The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 5 February 2026 at 09.30 – 12:45
Venue: Boardroom, Kao Park, London Road, Harlow

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	18
09.35: Staff Story: 'From Community to Career: Inclusive Pathways into Work'					
02 Chair and Chief Executive's reports					
10:00	2.1	Acting Chair's Report	Inform	Acting Chair	19
10:05	2.2	CEO's Report	Inform	Chief Executive	23
10:10		*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	28
10:25	3.2	Board Assurance Framework 2025-26 *Diligent Resources: BAF 2025-26*	Review/ Approve	Director of Corporate Governance	31
04 Patients					
10:35	4.1	Reports from Quality and Safety Committee on 30.01.26 • Part I • Part II	Assure	Committee Chairs	36 49
10:45	4.2	Maternity Reports: • Maternity Patient Safety Incidents (MPSIs) • Maternity & Perinatal Incentive Scheme • Homebirth Prevention of Future Deaths & PAHT Plans	Assure/ Approve	Interim Chief Nurse/ Director of Midwifery	54 56 62
11:00	4.3	Nursing, Midwifery and Care Staff Levels	Assure	Interim Chief Nurse	68
11:10	4.4	Nursing Establishment Review	Approve	Interim Chief Nurse	74

11:20	4.5	Learning from Deaths (Mortality) Report	Assure	Chief Medical Officer	87
		B R E A K 11:30 to 11:40			
05 People					
11:40	5.1	Report from People Committee 27.01.26	Assure	Committee Chair	94
11.45	5.2	Staff Survey Update (including Culture Update)	Assure	Chief People Officer	Verbal
11:55	6.1	Report from Performance and Finance Committee 29.01.26	Assure	Chair of Committee	104
12.00	6.2	Finance Update	Assure	Chief Finance & Infrastructure Officer	112
12:10	6.3	Integrated Performance Report (IPR) including: • Access Report	Discuss	Chief Operating Officer	120 151
12:20	6.4	Emergency Planning and Preparedness	Approve	Chief Operating Officer	166
07 Governance					
12:25	7.1	Report from West Essex Health and Care Partnership Board 15.01.26	Assure	Chair of Committee	172
12:30	7.2	Report from Executive Board Meeting 21.01.26	Assure	Chair of Committee	174
12:35		*Opportunity for members of the public to ask questions about the board discussions or have a question answered.*			
08 Closing administration					
	8.1	Any unresolved issues			
	8.2	Review of Board Charter			
	8.3	Summary of actions and decisions	-	Chair/All	
	8.4	New risks and issues identified	Discuss	All	
	8.5	Any other business	Review	All	
	8.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
12:45		Close			

Date of next Public Board meeting: 2 April 2026

The Princess Alexandra Hospital NHS Trust

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

Board Membership and Attendance 2025/26			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Acting Trust Chair	Darshana Bawa	Chief Executive	Thom Lafferty
Non-executive Director and Senior Independent Director (SID)	Elizabeth Baker	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 held in Public at PAHT Main Site (Lecture Theatre)
Thursday 11 December 2025 from 09:30 to 13:30

Present:

Darshana Bawa	**Acting Trust Chair (ATC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Liz Baker	Non-Executive Director (NED-LB)
David Baines	Non-Executive Director (NED-DB)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO)
Anna Jebb	Chief Operating Officer (COO)
Bola Johnson (non-voting)	Associate Non-Executive Director (ANED-BJ)
Andrew Kelso	Chief Medical Officer (CMO)
Thom Lafferty	Chief Executive Officer (CEO)
Giovanna Leeks (non-voting)	Chief People Officer (CPO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Chief Clinical Transformation Officer (CCTO)
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 (ICN)

In attendance:

Heather Schultz	Director of Corporate Governance (DCG)
Marcel Berenblut	Director of Communications (DoC)

In attendance (for specific items):

Finola Devaney (Patient Story)	Director of Clinical Quality & Governance (D-CQG)
Shahid Sardar (Patient Story)	Associate Director Patient Engagement & Experience
Claire Gibson (Patient Story)	Anticoagulation Lead (CG-AL)
Linda Machakaire (item 4.2)	Director of Midwifery (DoM)

Members of the Public:

Diane Deane-Bowers (for part)	Deputy Chair of Patient Panel (DC-PP)
Charlotte Collings	Lead Nurse for Safer Staffing and Workforce
Russell Edwards	Surgical Consortium
Mark Taylor (for part)	XY Laser Services

