in ED • RTT Incomplete Performance • Cost Improvement Plan The Trust IPR is under-going a review/refresh November 25 -Feb 26, with a new revised report due to be implemented in March 26 (using Feb 26 data). This new Integrated Performance Report will be reviewed in draft form through Operational Board and Executive Board (Feb 26), before it is presented for approval via PAF and the Trust Board in March 26.							
Recommendation:	The Board is asked to note/discuss this report.							

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

Previously considered by:	PAF.27.11.25 and QSC.28.11.25

The Princess Alexandra Hospital NHS Trust

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:	M7 IPR

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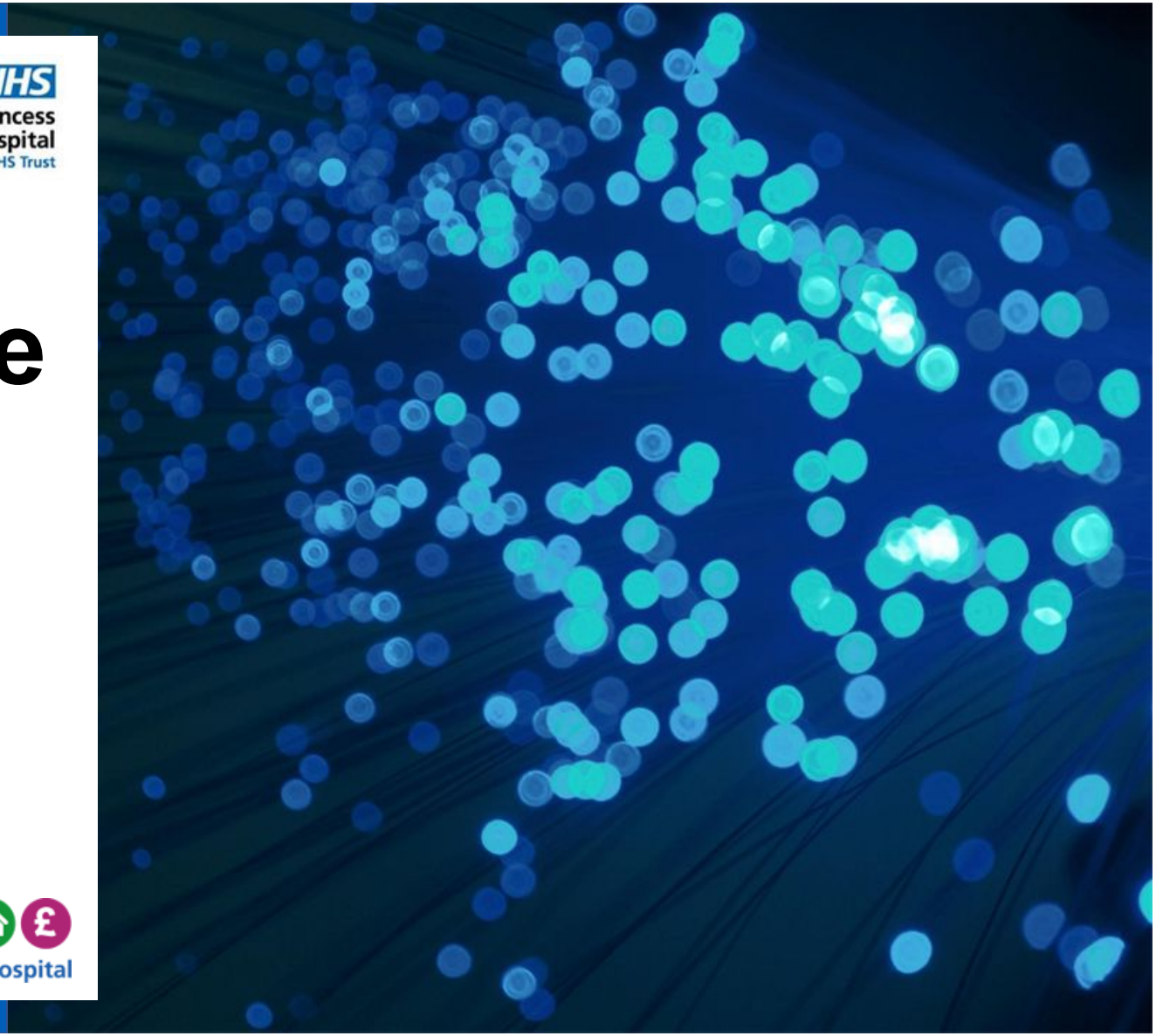
Integrated Performance Report:

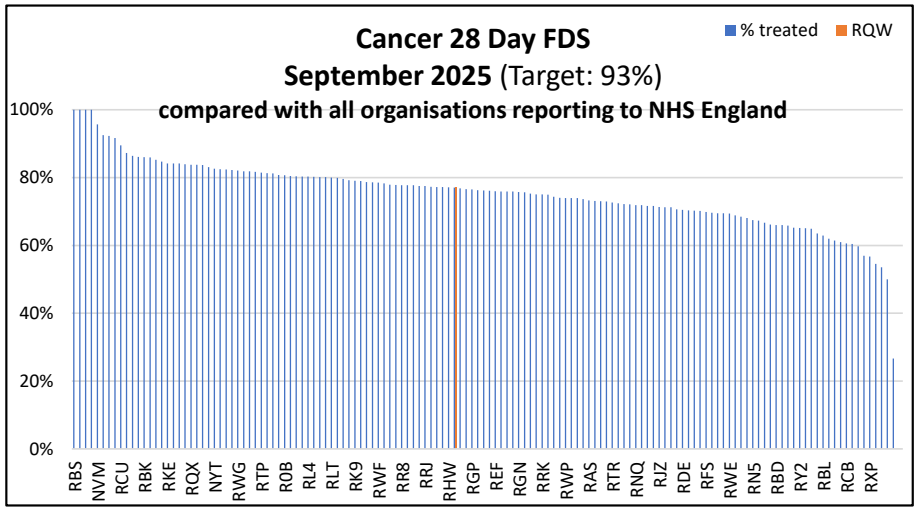


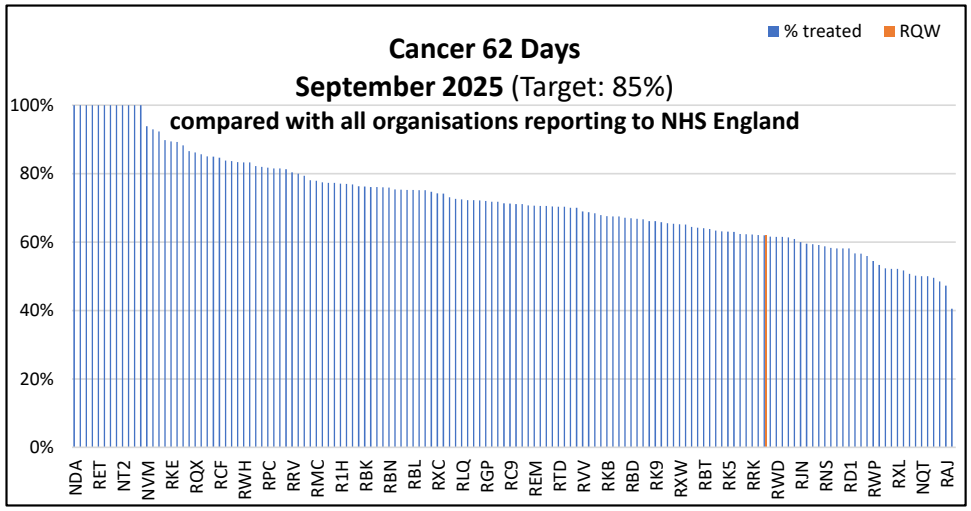
October 2025

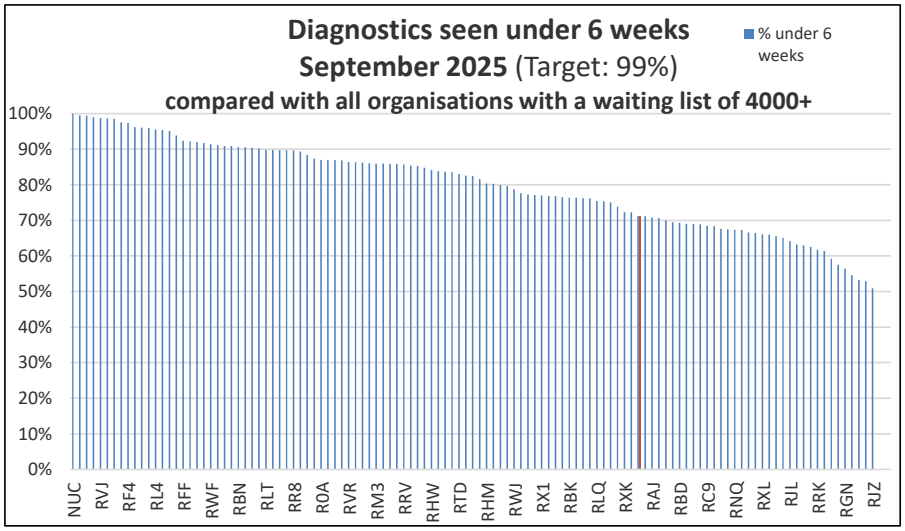
As at 17/11/2025

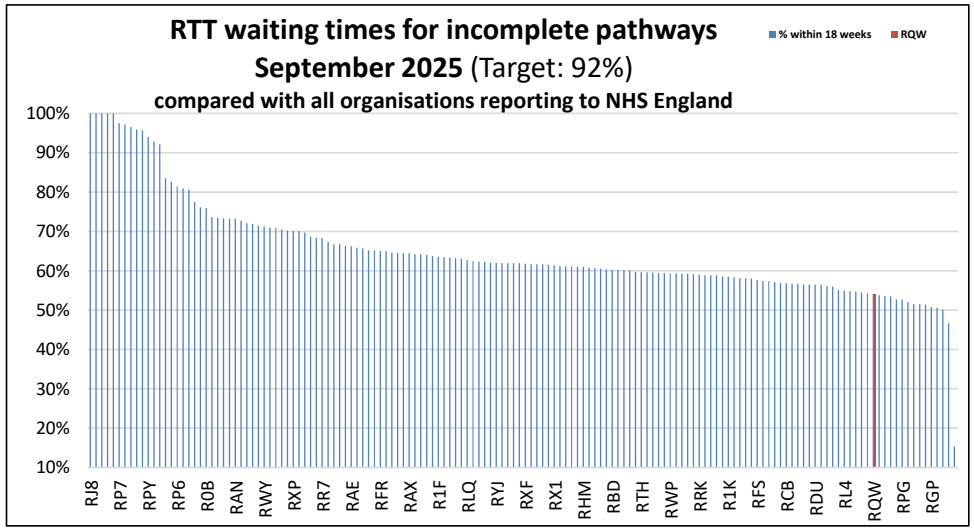
Your future • Our hospital

NATIONAL BENCHMARKING

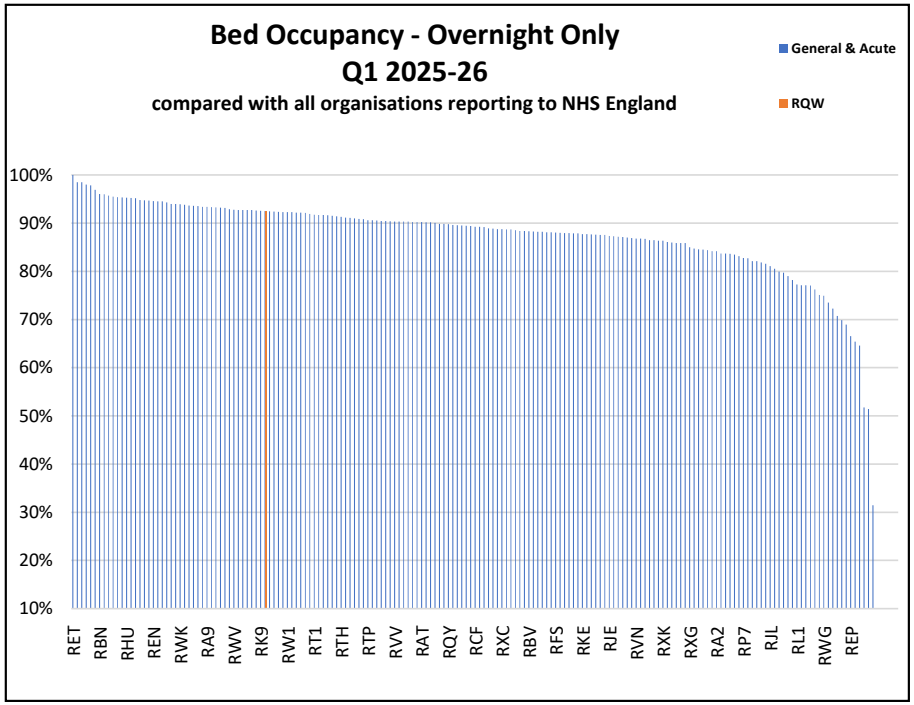


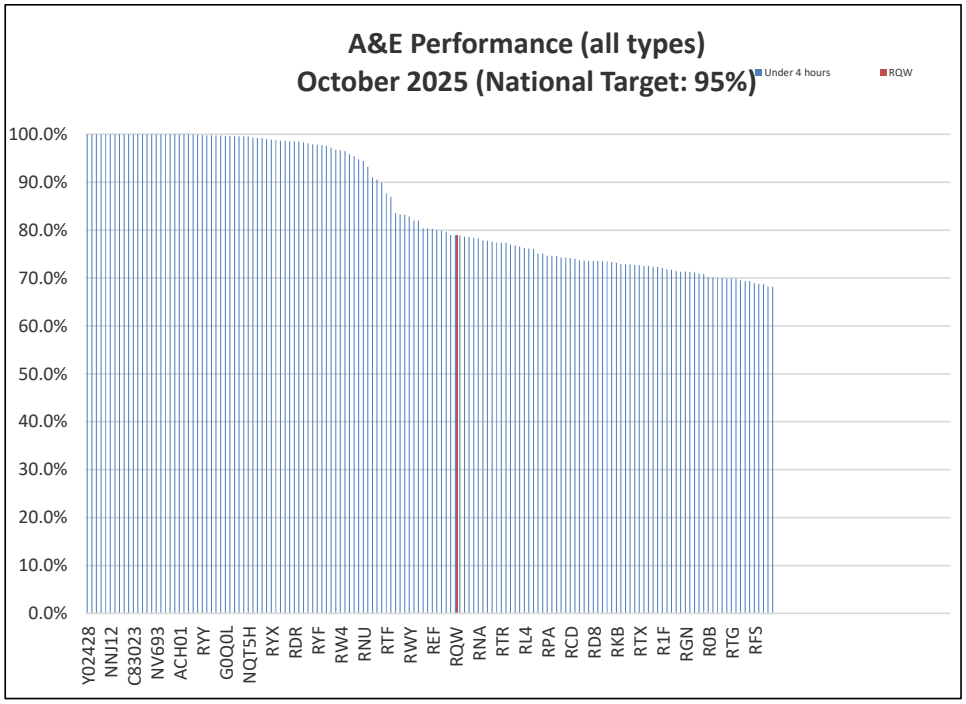




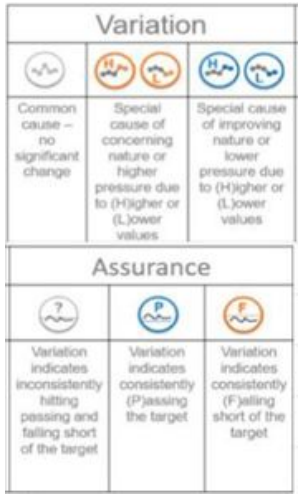


NATIONAL BENCHMARKING

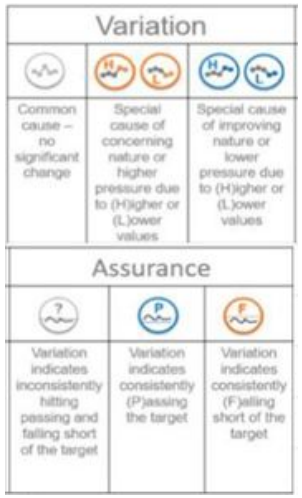




Pillar	KPI	Performance for last reporting month	SPC Trend	SPC Type
Patients	CTG Training Compliance Midwives	96.0%	Common cause variation	
Patients	CTG Training Compliance Doctors	68.2%	Special cause variation-cause for concern(indicator where low is a concern)	
Patients	Falls – total of Minor, Moderate & Severe	2	Common cause variation	
Patients	C-DIFF Hospital onset healthcare associated	3	Common cause variation	
Patients	Complaints - New	52	Special cause variation-cause for concern(indicator where high is a concern)	
Patients	FFT Patient Satisfaction	82.3%	Common cause variation	
People	Sickness Absence	4.70%	Common cause variation	
People	Staff Turnover Voluntary	7.80%	Special cause variation-improvement(indicator where low is good)	
People	Agency Staffing Spend	2.3%	Special cause variation-improvement(indicator where low is good)	
People	Bank Staffing Spend	9.8%	Common cause variation	
People	Appraisal – non-medical	69.6%	Special cause variation-cause for concern(indicator where high is a concern)	
People	Statutory & Mandatory Training	88.6%	Special cause variation-cause for concern(indicator where high is a concern)	
Places	Estates Responsiveness (Priority 2 - Urgent)	93.00%	Common cause variation	
Places	Domestic Services (Cleaning) Very High Risk	98.72%	Common cause variation	
Places	Domestic Services (Cleaning) High Risk	96.19%	Special cause variation-improvement(indicator where high is good)	
Places	Meals Served	33,646	Special cause variation-cause for concern(indicator where low is a concern)	
Places	Catering Food Waste	7.91%	Special cause variation-improvement (indicator where low is good)	



Pillar	KPI	Performance for last reporting month	SPC Trend	SPC Type
Performance	Proportion of Patient treated within 4 hours in ED	78.90%	Special cause variation-improvement(indicator where high is good)	
Performance	Proportion of Ambulance Handovers less than 15 minutes	22.4%	Common cause variation	
Performance	Proportion of Ambulance Handovers Between 15 & 30 minutes	34.4%	Special cause variation-cause for concern(indicator where high is a concern)	
Performance	Over 12Hrs in ED	1,117	Common cause variation	
Performance	Appointment Slot Issues (ASIs)	8,735	Special cause variation-improvement (indicator where low is good)	
Performance	Incomplete 52+ Under 18s PTL	9.00%	Special cause variation-improvement (indicator where low is good)	
Performance	Cancer 28 Day Faster Diagnosis	77.0%	Common cause variation	
Performance	Cancer 62 Day - Shared treatment allocation rules	62.0%	Common cause variation	
Performance	Cancer two week waits	69.5%	Common cause variation	
Performance	Diagnostic times – Patients seen within 6 weeks	71.2%	Common cause variation	
Performance	RTT Incomplete Performance	54.1%	Special cause variation-improvement(indicator where high is good)	
Performance	% Patients Under 18 Weeks Waiting for a 1st OPA	50.2%	Special cause variation-cause for concern(indicator where low is a concern)	
Performance	RTT over 65-week waiters	63	Special cause variation-improvement (indicator where low is good)	
Performance	RTT over 78-week waiters	17	Special cause variation-improvement (indicator where low is good)	
Pounds	Cost Improvement Plan	£2,239.00	Special cause variation-improvement(indicator where high is good)	
Pounds	Income	£38,579.00	Common cause variation	
Pounds	Operating Expenditure	-£35,028.00	Special cause variation-improvement (indicator where low is good)	
Pounds	Capital Spend	£2,058.00	Common cause variation	
Pounds	Bank Spend	£-2,277	Special cause variation-improvement (indicator where low is good)	
Pounds	Agency Spend	£-543	Special cause variation-improvement (indicator where low is good)	



PATIENTS SUMMARY

Patients Summary		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 Pressure Ulcer isn't included within the pack pending a review of the data set. There has been a reduction in recorded hospital acquired pressure ulcers following focused work across the clinical areas with the highest incidence. November was "Stop the Pressure" month with a focus across all in-patient areas to increase awareness and support ongoing training.	For increased visibility and awareness	
Patient experience	The number of complaints received by the organisation continues to be higher than Q1 2025/26. The increase is predominantly related to timeframes for scheduling of appointments and elective procedures. The Divisional teams are working to provide realistic timeframes to patients to support managing expectations. Thematically, the concerns raised for our inpatients remain unchanged and are aligned to the feedback received through our adult inpatient survey. FFT is also included within the IPR, with continued reporting showing sustained improvement in scores.	For increased visibility and awareness	
CTG Training compliance doctors	All doctors who are currently non-compliant with trainig are scheduled for training over the course of November.	For increased visibility and awareness	Dec-25

SPC for B.6 - CTG training compliance Midwives

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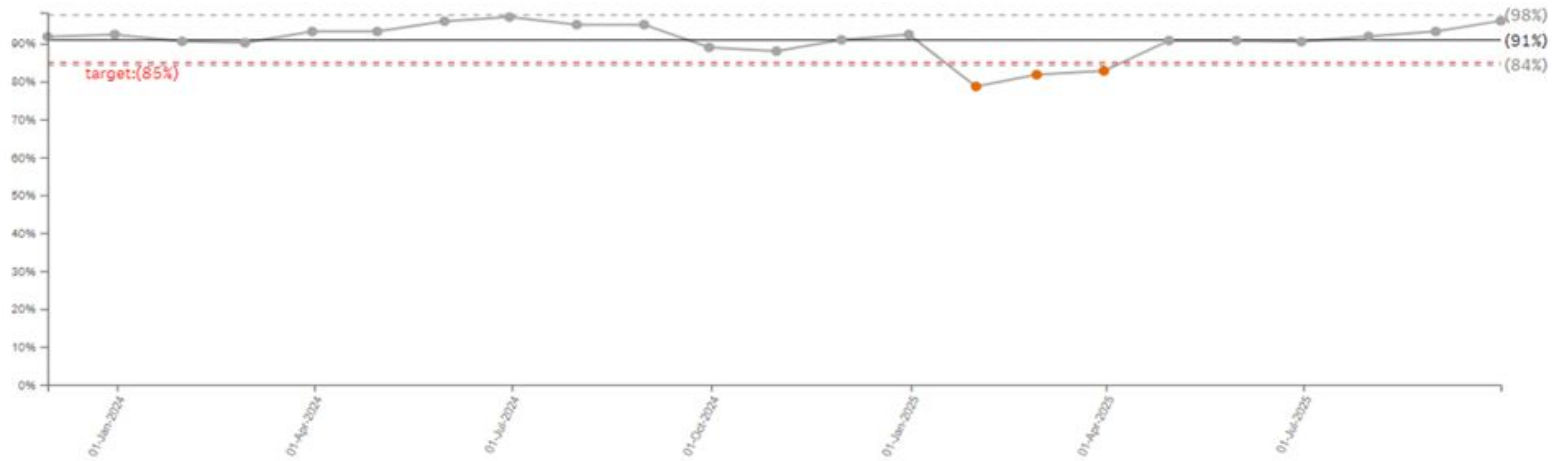
Previous month ...
August-2025

93.2%

Month to date v...
September-2025

96.0%

Target
September-2025
Target is at Trust-wide level



Latest
96.0%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for B.7 - CTG training compliance Doctors

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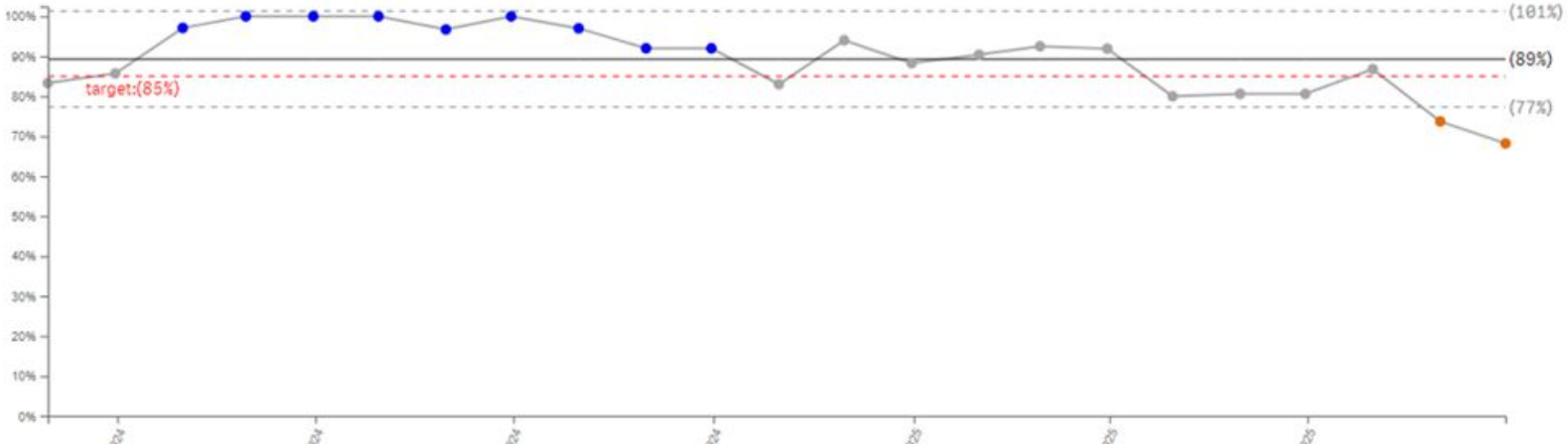
Previous month ...
August-2025

73.7%

Month to date v...
September-2025

68.2%

Target
September-2025
Target is at Trust-wide level



Latest
68.2%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

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

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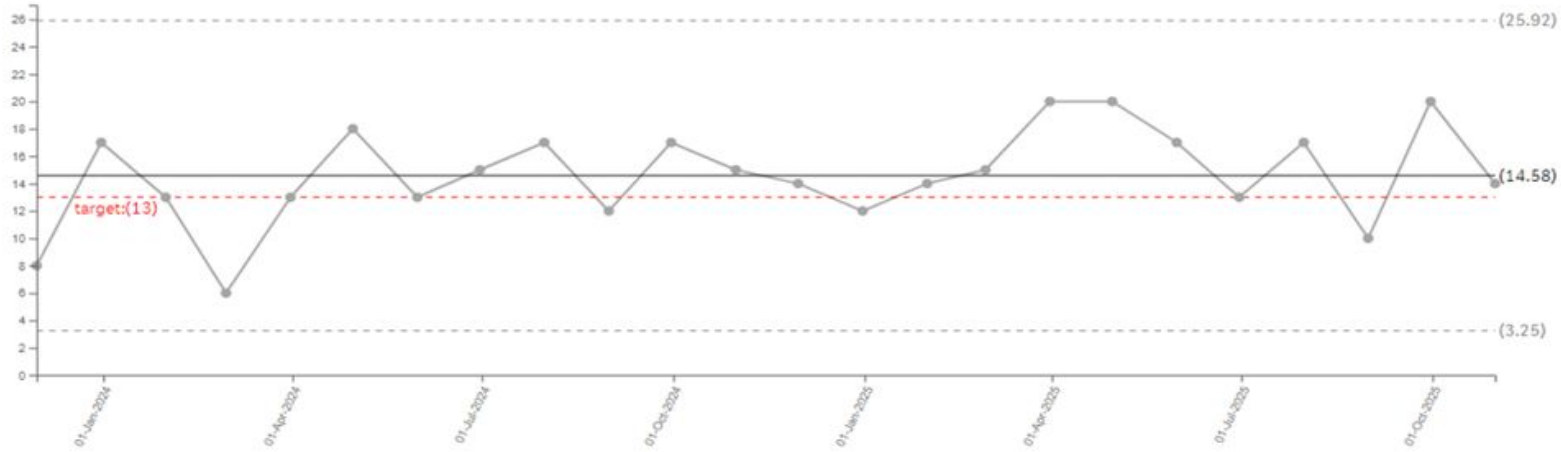
Previous month ...
October-2025

14

Month to date v...
November-2025

2

Target
October-2025
Target is at Trust-wide level



Latest
14
Variance Type
Common cause variation
Target
13
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for C.3 - C-DIFF Hospital onset healthcare associated

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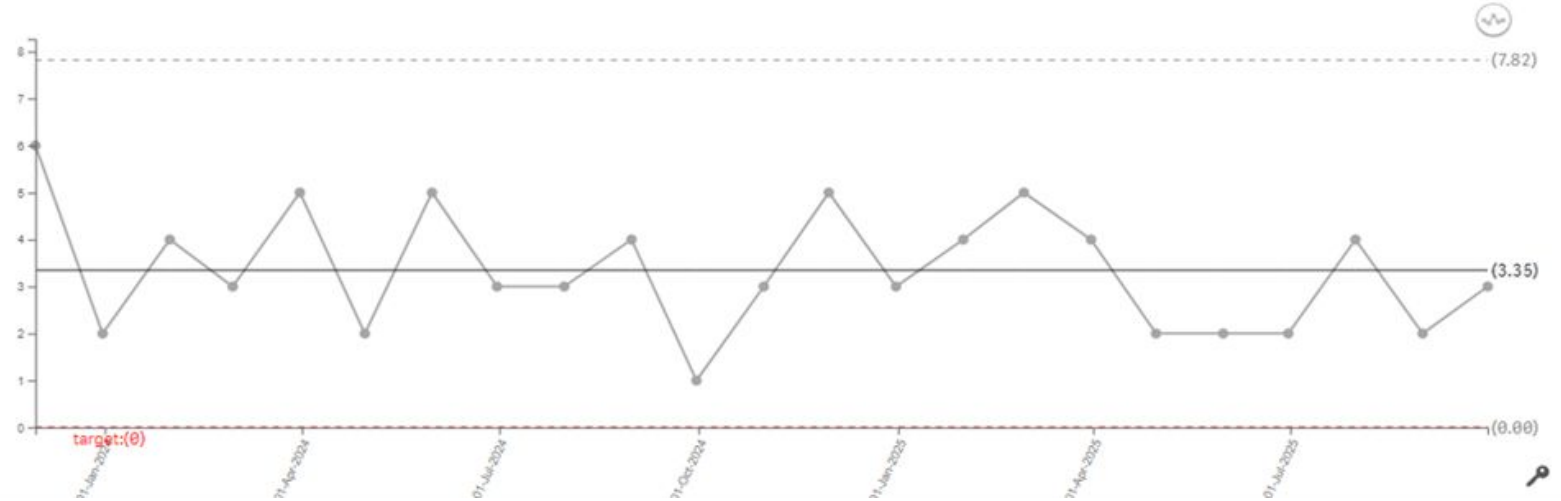
Previous month ...
August-2025

2

Month to date v...
September-2025

3

Target
September-2025
Target is at Trust-wide level



Latest
3
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.11 - Complaints - New

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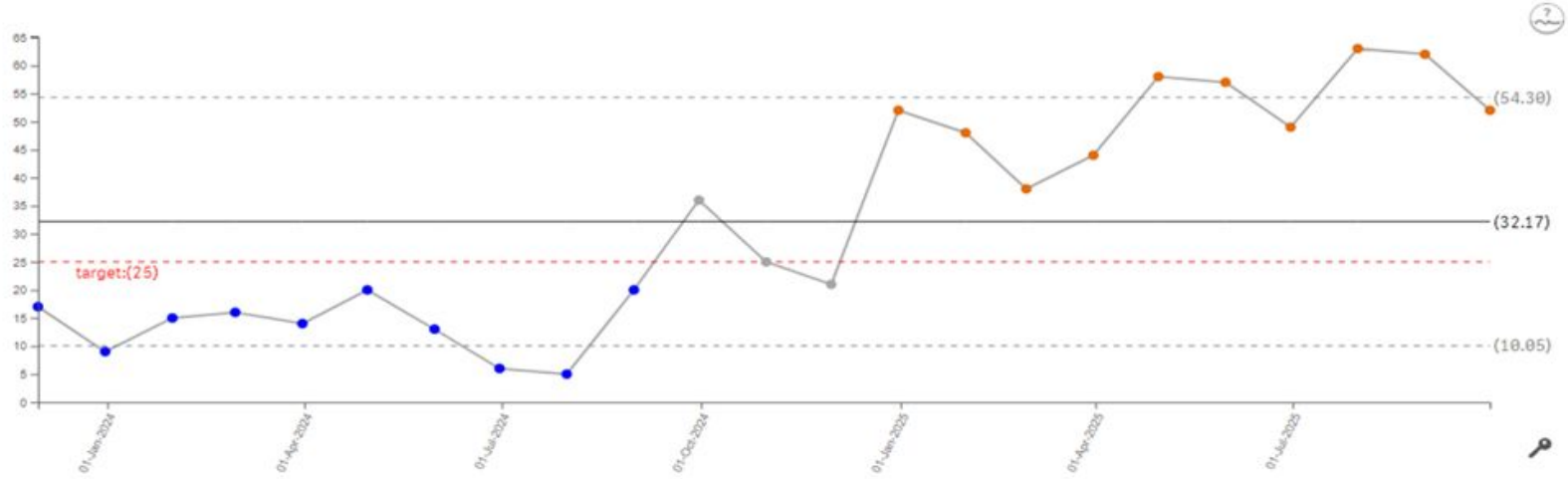
Previous month ...
August-2025

62

Month to date v...
September-2025

52

Target
September-2025
Target is at Trust-wide level



Latest
52
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.54 - FFT Patient Satisfaction

NHS The Princess Alexandra Hospital NHS Trust

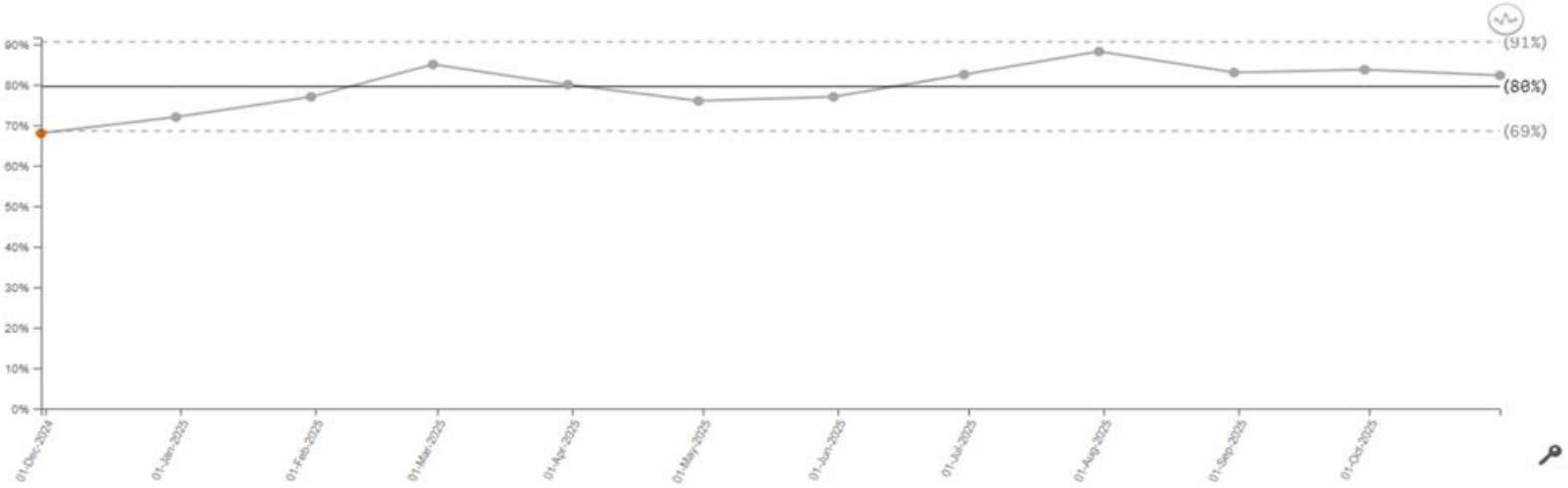
Previous month ...
September-2025

83.7%

Month to date v...
October-2025

82.3%

Target
October-2025
Target is at Trust-wide level



Latest
82.3%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

PEOPLE SUMMARY

People Summary	Board Sub Committee: People Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Appraisals – non-medical	Less than 1% decrease on last month and 12% above same period 2024.Early indications show some line managers are not finalising the appraisal form where the conversation has taken place.	For information	
Statutory & Mandatory training	Less than 1% decrease on last month and 12% above same period 2024.Lowest staff group compliance is Medical and Dental (59%)	For escalation	
Bank Staffing Spend	Reduction in bank spend by 0.6% - Increase in demand from facilities due to sickness and vacancies. Enhanced Care: continues to drive temporary staffing demand, especially in ED, Ray Ward, AAU, Charnley Ward. Awaiting start dates for newly qualified nurses	For information	
Agency Staffing Spend	Increase by 0.8% since previous month. Booking reasons are linked to vacancies with high usage in maternity due to awaiting start dates for newly qualified midwives	For information	
Sickness Absence	There has been an increase by 0.4% since last month. Cases of Flu, RSV and covid are on the rise. Currently 30% of PAHT front line staff are vaccinated against flu.	For information	