Apologies:

Parag Jasani (non-voting)	Associate Non-Executive Director (ANED-PJ)

Secretariat:

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 Board introduced themselves for the benefit of the public.
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 previous meeting held on 06.11.25 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:

	TB1.02.10.25/08 – Stroke Pathway The Chief Medical Officer (CMO) informed members an extensive piece of work in relation to Stroke Services was already underway with the ICB in an endeavour to improve this service. A Stroke Summit would now be held with colleagues at Queen's Hospital Romford who provided the service to understand their perception of the pathway. In terms of the associated service risk, this would continue to be reviewed at both Quality & Safety Committee and at Risk Management Group.
1.6	At this point the CEO highlighted the current reliance on BHRUT for stroke services, noting BHRUT was not within the Essex ICS. He asked the CMO therefore about other potential opportunities for stroke services in Essex. The CMO responded there were issues too within Essex so a view would need to be taken as to whether or not PAHT risked moving to another partner. The Hertfordshire component of the pathway should also not be forgotten. The ultimate decision as to who commissioned the pathway sat with the Stroke Delivery Network in the ICB so the Trust would work with them in order to provide the best possible pathway for patients.
1.7	In response then to a question from Associate Non-Executive Director Anne Wafula-Strike (ANED-AWS) as to whether stroke charities could help support patients, the CMO responded that whilst he did not have all the detail, he was aware that most stroke pathways were supported by the Stroke Association in some way.
1.8	TB1.02.10.25/154 – EM-SDEC Metrics (data to be provided) The Chief Operating Officer (COO) advised that EM-SDEC data would go through the Board Sub-Committees. In terms of ED 4 hour performance data, the organisation would not now be able to report on this due to the nature of how it was now reported.
Patient Story: From Acute to Community	
1.9	The ICN introduced Claire Gibson Anticoagulation Lead (CG-AL) and Shahid Sardar Associate Director of Patient Engagement & Experience (AD-PE&E). A short video clip was then played for the Board.
1.10	The story featured the Rowena Davey Centre, a community café and activity centre within a large community hall in Dunmow. The Anti-Coagulation Service, led by Claire Gibson, is based at Princess Alexandra but delivers its service in local community centres across the patch. This service ensures patients on blood thinners such as warfarin, remain safely 'in range' without the need to go to the hospital for their regular blood tests. The clip focussed on one patient named Peter who had recently attended the clinic after a ten-hour shift at work coming back from his job in London. He described the service as "local, convenient, easy to park and a life saver for someone working shifts." This reflected the real-world impact of bringing care closer to home.
1.11	The story linked with the NHS 10 Year Plan's commitment to shifting care from acute settings to community, highlighting that this didn't have to be complicated. Community centre environments existed throughout the Trust's geography and could help deliver better outcomes, improved patient experience and more sustainable services.
1.12	In response to the above the Director of Clinical Quality & Governance (D-CQ&G) informed members the Anticoagulation team had been shortlisted for an HSJ award in the previous year.
1.13	The Deputy Chair of the Patient Panel (DC-PP) asked whether the above service could be applied to other conditions, for example diabetes. CG-AL responded this was currently being considered.
1.14	The Chief Clinical Transformation Officer (CCTO) commended CG-AL for her leadership of the service and continued passion and enthusiasm. He asked how much self-testing and point of care testing could be introduced to enable patients to send their results directly to the hospital. CG-AL responded there were currently funding and IT issues relating to self-testers which were being worked through.
1.15	Associate Non-Executive Director Ben Molyneux (ANED-BM) then asked how colleagues had managed to deliver clinical services in a non-clinical space and also for some detail in relation to the associated workforce transition (acute to community). In response to the first question

	CG-AL confirmed the Rowena Centre service had been set up during COVID so there had been strict IPC procedures which continued to this day. She acknowledged the workforce had been a challenge initially. The establishment had required some revision and continuously required review. The service was changing and some roles were currently under review to ensure the service remained efficient and safe.
1.16	ANED Bola Johnson (ANED-BJ) then asked about the main challenges of running the service. CG-AL responded the key challenge was as described above; workforce. Engagement and training were key. Colleagues always worked in pairs in the community to ensure safety. IT was another challenge including wi-fi connectivity in more remote community settings.
1.17	The CEO then commended CG-AL on an amazing service, which was one that should be seen in future for the majority of healthcare. He had seen with his own eyes how this type of community service meant so much to patients. It was also very much aligned with the 'sickness to prevention' aspect of the NHS Ten Year Plan and should provide the organisation with the confidence to now move other services into the community and be a trailblazer in this regard.
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. In terms of the divisional restructure she commended the recent assessment centres which had taken place. She had been impressed with not only the process itself but also the strong engagement from the candidates. What had particularly stood out had been colleagues' passion for the roles they undertook daily and also their self-awareness of their own development needs.
2.2 CEO's Report	
2.2	The CEO introduced his report and reminded members this was his first public Board meeting since reaching the one year anniversary of his tenure as PAHT CEO. He informed members it remained an absolute privilege to lead PAHT and he was personally determined to ensure that colleagues worked together to positively change the fortunes of the organisation, the working experience of staff and critically the service experience of patients and members of the public. On this, real progress was starting to be made and firm foundations had now been established on which to build going forward.
2.3	The CEO continued with his update and following key headlines were noted: **Care Quality Commission (CQC):** The Trust remained in live inspection mode. The initial inspection had been in UEC/Surgery in mid-November followed by Medicine. The organisation had been required to respond to some CQC concerns in UEC related to corridor care and he commended the prompt way in which staff had responded to this in terms of providing assurance and evidence. The Well-Led inspection would then take place towards the end of January 2026. **People**: The CEO was delighted to advise Board colleagues that at the time of reporting, 62.7% of staff had participated in that year's Staff Survey exercise. This surpassed the internally-imposed target of 60% and was significantly above previous years' performance in this regard; setting an historical record for medical participation. **Resident Doctors' Industrial Action:** Further industrial action would run from 17.12.25 to 22.12.25. PAHT responded well to industrial action and he was confident the next bout would be no different. **Performance:** There had been a positive meeting with regional colleagues the previous week. Performance related to the ED 4 hour standard, cancer and RTT was significantly better than for 12 months previously and this should be celebrated.

	New Hospital Programme: The Board was currently considering its strategy and approach to its involvement within the national New Hospital Programme (NHP). The Trust's proposed development at Junction 7A of the M11 had been frustratingly delayed for many years with current estimates indicating that building works on the site would commence in 2032 at the very earliest. In the meantime, the risks associated with the Trust's deteriorating estate continued to grow and this had prompted a review, in close partnership with the national NHP team and local stakeholders. **Phlebotomy:** The Trust's Phlebotomy Service would move to the Harvey Centre in February 2026 and was part of the organisation's commitment to improving patient experience and accessibility to services.
2.4	ANED-AWS commended the move of Phlebotomy Services to the local Harvey Centre but asked what measures would be in place to ensure safety for staff who would now be working remotely.
2.5	The Chief Finance & Infrastructure Officer (CFIO) explained that the Harvey Centre had its own security and the local council had also made a commitment to police the town centre. The Harvey Centre was a busy shopping area and as such, staff working there were not as isolated as they possibly were on the Trust's satellite sites.
2.6	In response to an earlier comment on the cessation of corridor care, NED Liz Baker (NED-LB) asked how the organisation would protect the new designated cohort area so that it continued to function. The Interim Chief Nurse (ICN) responded colleagues were working hard not to use the corridors, focussing on plans to maintain flow. She acknowledged there would be times when the corridors may still need to be used but, a new surge plan was now in place and professional judgement would be used to support decision-making. This would ensure only the most appropriate patients were placed into those spaces; flow would be the key in achieving this.
Questions from the Public	
2.7	Claire Gibson (CG) noted that the staff working the service would be employed by HSL not the Trust and queried any impact this might have on the service. The CEO responded that contracts were in place which would include service criteria.
03 Risk	
3.1 Corporate Risk Register (CRR)	
3.1	This item was presented by the CMO and the paper was taken as read. He reminded members this provided a summary of the Trust's principle risks. Highest risk themes had not changed since the report's previous presentation.
3.2	In relation to Risk 85 (Emergency Care Access Standard) which was the highest scoring risk at 20, the CEO asked whether the risk description was correct, given the organisation was now meeting this standard. He asked whether the risk description should be broadened to be more about the general risk to patients when there were pressures at the front door.
3.3	The CMO responded there were two other risks which reflected what the CEO had just described but he agreed to review the wording and current risk score of Risk 85. The COO and Associate NED Bola Johnson (ANED-BJ) also agreed with the request for a review.
ACTION **TB1.11.12.25/16**	**Corporate Risk Register: Review the wording and current risk score related to Risk 85 (Emergency Care Access Standard).** **Lead: Chief Medical Officer**
3.4	In response then to a point made by NED-CM, the CMO responded a Board Development session on risk was planned for January 2026.
3.5	NED Liz Baker (NED-LB) then asked, in terms of the divisional restructure, whether risk mitigations would be reviewed to ensure those mitigating actions continued despite the changes in roles. The CMO responded this should be a 'lift and shift' and he had no concerns. The COO added a Transition Steering Group was in place to manage the transition to the new divisions and risk queries were part of the handover process.