SPC for D.23 - Sickness Absence

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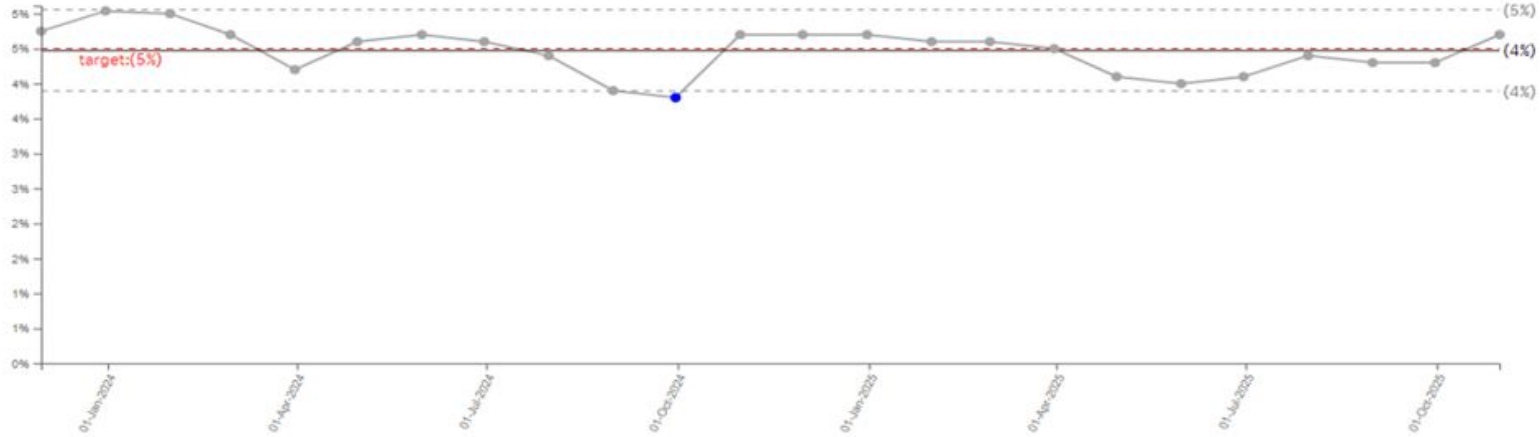
Previous month ...
September-2025

4.3%

Month to date v...
October-2025

4.7%

Target
October-2025
Target is at Trust-wide level



Latest
4.7%
Variance Type
Common cause variation
Target
5%
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.24 - Staff Turnover Voluntary

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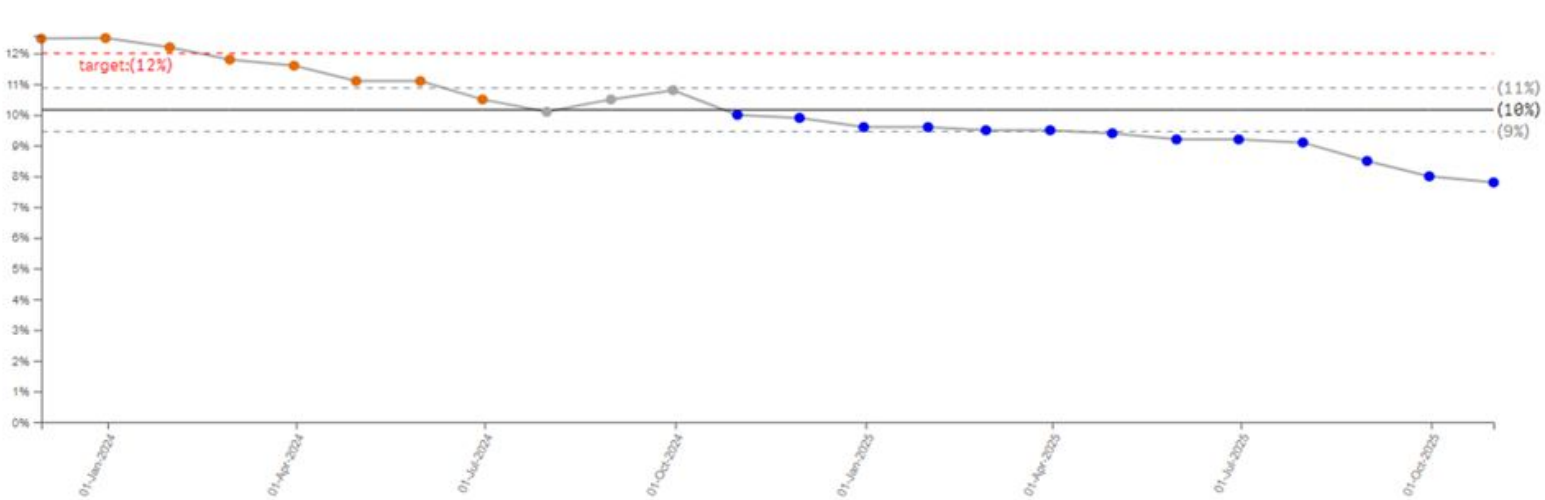
Previous month ...
September-2025

8.0%

Month to date v...
October-2025

7.8%

Target
October-2025
Target is at Trust-wide level



Latest
7.8%
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
12%
Target Achievement
The system is expected to consistently pass the target

SPC for D.28 - Appraisals - non medical

NHS The Princess Alexandra Hospital NHS Trust

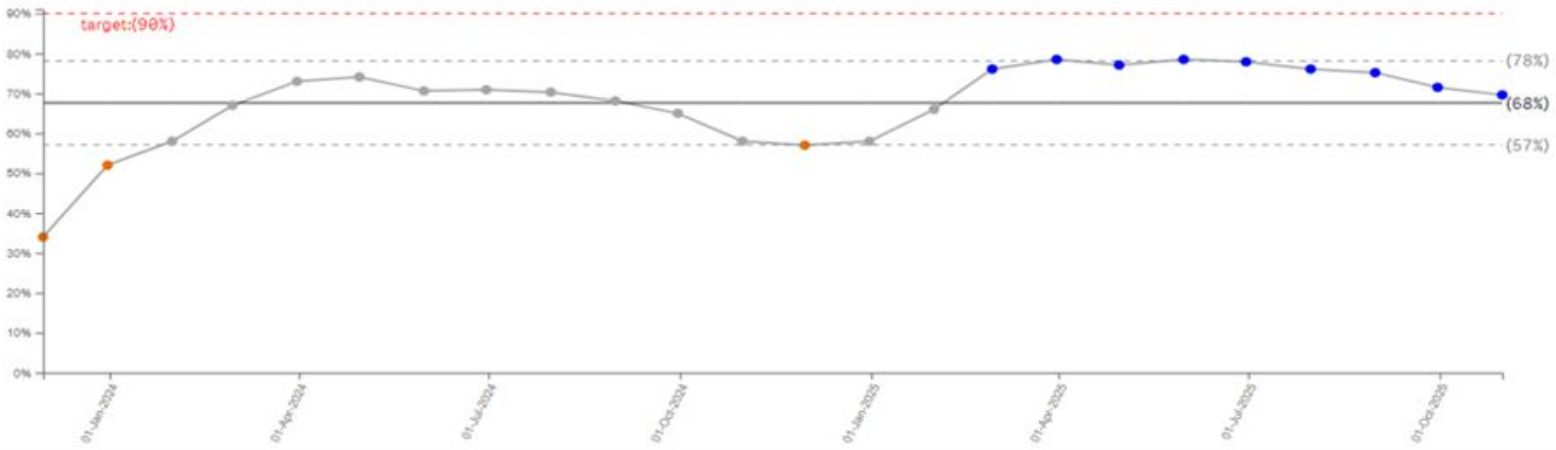
Previous month ...
September-2025

71.5%

Month to date v...
October-2025

69.6%

Target
October-2025
Target is at Trust-wide level



Latest
69.6%
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

NHS The Princess Alexandra Hospital NHS Trust

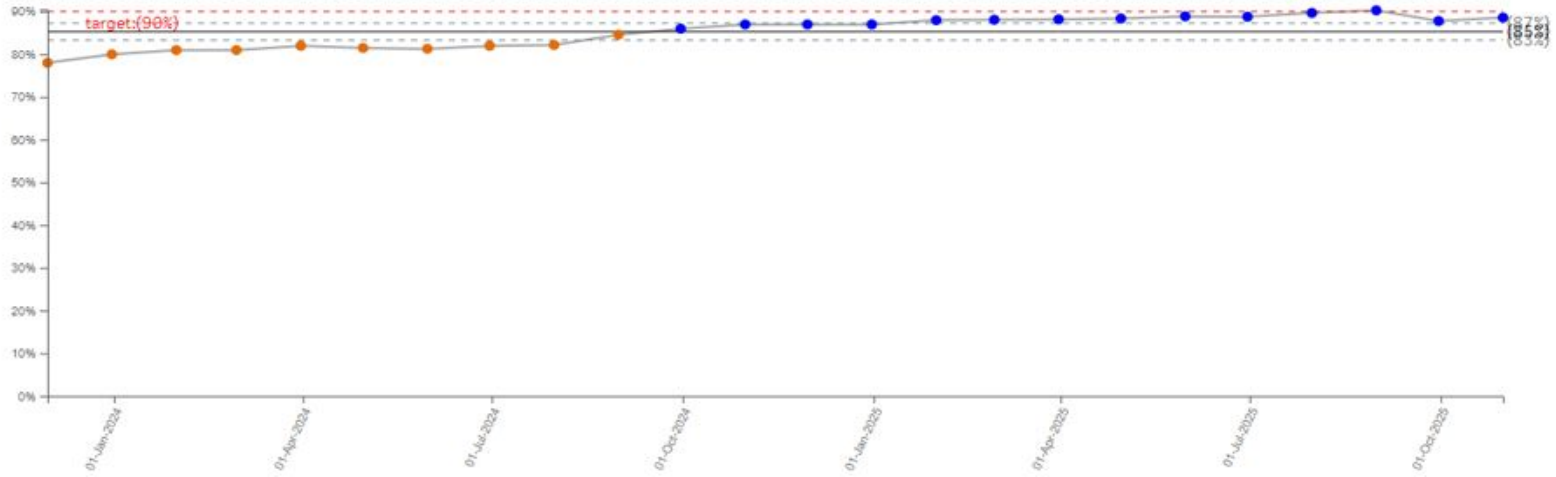
Previous month ...
September-2025

87.8%

Month to date v...
October-2025

88.6%

Target
October-2025
Target is at Trust-wide level



Latest
88.6%
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.25 - Agency Staffing Spend

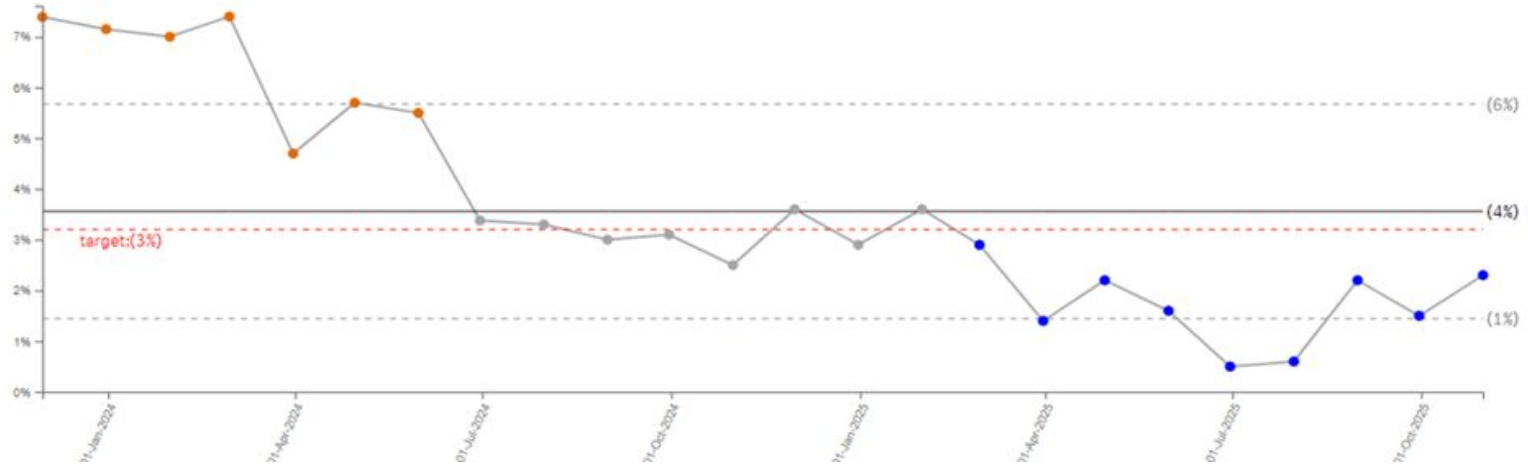
Previous month ...
September-2025

1.5%

Month to date v...
October-2025

2.3%

Target
October-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

Latest
2.3%
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

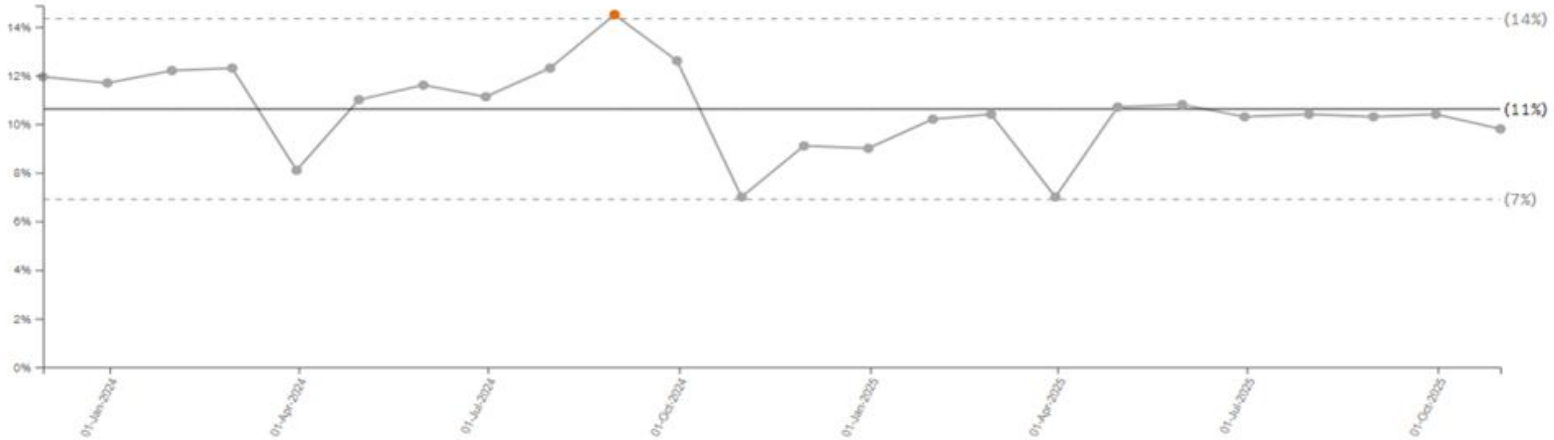
Previous month ...
September-2025

10.4%

Month to date v...
October-2025

9.8%

Target
October-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

Latest
9.8%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

PERFORMANCE

Performance	Board Sub Committee: Workforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Urgent and Emergency Care Standards	**4 Hour Standard -** The Trust achieved 78.9%% against a trajectory of 73% in October.		
	% of patients over 12 hrs in ED - The % of patients who are in ED over 12 hours has risen and is above trajectory at 11% for October against a trajectory of 9.5%. This due to reduced flow through the department. November month to date is 12% against a trajectory of 9%.		
	Average Hand over times - Handover times have deteriorated to 40.47 minutes, against a trajectory of 37 minutes.		

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

NHS The Princess Alexandra Hospital NHS Trust

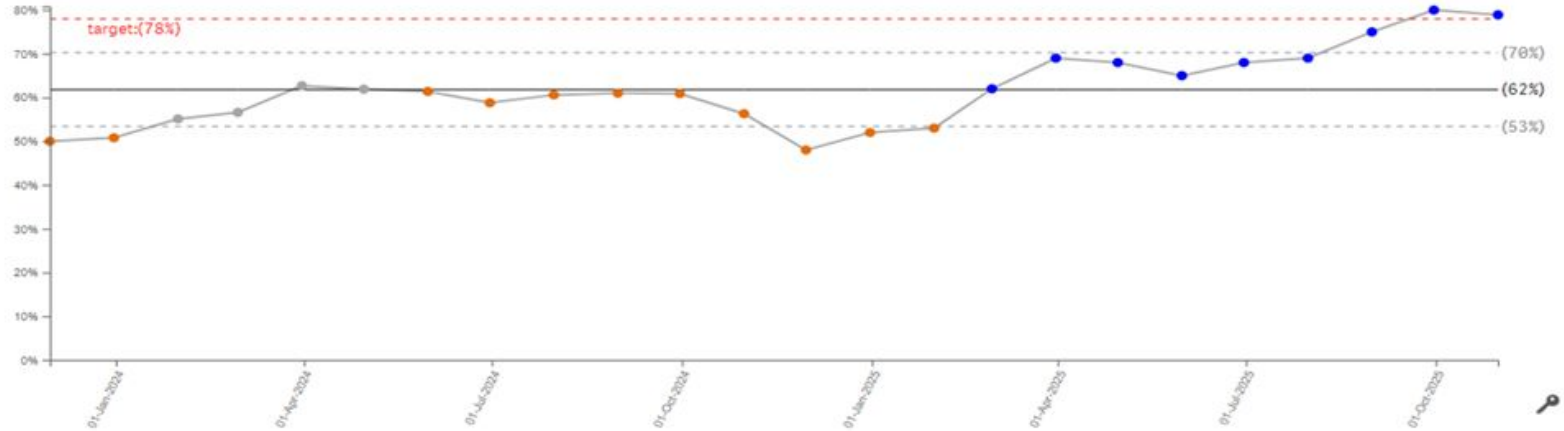
Previous month ...
September-2025

80.0%

Month to date v...
October-2025

78.9%

Target
September-2024
Target is at Trust-wide level



Latest
78.9%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
78%
Target Achievement
The system is expected to consistently fail the target

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

NHS The Princess Alexandra Hospital NHS Trust

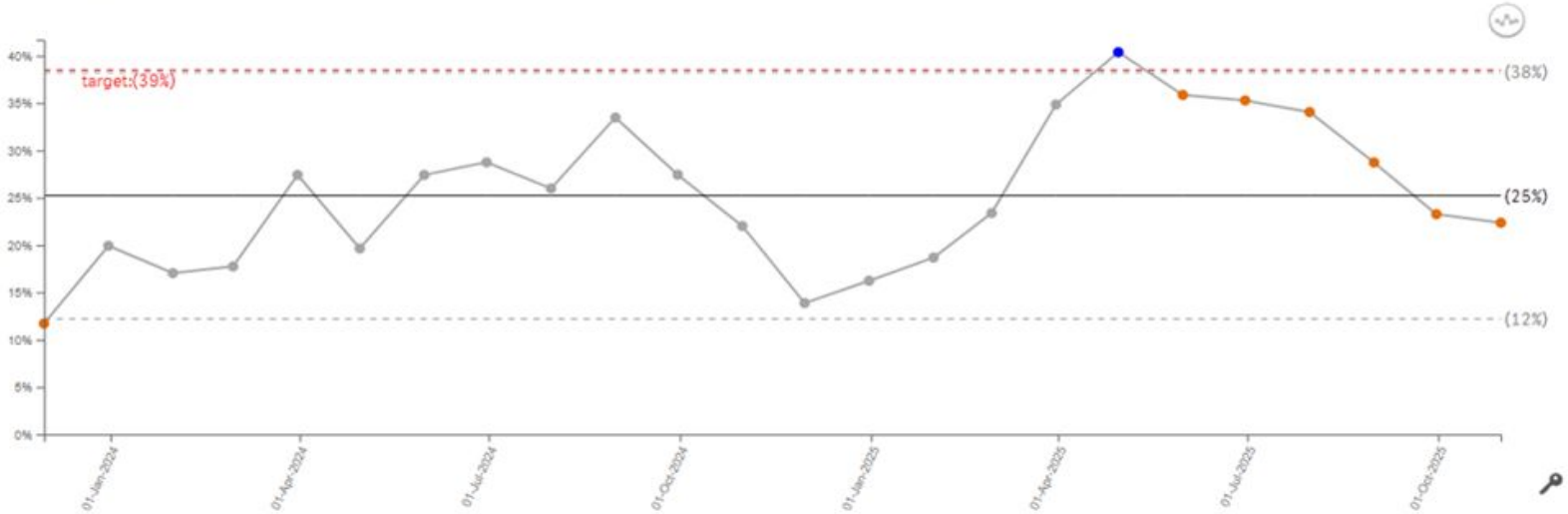
Previous month ...
October-2025

22.4%

Month to date v...
November-2025

15.9%

Target
October-2025
Target is at Trust-wide level



Latest
22.4%
Variance Type
Common cause variation
Target
39%
Target Achievement
The system is expected to consistently fail the target

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

NHS The Princess Alexandra Hospital NHS Trust

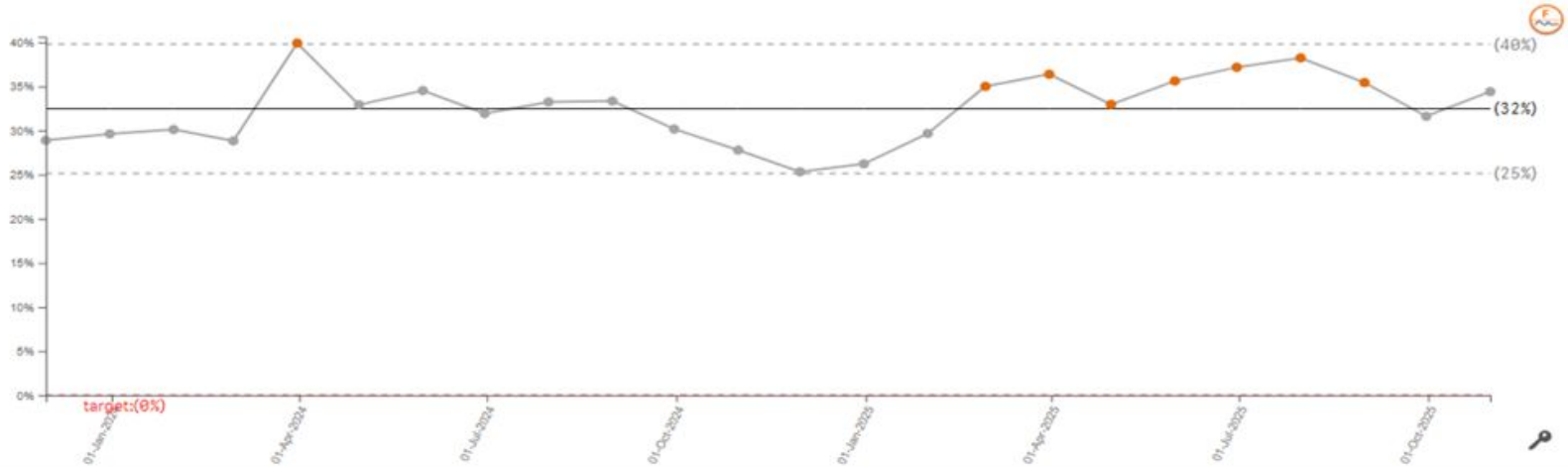
Previous month ...
October-2025

34.4%

Month to date v...
November-2025

27.6%

Target
October-2025
Target is at Trust-wide level



Latest
34.4%
Variance Type
Common cause variation
Target
0%
Target Achievement
The system is expected to consistently fail the target

SPC for E.50 Over 12Hrs ED

NHS The Princess Alexandra Hospital NHS Trust

Previous month ...
August-2025

1,193

Month to date v...
September-2025

1,117

Target
September-2025
Target is at Trust-wide level

Latest
1,117
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

SPC for E.48 ASIs

NHS The Princess Alexandra Hospital NHS Trust

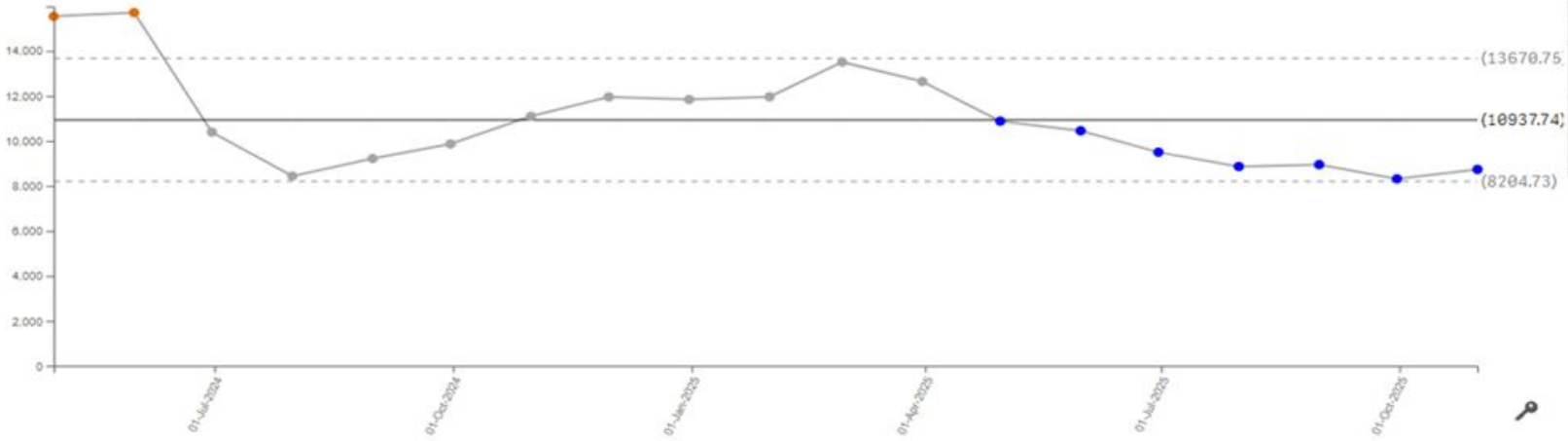
Previous month ...
September-2025

8,314

Month to date v...
October-2025

8,735

Target
October-2025
Target is at Trust-wide level



Latest
8,735
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

SPC for E.49 Incomplete 52+ Under 18s PTL

NHS The Princess Alexandra Hospital NHS Trust

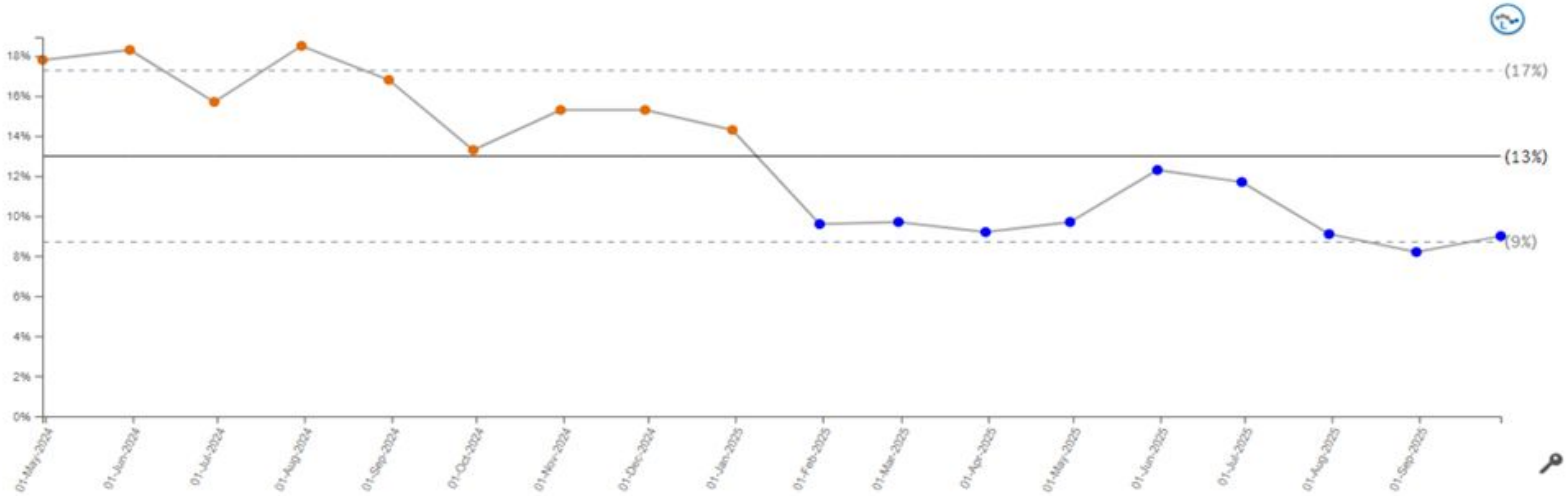
Previous month ...
August-2025

8.2%

Month to date v...
September-2025

9.0%

Target
September-2025
Target is at Trust-wide level



Latest
9.0%
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

SPC for C.22 - Cancer 28 Day Faster Diagnosis

The Princess Alexandra Hospital NHS Trust

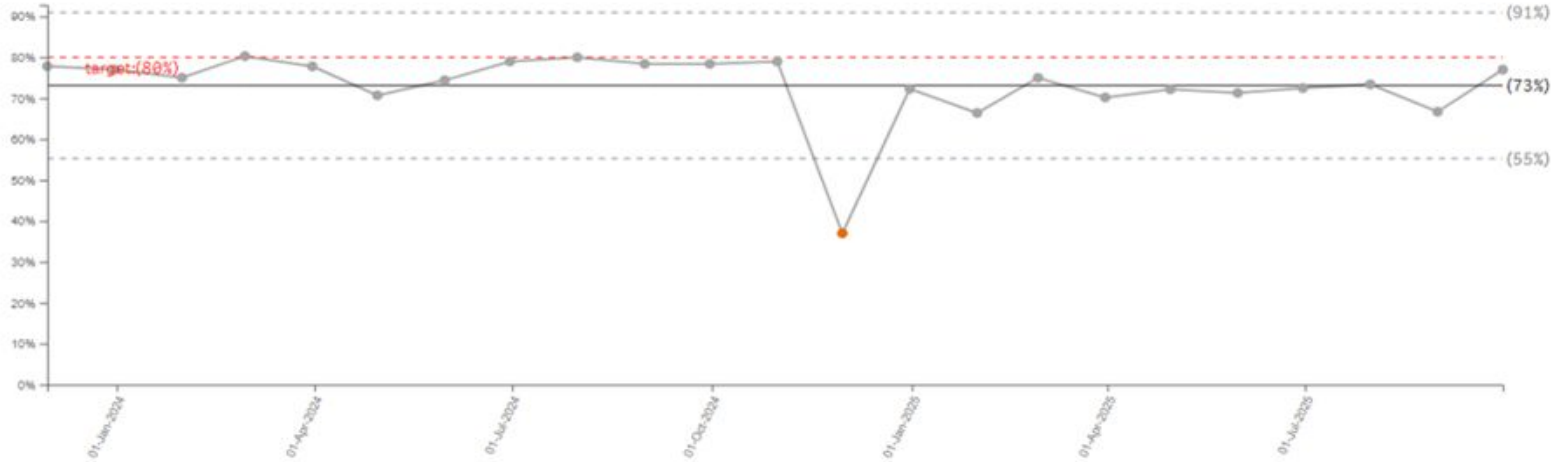
Previous month ...
August-2025

66.7%

Month to date v...
September-2025

77.0%

Target
September-2025
Target is at Trust-wide level



Latest
77.0%
Variance Type
Common cause variation
Target
80%
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

The Princess Alexandra Hospital NHS Trust

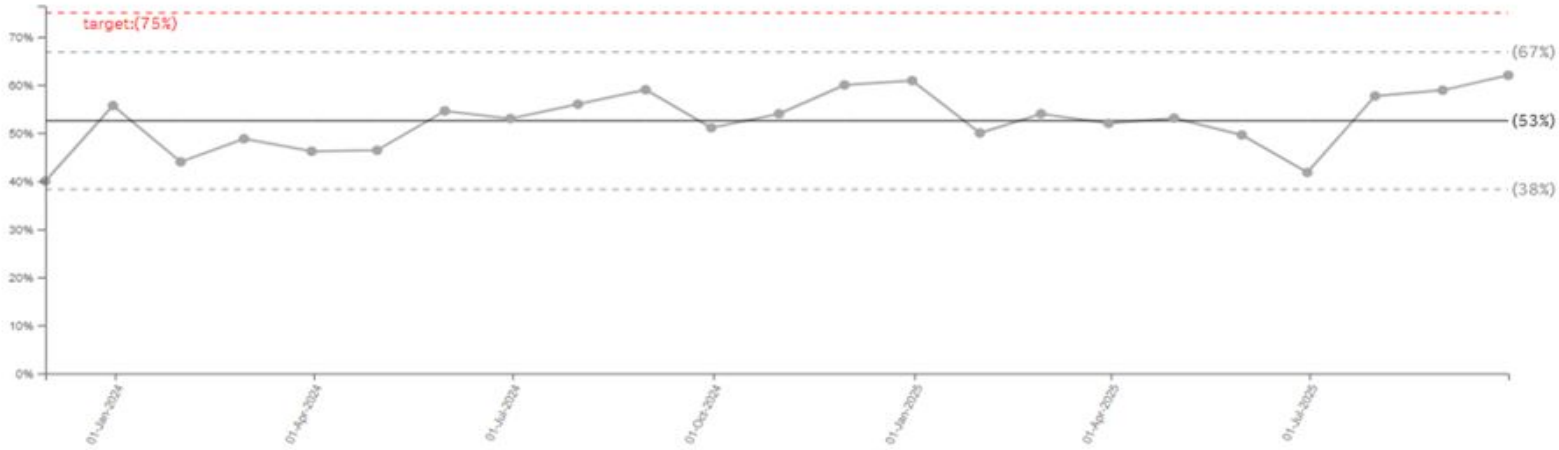
Previous month ...
August-2025

58.9%

Month to date v...
September-2025

62.0%

Target
September-2025
Target is at Trust-wide level



Latest
62.0%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system is expected to consistently fail the target