3.6	NED David Baines (NED-DB) then asked about the impact of Alex Health issues on care. The CMO responded this would be covered in the BAF discussion but essentially there was a triangulation process in place in terms of what was being seen on the ground, with incidents, complaints and interactions within the community.
3.7	The ATC thanked the CMO for his update, noting the request for a review of the narrative and risk score related to the ED standard risk.
3.2 Board Assurance Framework 25/26	
3.8	This item was introduced by the Director of Corporate Governance (DCG). She referenced the question above from NED-DB which related to risk 1.4 (EHR) and asked the risk lead (CCTO) whether he would like to add anything further. The CCTO then informed members that in terms of the risks related to Alex Health a robust structure was in place for the whole programme. Current issues related to adoption of the system by users. A good governance structure was in place including the establishment of a Digital Board. Additional/enhanced training was being provided for users. Managing workflows was challenging but a good cell structure was in place led by the COO with involvement from the People team. On a positive, a large cohort of colleagues were using the system well including nurses and clinicians.
3.9	In response to the above the COO added that the narrative relating to BAF Risk 1.3 (Operating Plan) had been updated to include a description of system adoption. The Chief Strategy Officer (CSO) provided further assurance that GPs were now part of the membership of the Executive Board (on rotation) which enabled the Trust to hear the views of system partners.
3.10	The DCG continued that BAF Risk 3.2 (System Pressures) was presented to the Board for review. No changes were proposed to the risk score. BAF risk 3.5 (new hospital) was also presented for formal closure following Board agreement in October 2025 to merge that risk with the Estates risk. This had also been discussed and agreed at PAF.
3.11	Reflecting on the risk trend over the year to date, the DCG noted that a significant portion of risks were quite static in terms of their scores, possibly because these were quite macro, complex risks which did not shift significantly. In contrast five risks had been closed in-year.
3.12	ANED-BJ then raised a point in relation to BAF risk 3.2 (system pressures) and asked if March 2026 was a realistic date for reducing the level of risk . The DCG responded the risk had been reviewed with the CSO and at the current stage March 2026 was the target date, but this would remain under review. The CSO added there had been significant movement that year to neighbourhood health/host provider so the required components were in place to achieve a reduction in the risk score.
3.13	In response to the above the CEO informed members that a few days previously EPUT had put a new Community Assessment and Treatment Unit (CATU) in place which was already receiving positive feedback from patients. He commended this development and highlighted that alternatives to the hospital front door were key. Going back to the risk discussion on Alex Health, he had been clear with stakeholders that in a few years' time there must be a single acute EHR in Essex, connected to Primary Care and now would be the optimal time to address that given EPUT/MSE were embarking on their own EHR journeys.
3.14	In line with the recommendation, the Board: • Formally noted the changes to BAF risks 1.3 and 1.4. • Reviewed BAF risk 3.2 (System Pressures). • Formally approved the closure of BAF risk 3.5 (New Hospital). • Noted the remaining BAF risks.
04 Patients	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	<u>QSC1.28.11.25 – Chair NED Oge Austin-Chukwu (NED-OA)</u> NED-OA presented her update and the key headlines from the last meeting of QSCI were: • Complaints numbers were rising so QSC had requested a breakdown of new/reopened cases. • IPC module now launched in Alex Health.