SPC for C.20 - Cancer two week waits

NHS
The Princess Alexandra Hospital
NHS Trust

Previous month ...
August-2025

57.4%

Month to date v...
September-2025

69.5%

Target
September-2025
Target is at Trust-wide level

Latest
69.5%
Variance Type
Common cause variation
Target
0%
Target Achievement
The system is expected to consistently pass the target

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

NHS
The Princess Alexandra Hospital
NHS Trust

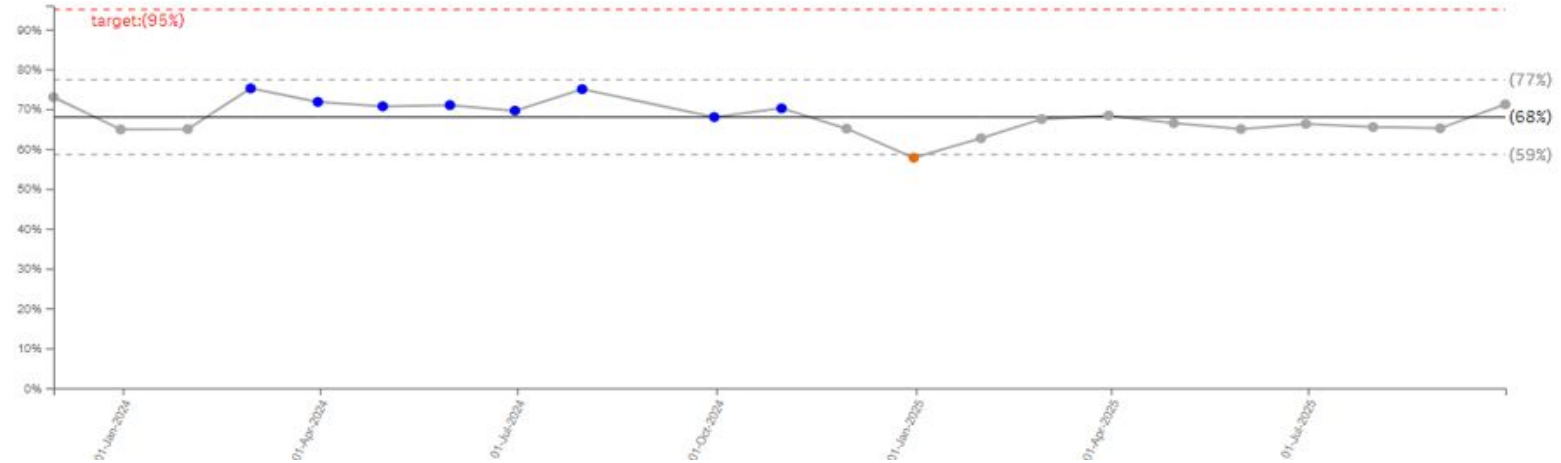
Previous month ...
August-2025

65.2%

Month to date v...
September-2025

71.2%

Target
September-2025
Target is at Trust-wide level



Latest
71.2%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

SPC for E.46 - RTT Incomplete Performance

NHS The Princess Alexandra Hospital NHS Trust

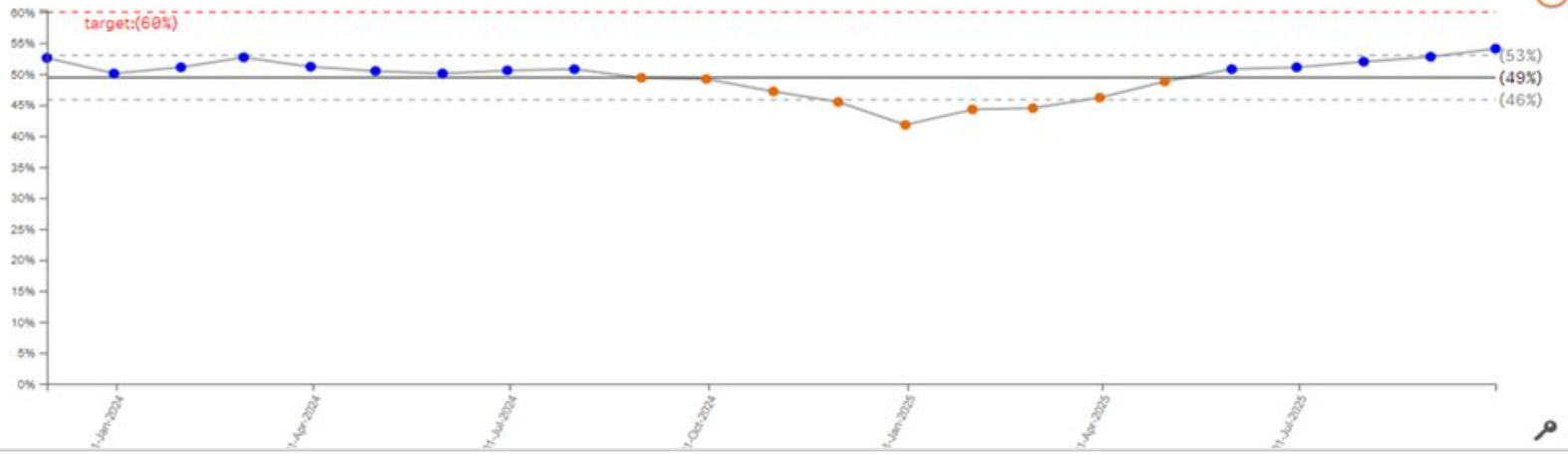
Previous month ...
August-2025

52.8%

Month to date v...
September-2025

54.1%

Target
September-2025
Target is at Trust-wide level



Latest
54.1%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
60%
Target Achievement
The system is expected to consistently fail the target

SPC for E.47 % Patients Under 18 Weeks Waiting for a 1st OPA

NHS The Princess Alexandra Hospital NHS Trust

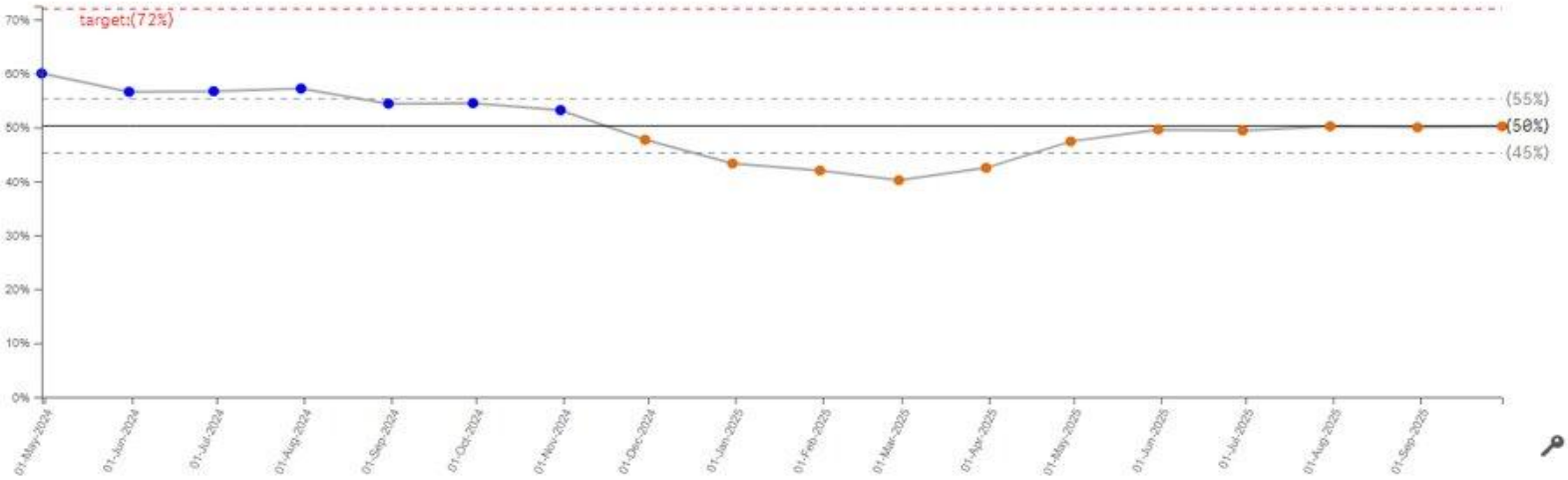
Previous month ...
August-2025

50.0%

Month to date v...
September-2025

50.2%

Target
September-2025
Target is at Trust-wide level



Latest
50.2%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
72%
Target Achievement
The system is expected to consistently fail the target

SPC for D.41 - RTT over 65 week waiters

NHS The Princess Alexandra Hospital NHS Trust

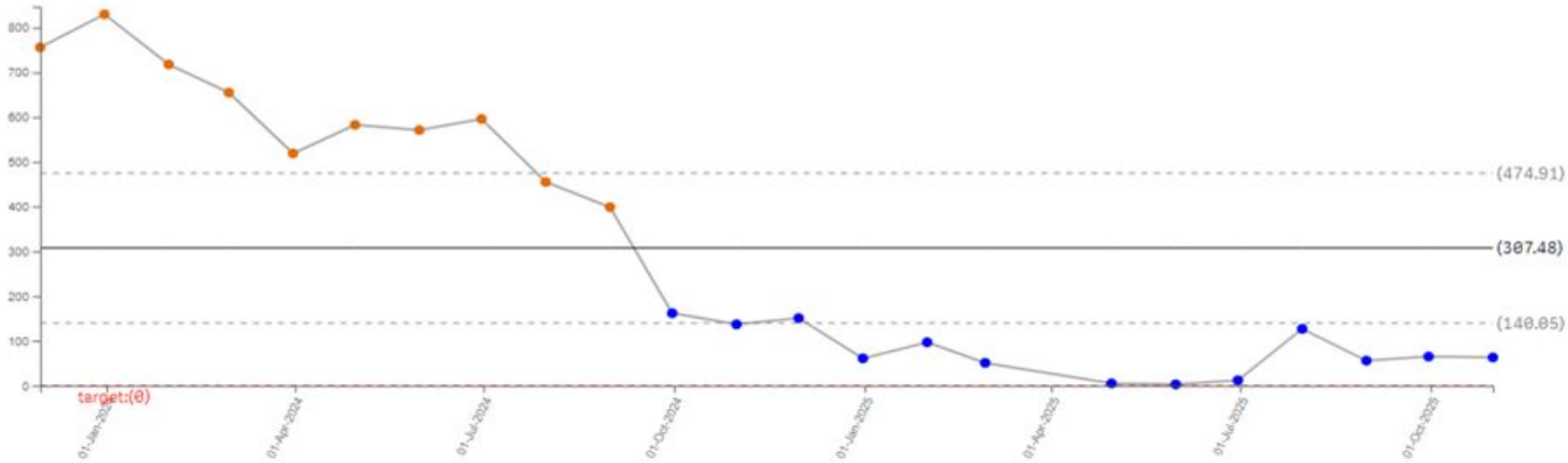
Previous month ...
September-2025

65

Month to date v...
October-2025

63

Target
October-2025
Target is at Trust-wide level



Latest
63
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system is expected to consistently fail the target

SPC for D.37 - RTT over 78 week waiters

NHS The Princess Alexandra Hospital NHS Trust

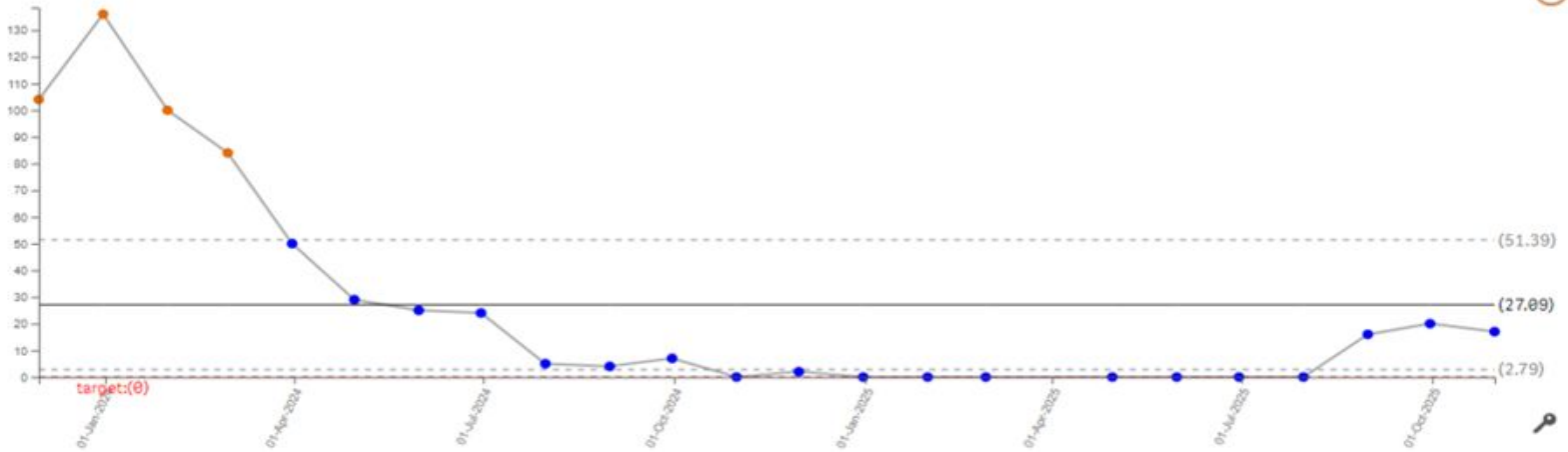
Previous month ...
September-2025

20

Month to date v...
October-2025

17

Target
October-2025
Target is at Trust-wide level



Latest
17
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system is expected to consistently fail the target

PLACES SUMMARY

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Estates	A&E Majors 2 - flooring works -InProgress	For information	
	Main chiller remedials - Main Serving theatre 3 & 4.	For escalation	
	Labour ward rooms - 7,8,9 and recovery refurbishment completed.	For information	

POUNDS SUMMARY

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Income/Activity	The Trust is being paid fixed ERF funding for 2025/26 but this relies on the Trust achieving performance targets submitted including RTT. Fixed payments will help mitigate ongoing data quality and recording issues following the implementation of Alex Health. However, achieving performance targets will be key otherwise the Trust risks having financial clawback and the Trust is on track to the trajectory of 60% remains. The RTT was 55.1% as per the plan. Data quality issues remain a challenge and the divisions need to ensure that the backlog is reduced and timeframe tod deal with outcoming clinic data amongst other data quality issues.	For information	
Capital Spend	The Trust total Capital resourcing for 2025/26 is £35.8m, this includes external PDC including the New Hospital project, CDC, and others. The capital plan was approved at the April 2025 CWG meeting and also approved at Trust Board due to the amounts involved.		
Cash	The Trust's cash balance is £17.7m. The Trust's cash reserves, which were bolstered by national Covid support, have declined as cash outflows continue to exceed inflows. Our current focus is on reducing the level of unpaid invoices and maintaining the Trust's improved 30-day BPPC performance.		
Surplus / Deficit	The Trust reported a surplus of £1.4m in month 7 against a planned surplus of £1.4m, therefore delivering plan. The position includes £3.3m of system support funding, which was planned, this however means there is a underlying deficit of £1.9m in month.		
PQP	The 25/26 PQP target is £26.2m. £2.2m PQP was delivered in month 7 against a plan of £2.2m. PQP delivery is on plan year to date. Delivery of the target is to become more challenging throughout the year due to phasing of an increase in the planned savings in the latter part of the financial year.		

SPC for F.1 - Surplus / (Deficit)

The Princess Alexandra Hospital NHS Trust

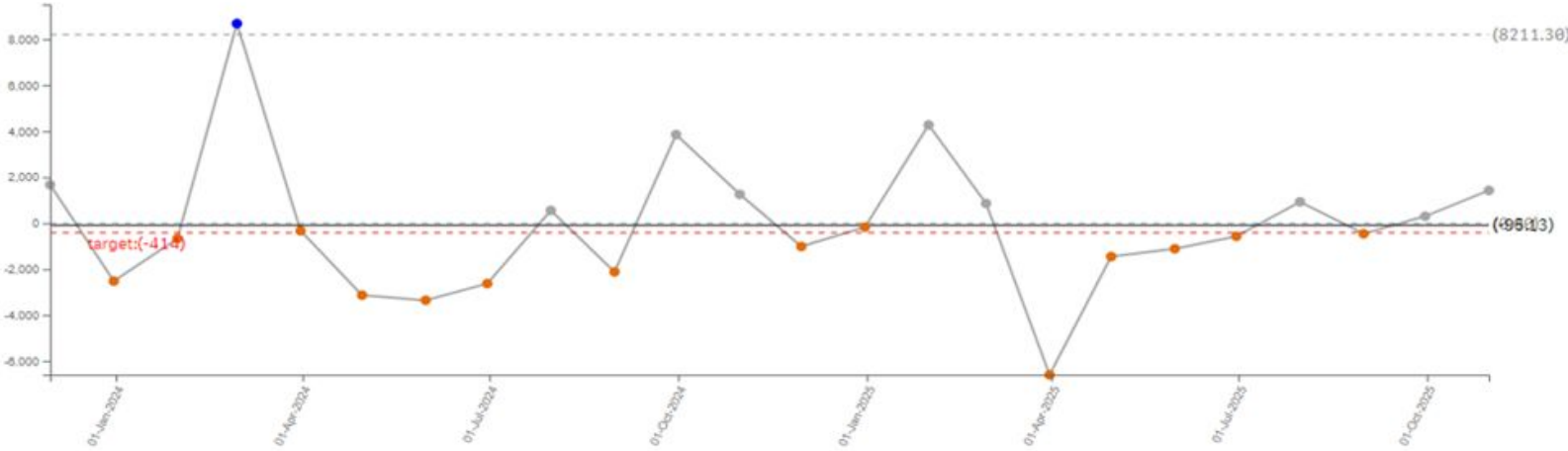
Previous month ...
September-2025

304

Month to date v...
October-2025

1,426

Target
October-2025
Target is at Trust-wide level



Latest
1,426
Variance Type
Common cause variation
Target
-414
Target Achievement
The system is expected to consistently pass the target

SPC for F.2 - Cost Improvement Plan

The Princess Alexandra Hospital NHS Trust

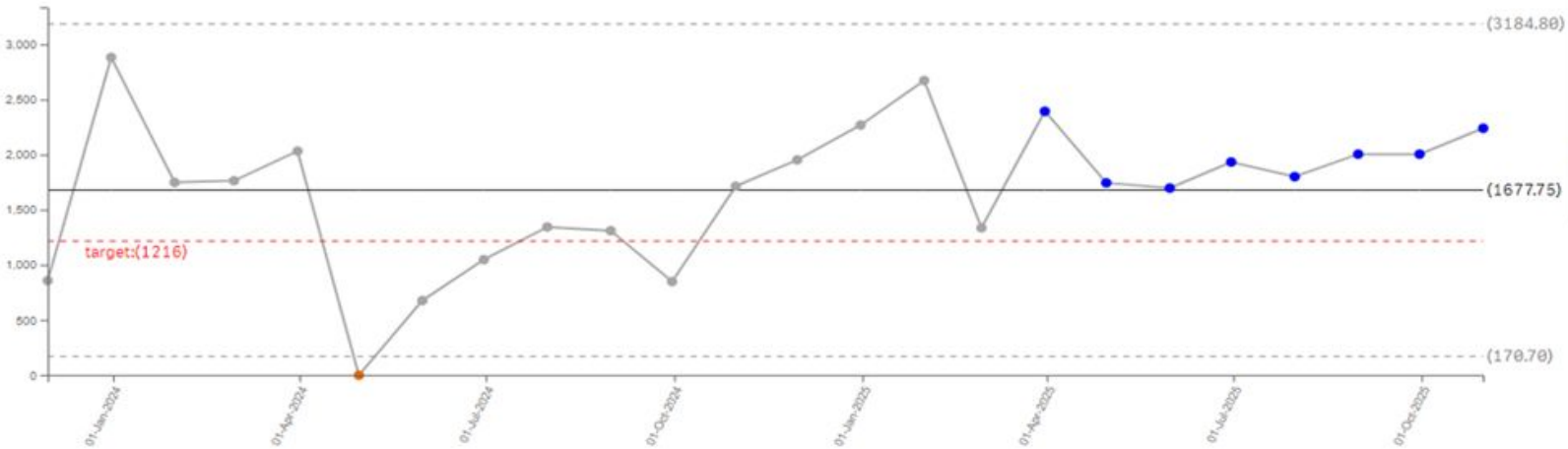
Previous month ...
September-2025

2,004

Month to date v...
October-2025

2,239

Target
October-2025
Target is at Trust-wide level



Latest
2,239
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
1216
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for F.3 - Income

NHS
The Princess Alexandra Hospital
NHS Trust

Previous month ...
September-2025

36,986

Month to date v...
October-2025

38,579

Target
October-2025
Target is at Trust-wide level

Latest
38.579
Variance Type
Common cause variation
Target
29966
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for F.4 - Operating Expenditure

NHS
The Princess Alexandra Hospital
NHS Trust

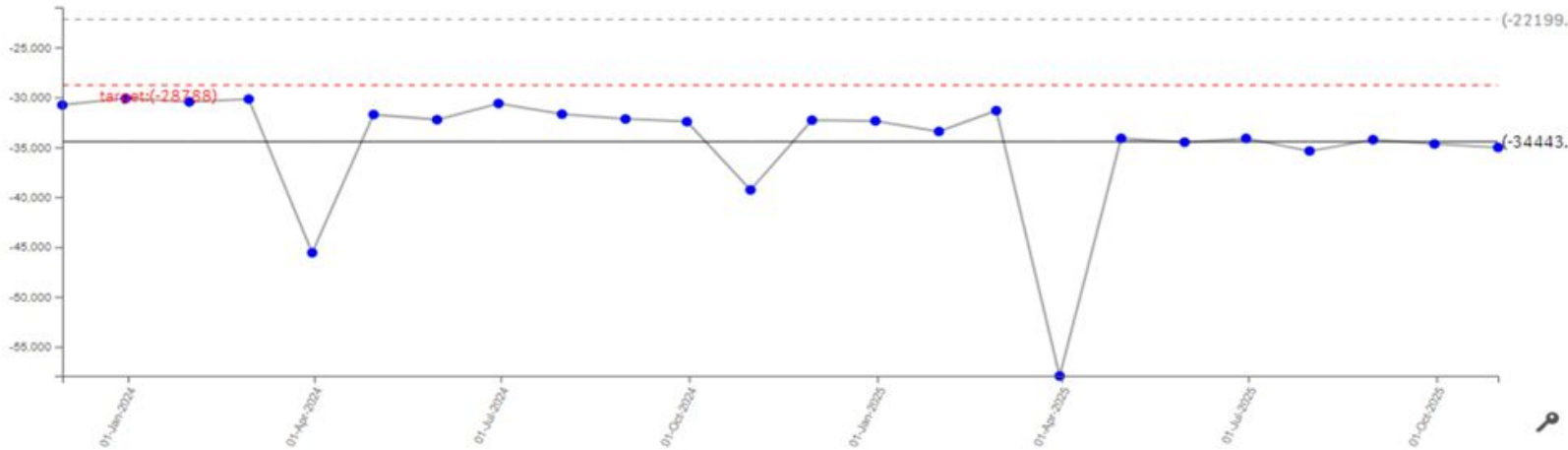
Previous month ...
September-2025

-34,673

Month to date v...
October-2025

-35,028

Target
October-2025
Target is at Trust-wide level



Latest
-35,028
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
-28788
Target Achievement
The system is expected to consistently fail the target

SPC for F.5 - Bank Spend

The Princess Alexandra Hospital NHS Trust

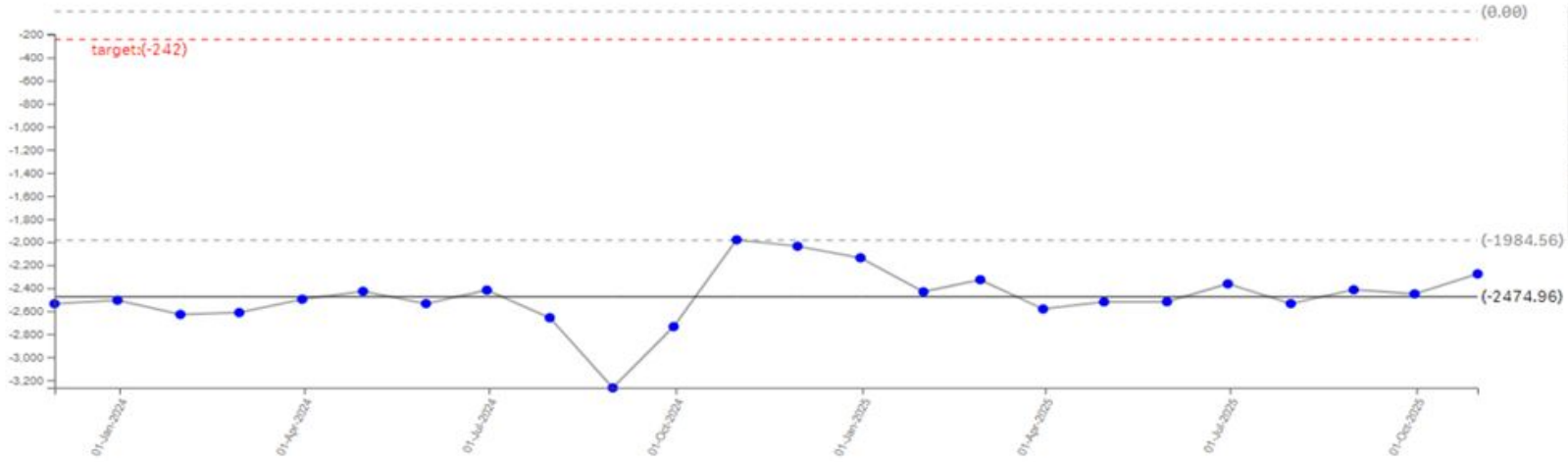
Previous month ...
September-2025

-2,451

Month to date v...
October-2025

-2,277

Target
October-2025
Target is at Trust-wide level



Latest
-2,277
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
-242
Target Achievement
The system is expected to consistently pass the target

SPC for F.6 - Agency Spend

The Princess Alexandra Hospital NHS Trust

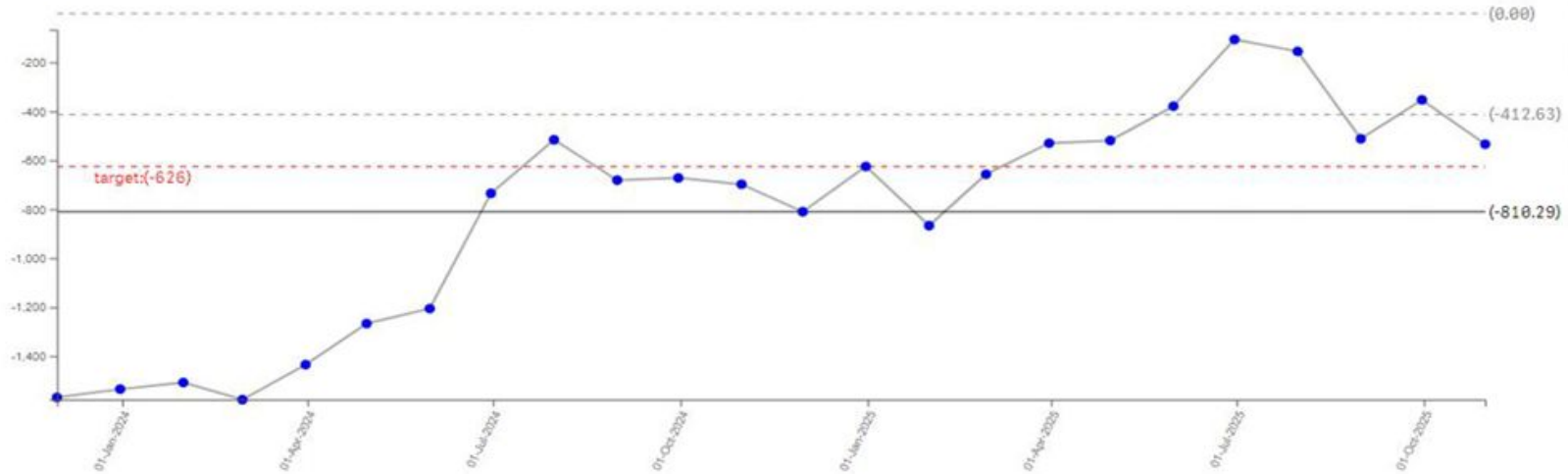
Previous month ...
September-2025

-353

Month to date v...
October-2025

-534

Target
October-2025
Target is at Trust-wide level



Latest
-534
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
-626
Target Achievement
The system is expected to consistently fail the target

SPC for F.7 - Capital Spend

NHS The Princess Alexandra Hospital NHS Trust

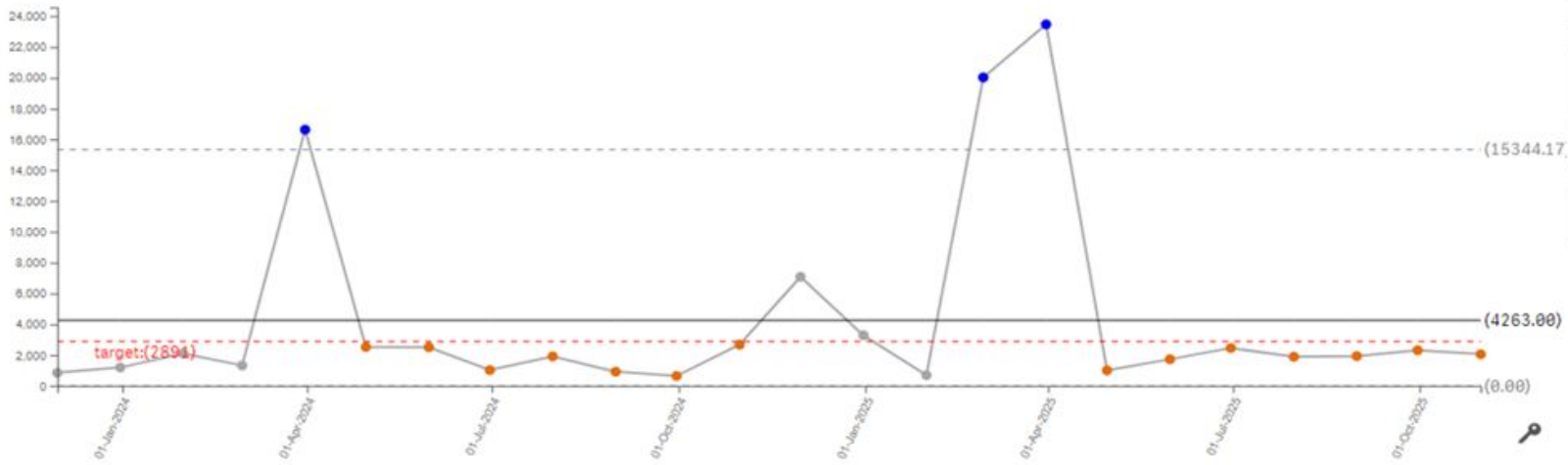
Previous month ...
September-2025

2,316

Month to date v...
October-2025

2,058

Target
October-2025
Target is at Trust-wide level



Latest
2.058
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
2891
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for F.8 - Cash Balance Actual

NHS The Princess Alexandra Hospital NHS Trust

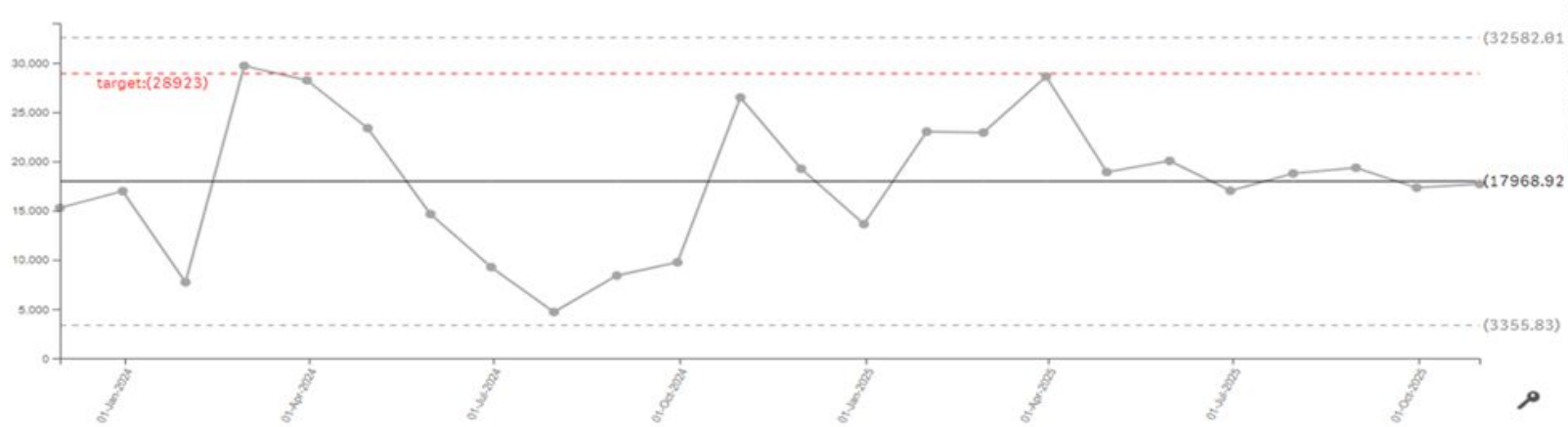
Previous month ...
September-2025

17,333

Month to date v...
October-2025

17,705

Target
October-2025
Target is at Trust-wide level



Latest
17.705
Variance Type
Common cause variation
Target
28923
Target Achievement
The system may achieve or fail the target subject to random variation

Trust Board (Public) – 11 December 2025

Agenda item:	6.3							
Presented by:	Anna Jebb, Chief Operating Officer							
Prepared by:	Rebecca Gildea, Associate Director of Performance							
Date prepared:	November 2025							
Subject / title:	Access Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**

Key issues:	This report provides a month 7 update against the 2025/26 Operating Plan, summarising performance against key statutory and contractual standards. It highlights areas escalated to Executive Board on 18/11/25 for action / escalation / assurance and outlines performance across alert, advise, and assured measures.
	