	• Assurance provided on patient cancer harms in Urology. Harm review process for other tumour sites now requested. • In terms of mortality, work continued to address the issues that had come to light in relation to the number of episodes of care and comorbidity recording. Investigations to date were showing there were no concerns around patient care. • A large number of open incidents currently, but they had all been triaged within 5 days and were being managed.
4.2	In response to a question from ANED-AWS, the ICN confirmed that complaints themes in the main related to communications, delays to treatment and cancellations. The Patient Experience Group had oversight of complaints and a plan was in place to contact all patients who were waiting to manage expectations.
4.3	The CEO then drew members' attention to point 3.4 in the paper relating to Regulation 28s (prevention of future deaths). He provided assurance there had been an Executive conversation on this and there would now be a deep dive, the outputs of which would be presented to QSC.
4.4	<u>QSCII.28.11.25 – Chair Associate NED Ben Molyneux</u> ANED-BM presented his update and the key headlines from the last meeting of QSCII were: • First month with sight of the new dashboard data and pleasing to note that all key metrics remained within normal variation. • The MOSS (Maternity Outcomes Signal System) system had launched and further updates would follow. • Progress had been made on overdue guideline compliance with extensions requested where national guidance had not changed and a plan was in place to clear all overdue documents by early 2026.
4.5	The ATC then flagged that the 90% target in terms of booking performance was consistently not being met, particularly for minority ethnic groups and she asked what could be done to improve that. The Director of Midwifery (DoM) responded that the Trust's performance in the East of England for this was this highest. She acknowledged however that currently black/Asian women were grouped as one so this needed some work. NED-OA added (as Maternity champion) that the Maternity Voices Partnership promoted listening exercises for BME women. She had been present at one but it had not been well attended as this cohort of women was hard to reach.
4.2 Maternity Reports	
4.6	<u>Maternity Patient Safety Incident Investigation (PSII) Report</u> This item was presented by the DoM. Key headlines to note were that there had been no new maternity PSII declared in Q2. One case (maternal death) had been investigated by MNSI and closed with no recommendations. There were currently 4 PSII investigations ongoing, which were 2 PSIIs and 2 MNSI cases – these would be closed by January.
4.7	Members had no questions.
4.8	<u>Quarterly Maternity Assurance Report (July to September)</u> This item was presented by the DoM and key headlines were: • Progress had been made on overdue guideline compliance, with extensions requested where national guidance had not changed and a plan was in place to clear all overdue documents by early 2026. • A bi-weekly local complaints management group had been established to address both new and historic complaints, with 25 open maternity complaints currently being managed. • A trajectory had been 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.
4.9	The CEO flagged the risk in Obstetrics related to insufficient evacuation routes for staff and one current route using the Cardiology area. The Phlebotomy Service would soon vacate this area and he asked whether that would mitigate the risk. The Chief Finance & Infrastructure Officer (CFIO) confirmed this would be reviewed

4.10	The Chief People Officer (CPO) asked whether any support was required in terms of currently expired documents. The DoM thanked the CPO for her offer of support. A new Governance Lead was now in place and there was good support from other teams and she believed this now had traction. The decision to consolidate some expired documents was also noted.
4.11	In response then to a question from the ATC in relation to the Internal Audit schedule of audits and whether maternity was covered within this, the DCG responded that an Internal Audit of maternity services governance had recently been undertaken.
4.12	<u>Maternity 6 Monthly Staffing Update</u> This update was presented by the DoM and the report detailed the maternity staffing position over the previous 6 months. The proactive over-recruitment of 14 midwives had been 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 had met all maternity incentive scheme staffing metrics throughout the year. The Birthrate+ October 2025 review had been validated and sent to the Trust on the 18.11.25. The report had yet to go through governance processes within the division and it would be presented to QSCII in January.
4.13	NED-OA asked whether the Birthrate+ tool was indicating an increase in establishment. The DoM responded that the tool was landing the establishment as requiring an increase, partially driven by an increase in headroom to 27% (it had previously been at 20%).
4.14	The CCTO then asked whether the report was stating that whilst there had been a decision to over-recruit, this had still been insufficient. He asked whether temporary/bank spend would reduce in Q4. The DoM responded the review was based on the funded establishment from the previous review. Previously this had been at 20% and many of the staffing issues had related to the rising vacancy rate. She provided assurance that bank/agency spend would reduce in Q4.
4.15	As a final point ANED-BM commented that he supported the over-recruitment and culture work. His view was there appeared to be a vicious circle of burnout, under-staffing, red flags over the summer and an increase in bank/agency spend. The focus needed to remain on recruitment and retaining colleagues once they joined.
4.16	<u>Maternity & Perinatal Incentive Scheme Update including Saving Babies Lives</u> The DoM reported full compliance with the Maternity & Perinatal Incentive Scheme (MPIS), except for historic non-compliance in two areas that could not be rectified (use of PMRT tool and MSDS data quality). Saving Babies Lives requirements had been 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 had been achieved across disciplines and ongoing work was in place to address future MNVP funding requirements as per MPIS standards.
4.17	The CEO noted the two safety actions at risk and asked about confidence in terms of the new scheme in the year ahead. The DoM responded the process was always to undertake an early review in April to identify any key changes from the previous year and elements which might potentially be at risk.
4.18	The CCTO added there had been investment in the data quality issue with some dedicated resource for the issues that had been unresolvable in the current year.
Break 11:28 to 11:45	
4.3 Nursing Midwifery and Care Staff Levels	
4.19	This update was presented by the ICN. She reported 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 in enhanced care needs. The mid-year nursing review (full year establishment review) and midwifery establishment review (Birthrate+ review) would be presented to the Board for approval in February 2026.