	Escalations to Executive Board on 18th November:
	• RTT and Diagnostics off trajectory; timelines for recovery required – **recovery plans mobilised.**
	• Approval sought for external validation and additional BI/operational resources – **approved.**
	• Rapid training rollout for Alex Health booking/outcoming compliance gaps – **commenced.**
	• RTT 65+ week breaches pose risk into December – **recovery plans mobilised.**
	
	Performance Overview by Measure
	Alert Measures
	• DM01 and RTT 65+ weeks / 52+ 1st OPA booked off forecast, requiring:
	  ○ Urgent validation of reporting output
	  ○ Specialty-level recovery planning
	  ○ Accelerated booking activity
	• Endoscopy DM01 data accuracy is a critical dependency for performance recovery
	
	Advise Measures
	• Cancer 62-day and RTT incomplete pathways show improvement due to:
	  ○ Additional capacity
	  ○ Validation resource
	  ○ Strengthened PTL governance
	• Urgent and Emergency Care performance is stabilising with:
	  ○ Winter actions underway
	  ○ EMSDEC redesignation
	  ○ GP streaming implementation
	
	Assured Measures
	• Improved performance across:
	  ○ Cancer 31-day and 28-day FDS standards
	  ○ A&E 4-hour performance
	  ○ Diagnostics (MRI, CT, Echocardiography)
	• All showing consistent improvement and on-track compliance trajectory							

Recommendation:	The report is provided for information and assurance. 1. The Board to note emerging/active risks escalated to Executive Board 18/11/25 2. The Board to note actions in transit and associated mitigations under the Alert, Advise and Assured measure section of this report. 3. Performance metrics (submitted) included in the appendix section of this report for oversight.							
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	X		X					

Previously considered by:	Operational Board, PAF.27.11.25 and QSC.28.11.25
Risk / links with the BAF:	1.0 Covid-19 1.1 Variations in clinical quality of care
Legislation, regulatory, equality, diversity and dignity	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:	Dashboard

modern • integrated • outstanding

6.3

Performance Summary – Month 7 (October 25)

Escalations to Executive Board on 18th November:

- **Additional top up training on Alex Health for all teams – where user compliance is poor in relation to Outcoming Clinics / Booking – this is to be quantified through the Worklist programme –** *PAF Committee to note end user training commenced 17/11/25*
- **Support with additional validation ask through Winter –** *PAF Committee to note validation resource/AI solution approved at Execute Board 18/11/25*
- **Additional BI resource to support with rapid D&C required to quantify ongoing additional resource required for under- performing specialties – e.g. T&O, ENT, Ophthalmology –** *PAF Committee to note first draft D&C output completed and out for service review 19/11/25*
- **RTT 65+ December breach forecast – behind forecast for October (-8), November will require significant operational oversight and additional resource / strategic focus to deliver (13 month end). December could pose risk –** *PAF committee to note service teams are actively mobilising capacity gaps / requests for additional activity. Detailed plans at specialty level, including mitigations and assurance will be communicated at the next Tiering meeting 20/11/25*

Alert Measures – Investigate and Take Urgent Action

Where we are showing concerning variation, and are likely to fail the target

What	What is already in place?	Next Steps	Target Date	Who?
Diagnostics within 6 weeks (>95%)	Endoscopy (all modalities), Neurophysiology, Urodynamics – working through the reporting issues – validation of the DM01 report Audiology – insourcing put in place & recruitment to additional substantive posts	• Complete validation of the DM01 report, so we can start accurately reporting externally. • Need to quantify the combined requirement of ABR look back exercise with the ongoing additional resource required to hit the target. Rapid D&C to be completed, and resource required quantified.	Dec 25 Jan 26	BI, AD Perf, All Divisions CSS
RTT 65+ weeks	• Additional capacity being put on for ENT/T&O/Gynae/Gastro • Continued validation of PTL inc 'super' PTL's and newly deployed Divisional 'Access' Meetings • Delivery plans being worked up	• Quantify combined requirement of OPA 'swap outs' and additional activity to deliver **0 breaches** by 21/12 • Specialty plans urgently required	Dec 25	All divisions
1st OPA >52 Cohort	• Currently 33% booked by 31/01/26	• Urgent plan to book outstanding 67% (~5k OPA) by 31/01/26	Jan 26	All divisions

Advise Measures – Investigate and take Action

Where we are either failing the standard (but improving), passing the standard (but deteriorating) or simply not consistently hitting the target

What	What is already in place?	Next Steps	Target Date	Who?
Cancer 62 days	• Additional breast capacity (1 stops/theatres) • Derm (community provision & additional cap) • Urology & Endoscopy Diagnostic Insourcing	• Implement the Urology BC- support may be required to put together a recruitment timeline, to ringfence dedicated recruitment resource and to ensure successful recruitment into the consultant post (e.g. headhunting, joint post with another trust other incentives). • D&C for LGI and UGI – understand ongoing capacity required, urgently address. • Refreshed Head and Neck improvement plan to be agreed and delivered	Mar 26 Dec 25	Surgery Divisional team
RTT Incomplete RTT <65weeks RTT < 52 weeks	• Additional capacity being put on for ENT/Oph/Gynae/Cardiology • Continued validation of PTL. • Increased PTL grip over Q3/4, 25/26	• D&C needed for under-performing specialties – substantive capacity gap to be quantified. • Additional agency validation resource to be implemented for Nov-Mar 26 • Work underway to understand user issues with Alex Health and correct non-compliance. • Agency validation and AI solution deployment to target missed 'clock stops' through clinic letters	Dec 25 Nov 25 Feb 26	Surgery & Chaws AD Perf. COO & AD Perf.
1st OPA < 18 weeks	Proposal approved for temporary additional booking resource devolved to divisions, to book long waiting 1st appts. Most actions as per above for RTT.	• Review of overall booking/validation model for Trust – likely to require consultation. • Robust D&C modelling – BI support required	Jan 26	COO / Deputy COO
Average Ambulance Handover times < 30 mins	• Alternative pathways • Multiple ambulance bay process in place Escalation triggers	• Ambulance conveyance trial with PAHT • Trust wide full capacity plan review	Nov 25	UEC Divisional Teams
12 hour stays in ED	• Re-designation EMSDEC • GP Streaming Front Door	• Implement High Impact Actions for Winter (re-set AAU, GP letters direct to SDEC, implement new Surge Plan, Increased CT capacity, additional ward based pharmacy prescribers)	Nov-Feb 26	All divisions
Diagnostics within 6 weeks (>95%)	Additional MRI capacity in place	Will hit target for MRI by December	Dec 25	CSS

Assured Measures – Celebrate & Learn!

Where we are performing well, either consistently passing the standard, or showing improvement towards the target.

What	What is already in place?	Next Steps	Target Date	Who?
31-day cancer standard	Additional capacity in place for Breast (Theatre Lists) & Dermatology (Minor Ops).	Sustain current high performance against this standard	Ongoing	All
28-day FDS standard	Urology prostate triage embedded by day 3 Additional 1st Appt capacity Derm Endoscopy Insourcing Lung team's additional processes i.e. weekly clinical and ops meeting to proactively manage the PTL.	Gynae D&C/clinic standardisation – outputs – implement additional capacity Urology – implement approved BC (additional diagnostic & consultant capacity)	Jan 26 Mar 26	CHAWS Surgery Trio
A&E 4 hr standard	Front door streaming model in place Re-designation of EMSDEC Additional resource agreed for Winter	Assess Front Door model – and requirement for ongoing model Implement Winter funding resource	Nov 25	

Appendix 1 - Raw Data

Cancer Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance												
		April		May		June		July		August		September		Live
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	
Cancer 28 Day Standard	80%	77%	72.20%	77%	71.30%	77%	72.50%	77%	73.4%	77%	66.7%	77%	77%	
Cancer 31 Day Standard	96%	93%	95.20%	93%	89.50%	94%	93.90%	95%	91.9%	96%	96.9%	96%	93.9%	
Cancer 62 Day Standard	75%	65%	53.10%	67%	49.60%	71%	41.80%	71%	57.7%	72%	58.9%	72%	61.7%	

RTT Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance												
		April		May		June		July		August		September		Live
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	
RTT Incomplete Standard	65% - National 60% - Planning target	47.7%	48.8%	49.5%	50.8%	50.7%	51.1%	51.9%	52.0%	52.3%	52.8%	53.7%	54.1%	
RTT 65 + week waiters	0	0	5	0	3	0	12	0	27	0	46	0	39	
RTT >52week Standard	498	2748	2403	2494	2175	2278	2265	2066	2402	2300	2449	2200	2157	
	1%	5.0%	4.7%	4.6%	4.4%	4.3%	4.7%	3.9%	5.1%	3.6%	5.5%	3.2%	5%	
RTT 1st OPA Standard	72% - National 67% - Planning target	47.4%	47.4%	49.2%	49.6%	50.9%	49.4%	52.7%	50.2%	54.5%	50.0%	56.3%	50.2%	
Aged 18 and under RTT metrics – Incomplete 52 + weeks	0	220	232	175	267	137	264	103	219	73	201	50	194	
		8%	9.7%	7%	12.3%	6%	11.7%	5%	9.1%	4%	8.2%	3%	9%	
Reduction in ASIs	0		12074		10071		9197		8683		8591		8157	

Diagnostic Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance											
		April		May		June		July		August		September	
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Magnetic Resonance Imaging (MRI)	95%	95%	95.45%	95%	90.69 %	95%	86.38%	95%	80.83%	95%	86.90 %	95%	90.7%
Computed Tomography (CT)	95%	92%	92.81%	95%	93.54 %	95%	99.39%	95%	99.85%	95%	98.63 %	95%	96.59%
Non-obstetric Ultrasound (NOUS)	95%	74%	69.46%	73%	70.99 %	74%	74.98%	74%	77.40%	75%	75.38 %	75%	82.42%
Colonoscopy	95%	92%	30.96%	92%	29.28 %	93%	23.98%	94%	25.55%	95%	15.90 %	95%	20.33%

Operating Plan Performance Measure	% Target by March 26	Month End Performance											
		April		May		June		July		August		September	
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Flexi Sigmoidoscopy	95%	90%	24.04%	90%	25.83 %	90%	26.56%	90%	21.48%	93%	15.29 %	93%	23.66%
Gastroscopy	95%	93%	29.14%	93%	22.40 %	93%	20.26%	94%	20.60%	94%	16.45 %	94%	25.81%
Echocardiography	95%	80%	87.69%	85%	97.25 %	87%	96.52%	87%	95.84%	87%	98.15 %	87%	98.62%
Audiology Assessments	95%	15%	19.86%	15%	15.52 %	15%	18.57%	15%	17.27%	15%	13.47 %	15%	15.51%
Cystoscopy	95%	TBC	50.00%	TBC	46.15 %	TBC	40.00%	TBC	50.00%	TBC	42.11 %	TBC	42.86%

Urgent Care standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance												
		April		May		June		July		August		September		Live
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	
A&E 4h Standard	78%	67%	68.4%	69%	64.80%	70%	68.0%	71%	69.10%	71%	75.00%	73%	80%	80.5%
A&E 12h Standard	6.5%	7.99%	6%	7.8%	8.0%	7.6%	6%	8.4%	8%	12%	12%	10%	11%	9%
Ambulance Handovers	30 mins	35 mins	25.38 mins	35 mins	28.36 mins	35 mins	25.42 mins	35 mins	28.39 mins	35 mins	34.22 mins	35 mins	45.30 mins	28.31 mins

Appendix 2 – Non-Elective and Elective Benchmarking

A. 4 Hour

System	Trust level performance	Performance in October last year	October to date	Comparison to last year	Plan	Comparison to plan	Required to achieve plan for remainder of month	Average over last 7 days	Wed 05 Nov	Tue 04 Nov	Mon 03 Nov	Sun 02 Nov	Sat 01 Nov	Fri 31 Oct	Thu 30 Oct
BLMK	Bedfordshire Hospitals NHS Foundation Trust	73.9%	71.2%	-2.7%	76.9%	-5.7%	78.0%	70.8%	67.7%	63.8%	78.7%	72.8%	73.4%	68.1%	71.5%
BLMK	Milton Keynes University Hospital NHS Foundation Trust	73.1%	70.0%	-3.1%	74.5%	-4.5%	75.5%	70.0%	64.5%	73.7%	66.9%	77.3%	67.4%	68.4%	71.8%
C&P	Cambridge University Hospitals NHS Foundation Trust	65.9%	70.4%	4.5%	74.1%	-3.7%	74.8%	71.7%	69.4%	68.9%	71.3%	70.5%	72.2%	75.9%	74.3%
C&P	North West Anglia NHS Foundation Trust	61.6%	64.1%	2.6%	70.2%	-6.1%	71.4%	65.3%	65.0%	62.9%	64.0%	63.6%	65.5%	66.1%	70.3%
HWE	East and North Hertfordshire NHS Trust	67.2%	74.5%	7.3%	73.1%	1.4%	72.9%	74.0%	71.5%	72.9%	74.7%	79.2%	74.6%	78.8%	66.9%
HWE	The Princess Alexandra Hospital NHS Trust	48.8%	79.4%	30.7%	72.0%	7.4%	70.5%	78.4%	81.9%	79.2%	81.0%	76.6%	77.5%	77.3%	73.5%
HWE	West Hertfordshire Teaching Hospitals NHS Trust	75.9%	82.4%	6.4%	83.6%	-1.2%	83.9%	82.4%	83.9%	82.1%	80.3%	86.8%	79.3%	84.7%	80.0%
MSE	Mid and South Essex NHS Foundation Trust	69.9%	72.7%	2.7%	77.0%	-4.3%	77.9%	73.2%	70.2%	70.8%	76.7%	73.9%	71.4%	73.8%	75.2%
N&W	James Paget University Hospitals NHS Foundation Trust	62.7%	76.5%	13.8%	70.1%	6.4%	68.8%	76.1%	73.3%	76.5%	71.6%	84.8%	76.7%	64.6%	83.6%
N&W	Norfolk and Norwich University Hospitals NHS Foundation Trust	80.3%	78.7%	-1.7%	80.2%	-1.5%	80.5%	78.4%	76.6%	80.6%	80.9%	80.3%	75.0%	74.1%	80.5%
N&W	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	62.6%	60.5%	-2.2%	68.9%	-8.4%	70.6%	62.6%	55.6%	54.3%	66.8%	57.3%	67.9%	70.5%	66.2%
SNEE	East Suffolk and North Essex NHS Foundation Trust	70.8%	72.0%	1.2%	73.2%	-1.2%	73.4%	72.1%	69.2%	68.4%	73.3%	76.6%	72.9%	69.8%	74.9%
SNEE	West Suffolk NHS Foundation Trust	64.3%	66.8%	2.5%	72.0%	-5.2%	73.0%	69.5%	58.1%	65.7%	70.7%	75.2%	65.8%	78.2%	76.0%
	Region	69.2%	72.6%	3.4%	76.3%	-3.7%	77.0%	72.8%	70.3%	70.7%	74.4%	75.2%	72.5%	73.0%	74.1%

B. 12 Hour

									Last 7 days performance						
System	Trust level performance	Performance in November last year	November to date	Comparison to last year	Plan	Comparison to plan	Required to achieve plan for remainder of month	Average over last 7 days	Fri 31 Oct	Thu 30 Oct	Wed 29 Oct	Tue 28 Oct	Mon 27 Oct	Sun 26 Oct	Sat 25 Oct
BLMK	Bedfordshire Hospitals NHS Foundation Trust	5.1%	2.8%	-2.3%	4.2%	-1.4%	4.2%	4.7%	2.7%	5.0%	6.3%	7.1%	5.3%	4.8%	1.2%
BLMK	Milton Keynes University Hospital NHS Foundation Trust	5.8%	#N/A	#N/A	6.3%	N/A	#N/A	7.1%	No Data	No Data	No Data	No Data	No Data	0.0%	7.4%
C&P	Cambridge University Hospitals NHS Foundation Trust	11.7%	12.4%	0.6%	7.0%	5.4%	6.8%	12.8%	13.0%	11.9%	13.2%	12.0%	14.7%	10.2%	15.1%
C&P	North West Anglia NHS Foundation Trust	12.0%	13.4%	1.4%	12.3%	1.1%	12.3%	14.7%	15.6%	14.7%	15.3%	17.8%	12.7%	11.6%	14.6%
HWE	East and North Hertfordshire Teaching NHS Trust	13.0%	9.6%	-3.4%	8.3%	1.3%	8.3%	11.9%	9.8%	15.3%	12.5%	13.0%	11.7%	7.2%	13.4%
HWE	The Princess Alexandra Hospital NHS Trust	19.7%	13.9%	-5.8%	9.0%	4.9%	8.8%	11.2%	14.3%	7.4%	11.9%	15.8%	10.5%	9.6%	7.8%
HWE	West Hertfordshire Teaching Hospitals NHS Trust	8.8%	8.6%	-0.2%	8.4%	0.3%	8.4%	10.7%	7.2%	12.7%	7.7%	9.7%	10.9%	13.6%	14.2%
MSE	Mid and South Essex NHS Foundation Trust	8.6%	11.2%	2.6%	9.8%	1.4%	9.7%	12.4%	13.6%	11.4%	13.6%	15.1%	11.8%	9.9%	11.4%
N&W	James Paget University Hospitals NHS Foundation Trust	9.3%	7.4%	-1.9%	7.7%	-0.3%	7.7%	8.3%	12.1%	3.9%	10.0%	9.5%	9.3%	7.0%	7.0%
N&W	Norfolk and Norwich University Hospitals NHS Foundation Trust	4.9%	6.3%	1.5%	3.5%	2.8%	3.4%	5.0%	7.3%	6.4%	6.0%	4.7%	3.8%	2.7%	4.4%
N&W	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	13.5%	22.0%	8.5%	11.8%	10.2%	11.4%	17.8%	20.6%	21.3%	14.6%	20.3%	15.8%	13.6%	19.6%
SNEE	East Suffolk and North Essex NHS Foundation Trust	13.3%	11.5%	-1.8%	13.8%	-2.3%	13.9%	15.2%	14.0%	11.4%	19.1%	19.9%	16.5%	13.4%	12.6%
SNEE	West Suffolk NHS Foundation Trust	11.4%	1.6%	-9.8%	6.0%	-4.4%	6.2%	6.8%	4.4%	2.9%	7.9%	6.1%	13.1%	10.4%	2.4%
	Region	10.0%	9.9%	-0.2%	7.5%	2.4%	7.4%	11.0%	11.2%	10.4%	11.8%	12.9%	11.1%	9.2%	10.0%

C. Cancer – 62day

	Jun-25	Jul-25	Aug-25			
	% in target (Total)	% in target (Total)	Cases	Breaches	% in target (Total)	Change from last month
EAST AND NORTH HERTFORDSHIRE NHS TRUST	81.9%	82.9%	199.5	27.5	86.2%	3.3%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	78.8%	78.0%	172	36	79.1%	1.1%
WEST SUFFOLK NHS FOUNDATION TRUST	73.6%	70.6%	133	29	78.2%	7.6%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	72.3%	70.1%	239.5	60	74.9%	4.8%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	67.0%	68.8%	227.5	60	73.6%	4.8%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	72.4%	66.1%	270	75.5	72.0%	5.9%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	66.5%	64.0%	135.5	46	66.1%	2.0%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	66.1%	69.9%	393.5	137.5	65.1%	-4.8%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	54.6%	55.0%	271	100.5	62.9%	7.9%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	60.1%	70.7%	103	40	61.2%	-9.5%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	41.8%	57.7%	140	57.5	58.9%	1.2%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	39.6%	46.1%	456.5	242	47.0%	0.9%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	53.4%	49.8%	101.5	57	43.8%	-5.9%
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	32.6%	30.0%	17.5	10.5	40.0%	10.0%
Total	62.1%	64.3%	2860	979	65.8%	1.5%

RAG rating used

Dark Green ≥85%
Light Green 75-85%
Amber: 70-75%
Red <70%

D. 28 Day FDS

	Jun-25	Jul-25	Aug-25			
	% in target (Total)	% in target (Total)	Cases	Breaches	% in target (Total)	Change since last month
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	85.4%	86.9%	1,727	222	87.1%	0.2%
WEST SUFFOLK NHS FOUNDATION TRUST	74.0%	80.5%	1,249	251	79.9%	-0.6%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	80.6%	82.1%	2,291	462	79.8%	-2.2%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	80.2%	79.8%	1,628	343	78.9%	-0.8%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	77.9%	78.4%	2,618	568	78.3%	-0.1%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	77.3%	77.6%	1,465	332	77.3%	-0.2%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	74.5%	78.3%	1,162	293	74.8%	-3.5%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	75.9%	74.4%	2,708	714	73.6%	-0.8%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	69.2%	79.4%	3,252	865	73.4%	-6.0%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	73.9%	74.9%	4,342	1,201	72.3%	-2.5%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	72.5%	73.5%	1,777	591	66.7%	-6.8%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	70.0%	69.4%	1,300	519	60.1%	-9.3%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	56.9%	64.9%	6,465	2,614	59.6%	-5.4%
Total	71.8%	75.0%	31,984	8,975	71.9%	-3.1%

RAG rating used
Green: ≥80%
Amber: 75-80%
Red: <77%

E. Elective – Waiting for First Attendance

Org c	Org Name	Baseline (w-e 01 Dec 24)	w-e 21 Sep 25	w-e 28 Sep 25	w-e 05 Oct 25	w-e 12 Oct 25	w-e 19 Oct 25	w-e 26 Oct 25	
		% waiting for first attendance within 18w	% waiting for first attendance within 18w	% waiting for first attendance within 18w	% waiting for first attendance within 18w	% waiting for first attendance within 18w	% waiting for first attendance within 18w	% waiting for first attendance within 18w	Distance from Mar-26 target*
Y61	EAST OF ENGLAND	58.7%	58.9%	58.8%	59.1%	59.1%	59.2%	59.1%	-7.9%
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYN	54.2%	60.5%	60.7%	61.3%	61.7%	61.9%	61.1%	-5.9%
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH IN	58.6%	61.5%	61.2%	62.1%	62.0%	62.3%	62.3%	-4.7%
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGR	58.6%	62.9%	62.4%	62.7%	62.7%	62.9%	63.0%	-4.0%
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE	56.4%	51.9%	51.7%	51.8%	51.6%	51.5%	51.6%	-15.4%
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CAR	59.9%	56.1%	56.2%	56.2%	56.4%	56.4%	56.2%	-10.8%
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRA	65.5%	64.2%	64.1%	64.2%	64.3%	64.3%	64.3%	-6.3%
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION T	56.2%	62.8%	63.1%	63.6%	63.6%	63.5%	62.2%	-4.8%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUN	63.6%	61.7%	61.5%	62.3%	62.2%	62.4%	62.4%	-6.2%
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	65.7%	67.5%	66.9%	67.6%	67.2%	67.7%	68.1%	-2.6%
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDA	63.2%	61.9%	61.6%	61.6%	61.6%	61.6%	61.6%	-6.6%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOU	64.4%	56.1%	56.0%	56.1%	56.2%	56.6%	56.7%	-12.7%
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUS	56.4%	51.9%	51.7%	51.8%	51.6%	51.5%	51.6%	-15.4%
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FO	47.7%	55.1%	54.9%	55.7%	57.0%	58.2%	58.4%	-8.6%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITAL	58.0%	55.8%	56.0%	55.5%	55.5%	55.2%	55.0%	-12.0%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	53.5%	60.2%	59.8%	60.7%	60.6%	60.9%	61.0%	-6.0%
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION	77.4%	92.5%	92.7%	93.1%	93.2%	94.0%	93.7%	11.3%
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUS	47.7%	51.0%	50.2%	50.3%	50.8%	50.9%	50.9%	-16.1%
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN,	61.0%	57.1%	57.0%	58.0%	58.8%	59.3%	58.7%	-8.3%
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	68.4%	69.6%	69.6%	69.5%	69.6%	69.2%	69.0%	-4.4%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	73.9%	71.8%	72.6%	73.1%	73.7%	73.4%	73.4%	-5.5%

F. Elective – Total Waiting trend

Total Incomplete Pathways

Org code	Org Name	w-e 21 Sep 25	w-e 28 Sep 25	w-e 05 Oct 25	w-e 12 Oct 25	w-e 19 Oct 25	w-e 26 Oct 25	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week average
Y61	EAST OF ENGLAND	864,584	863,512	864,592	868,216	869,985	865,588	-4,397	519	-4,916
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE	121,162	121,110	121,394	122,912	123,057	122,067	-990	239	-1,229
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOA	152,689	152,325	152,844	152,587	152,926	152,355	-571	8	-579
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	144,064	144,242	144,220	144,646	144,902	144,268	-634	7	-641
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	178,044	178,550	179,268	180,955	181,965	181,184	-781	659	-1,440
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	146,960	146,483	145,762	145,852	145,793	144,447	-1,346	-509	-837
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	121,665	120,802	121,104	121,264	121,342	121,267	-75	116	-191
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	85,306	85,306	85,704	86,133	86,477	86,327	-150	255	-405
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	67,956	67,934	68,218	68,086	67,815	67,507	-308	-107	-201
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	50,671	51,025	51,118	51,552	52,199	52,195	-4	293	-297
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	88,387	88,189	88,189	88,189	88,189	88,189	0	0	0
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	35,360	34,811	34,898	34,934	34,825	34,427	-398	-96	-302
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	178,044	178,550	179,268	180,955	181,965	181,184	-781	659	-1,440
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	35,856	35,804	35,690	36,779	36,580	35,740	-840	-16	-824
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	83,095	83,258	82,688	82,812	82,977	82,591	-386	-167	-219
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	78,599	78,307	78,570	78,448	79,043	78,870	-173	141	-314
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	6,134	6,084	6,056	6,053	6,068	5,978	-90	-27	-64
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	44,749	44,552	44,456	44,167	43,668	43,207	-461	-336	-125
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TF	28,505	28,414	28,176	28,106	27,991	27,429	-562	-246	-316
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	48,644	48,665	48,646	48,927	49,035	48,866	-169	50	-219
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	33,278	32,613	32,915	33,075	33,153	33,078	-75	116	-191

BOARD OF DIRECTORS: Trust Board 11 December 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 December 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 External Audit Update	Yes	No	No	The Committee noted the update received form the CFIO regarding the appointment of the Trust's new external auditors.
3.1 Internal Audit Progress Report and	Yes	Yes	Yes	The Committee was assured on the progress of the 2025/26 audits with two reports finalised since the last meeting. Reports Finalised: • 25/26 Final Internal Audit Report – People Deployment (Rostering) - Moderate (Design) & Limited (Effectiveness) Assurance • BDO – 25/26 Final Internal Audit Report – Divisional Governance (Surgery and Critical Care)- Substantial (Design) & Moderate (Effectiveness) Assurance The Health and Safety audit is at draft stage and expected to be finalised before the March 2026 Committee meeting. Two further reviews (key financial systems and tissue viability) are in fieldwork and will be ready for the March meeting. The committee agreed to defer the corridor care audit (now termed "temporary escalation space audit") to potentially 2026/27, aligning with recent operational changes whereby the Trust has implemented a cohorting space to. The Committee noted ongoing challenges with data quality, particularly in rostering, and agreed that a report would be prepared and the CFIO and DCG would discuss offline

BOARD OF DIRECTORS: Trust Board 11 December 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 December 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				which committee would receive the report prior to the Board receiving it.
3.2 Internal Audit Follow Up Report	Yes	Yes	No	17 internal audit recommendations were due for follow-up; of these, 8 were fully complete, 6 were in progress, and 3 were overdue. There had been improved engagement and review by executive leads at the draft report stage which had led to more realistic implementation dates being agreed for recent actions, reducing the risk of future delays. Overall, the Committee was assured in regard to the good progress in closing longstanding recommendations however it was noted that some recommendations had been deferred and required ongoing monitoring. The committee requested that recommendations from older audit reports not yet implemented, are also included in the follow up report.
3.3 Counter Fraud Progress Report	Yes	Yes	No	The Committee was assured in regard to the progress against the 2025/26 counter fraud plan. The fraud risk assessment was underway using the new NHS template, with 24 areas selected and responses due by late December. Two new referrals had been received and investigated during the reporting period, with two cases closed, including one previously not reported due to sensitivity. The National Fraud Initiative's company house data matches were completed with no concerns identified; payroll-to-payroll matches were in progress, pending HR information. A local

BOARD OF DIRECTORS: Trust Board 11 December 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 December 2025

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				proactive exercise focused on expenses fraud was progressing, with results expected for the March Audit Committee.
4.1 Waivers, Losses, Special Payments & Debt Write Offs	Yes	No	No	During the period 1st July 2025 to 30th September 2025: •The value of losses and special payments totalled £10k (6 cases). •There is no additional bad debt identified in this period •15 waivers totalled £1,020,322. 1 was non-compliant (£57.6k). The Committee discussed the importance of reducing reliance on sole suppliers and aligning contracts across the ICB footprint to improve resilience, with ongoing quarterly contract reviews and a proposal for a future deep dive on sole supplier exposure.
4.2 Annual Accounts 2025/26 - Reporting Timetable	Yes	No	No	The Department of Health and Social Care (DHSC) have confirmed the key submission dates for the 2025/26 Accounts and Annual Report timetable. • Draft Annual Accounts submission to NHSE: 27 April 2026 (noon) • Final signed and audited Accounts and Annual Report submission: 26 June 2026 (noon) The Committee approved the Annual Accounts 2025/26 reporting timetable.
4.3 Clinical Audit	Yes	Yes	No	The Trust's clinical audit programme included the ongoing participation in the majority of national clinical audits, which form the core of the Trust-wide programme. It was confirmed that a review of the clinical effectiveness programme was underway, with

BOARD OF DIRECTORS: Trust Board 11 December 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 December 2025

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				a focus on enhancing the dissemination of lessons learned and aligning audit processes with patient safety and incident reporting mechanisms. The Committee discussed the status of clinical audit recommendations, noting that while many actions were in progress or completed, a number remained outstanding or under review. A report on sharing the learning from audits will be presented to QSC and Audit Committee in the new year.
4.4 CQC Compliance	Yes	Yes	No	Following the 2021 and 2023 CQC inspections, the Trust had received 85 recommendations, of which 66 had been closed and embedded into business as usual, with external assurance from ICB colleagues. 18 actions remained open: 8 were rated green and undergoing final testing before closure, and 11 were rated amber, with 8 of these relating to training and appraisal processes being monitored through the People Committee. No actions were rated red at the time of reporting. The Trust continued to monitor progress monthly through the Quality Compliance Improvement Group and the PMO, with escalation to the Quality and Safety Committee. The Trust was undergoing a live CQC inspection, and the action plan would be updated as new recommendations emerged. The Committee agreed to receive a further update in six months' time.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 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:	**20 November 2025**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 'Pride in Place' Bid	Y	Y	N	The Committee was assured that the Pride in Place bid for Harlow is in alignment with the WE HCP aims and requested that the 3 year board investment plan is presented to a future meeting when prepared.
2.3 National Neighbourhood Health Implementation Programme Update	Y	Y	N	The programme is progressing well in line with the national timetable. Interim funding request to the Better Care Fund awaiting decision. Next focus on outcome measures, future funding flows & contract models with the national team. Ongoing updates to the committee.
2.4 Essex Commissioning Intentions	Y	Y	N	Collating a West Essex HCP response to the draft commissioning intentions which include the host provider model but will require WE HCP leadership to facilitate the model in the new Essex ICB.
2.5 Community Hospital Bed Proposal	Y	Y	Y	The winter pilot proposals were approved and the committee requested that outcome measures were proposed and reviewed by the WE HCP Quality & Transformation group.
2.6 West Essex Careers Pathway Initiative	Y	Y	N	The initiative was supported, EPUT joining in January 2026.

BOARD OF DIRECTORS:	**Trust Board (Public) – 11 December 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:	**20 November 2025**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.7 WEHCP Locality Highlight Reports	Y	Y	Y	The Cambridge University Hospital pathology issues was referred back to the WE HCP Finance & Commissioning Group for resolution to maintain effective patient pathways in north Uttlesford.
3.1 Host Provider Delegation Proposal	Y	Y	Y	New Essex ICB support the host provider operating model for implementation in 26/27, WE HCP will prepare the governance & assurances to be ready 1/4/26. Also supportive of discussion regarding the East Herts border membership of WE HCP, discussions to commence.
4.1 WEHCP Commissioning Assurance Report	Y	Y	N	The committee was assured but asked for support on stroke pathways, east Hertfordshire flows and the status of Nightingale ward for winter. The committee approved the business case to deliver Insulin Pump service to adults in west Essex.
4.2 Planning Update	Y	Y	N	The committee agreed that the WE HCP executive team would review the planning submission for approval with an emailed explanation to the committee to ensure all are informed.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board – 11th December 2025**			**AGENDA ITEM: 7.3**
REPORT TO THE BOARD FROM:	**Executive Board (EB)**			
REPORT FROM:	**Committee Chair – Tom Burton**			
DATE OF COMMITTEE MEETING:	**18th November 2025**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
CEO Strategic update	Y	Y	N	CQC inspection: The CQC carried out an unannounced inspection of UEC and Surgery on the 11th & 12th November. The trust is working through the actions that came out of the inspection. There will be a CQC well led inspection taking place at the end of January 2026 • GP Front Door Model: • The GP front door model in the Emergency Department is working well and early signs are positive. Divisional Clinical Restructure Some of the new posts have been formally announced. The interviews for posts in the new structure continue and are due to conclude at the end of December.
Health Inequalities	Y	Y	N	EB noted the update from the CMO on progress with Health Inequalities. EB discussed the expectation that EB will routinely report to the Board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivation. The COO highlighted that the Integrated Performance Report (IPR) is under review and will include ethnicity and inequalities. Further consideration is being given how Executive Board members will routinely report to Board on this.

Strategy Refresh (RISE)	Y	Y	N	EB noted the presentation on 'RISE' and the progress being made. The RISE Strategic Framework aims to restore hope and ambition to PAHT. EB discussed the wording, clinical input into the development of the strategy as well as hearing the voice of the Trust's patients and community.
Community Bed Review recommendations	Y	N	N	EB noted the update from EPUT on the Community Bed Review and the recommendation to reconfigure Poplar ward (22 beds) at St Margaret's Community Hospital to operate as Short-Stay Community Assessment and Treatment Unit (CATU) for Winter 2025/26 commencing 1st December 2025.
Finance Update	Y	Y	N	EB noted M7 financial plan delivered an actual surplus of £1.4m against a planned surplus of £1.4m, resulting in a YTD deficit of £0.9m which is on plan
Planning Update, to include commissioning intentions	Y	Y	N	EB noted that release of the full planning guidance and templates had been delayed. Internally work on planning continues with baselines being finalised and further demand and capacity planning to take place between now and January 2026 to ensure delivery of the performance targets.
Linen & Laundry Tender Approval	Y	N	N	EB approved the new Linen & Laundry contract.
Additional Validation Resource	Y	Y	N	EB approved additional validation resource and deployment of the LUNA ROVER AI validation tool to sustain improvements. Both are funded within the existing Operational Performance budget.
MSK Service Review	Y	Y	N	EB noted the report and the future considerations for the MSK Service contract as detailed in the report.

Performance Reports	Y	N	N	The Operational Board report was noted by EB Surge plan – EB noted the first iteration of the revised surge plan. It has been developed to enhance and ultimately replace the existing Full Capacity Protocol, offering a more agile, coordinated, and sustainable approach to managing demand across all services. Cancer Action Plan – EB noted the cancer action plan is on track, the launch of the new Cancer Board is1st December. The Trust was commended at the NHSE Tier 1 meeting on the 6th November for the upward trajectory for the 62-day metric for the performance delivered in September and the early indicators for October performance.
Risk Management Group Report & Corporate Risk Register	Y	Y	N	EB approved Risk ID 801 for inclusion to the Corporate Risk register. The risk has a score of 4 x 4 = 16 and relates to the risk to cardiology service if funding is not approved by end of December for equipment that is outside of its recommended replacement time with no appropriate maintenance contract in place. EB noted the Corporate Risk Register update report.
IG Steering Group Assurance Report	Y	N	N	EB noted the IG Steering Group Assurance Report
CDC Update	Y	Y	N	EB noted the CDC report and the delay to the opening date due to power issues. Impact has been modelled to understand impact on wider programme timelines. Work continues in relation to the pathways and recruitment.
Any Other Business	Y	N	N	EB noted the staff survey response rate at the date of this meeting was at 51.4% with a target of 60% by the closing date of 20th November 2025.