4.20	In response to the above the CEO highlighted that the report provided numerical assurance, but on the ground it was clear that concerns were often raised about short-staffing. He asked how the two could be balanced out. The ICN responded some of this came down to culture in the ward areas. In terms of numbers, the hospital was currently 'staff rich' compared to previous years. She acknowledged there were days when wards were short and staff were moved which was not a good experience for staff. Some work had been undertaken in the areas noting the highest shortfalls and a recommendation coming out of the establishment review would be to review enhanced care.
4.21	ANED-BM then flagged there had been a rise in pressure ulcers in the last reporting period but this appeared to be presented as a success story. He asked for some additional detail. The ICN responded that the aim was for zero pressure ulcers. She acknowledged there had been an increase in the previous reporting period and there had been some focussed work by the Pressure Ulcer Prevention Group. There would be a continued focus through Q1 The Fundamentals of Care Programme would launch in February but already some improvements had been seen in terms of severity. 9 wards had reported zero pressure ulcers in November and one ward had had no hospital acquired pressure ulcers for the previous 12 months. Pressure ulcer prevalence on Tye Green Ward was due to the patient cohort there.
4.22	NED-CM agreed to pick up offline with the ICN, the detail around care hours per patient day.
ACTION **TB1.11.12.25/17**	**Meet to discuss care hours per patient day.** **Lead: NED Colin McCready/Interim Chief Nurse**
4.23	In response then to a question from the ATC, the ICN responded that the reason for the overfill of healthcare support workers was due to enhanced care needs.
4.4 Learning from Deaths Update	
4.24	This update was presented by the CMO. He reminded members this had been discussed at length at the last Board meeting and at Board Sub-Committees. The position now was somewhat better. In-month SMR had been within normal limits for the previous four months. Rolling SMR was above expected but had been reducing for the last two months, and was driven by excess indices in November 24 and January/February 25. HSMR and SHMI were both within normal limits.
4.25	The CMO then reminded members that in terms of mortality reviews, the organisation undertook structured judgement reviews (SJRs) and Medical Examiner reviews. CUSUM alerts were not indicating any signals but the position would continue to be monitored closely and improvement actions would continue to include a focus on coding and education.
4.26	The CMO continued that weekend HSMR was above expected and for some time had been driven by the crude death rate. All cases had been reviewed and no care or treatment issues had been found. This position would continue to be reported to the Strategic Learning from Deaths Group and QSC but his view was something additional was now required. A better understanding was required about what was happening to patients admitted at the weekend so some wider triangulation would now be undertaken on the admission route to delve deeper into this. The outputs would be reported to January QSC.
4.27	ANED-BM then highlighted that QSC had requested projections on mortality rates to understand ongoing variance. He also asked how much medical staffing changes at weekends were impacting on weekend mortality and should some consideration be given to both nursing/medical staffing. The CMO agreed that weekend staffing in its entirely needed to be a focus. In terms of projections he didn't believe the Trust had the in-house ability to create these and if it did, these would be based on assumptions and not on reality.
4.28	The ATC then flagged that in figure 2 the HSMR 24 month rolling position had been rising for the previous 18 months. The CMO responded this had now levelled off in-month. Whilst this did not provide total assurance, what was most important was that in-month HSMR was now within normal limits. In summary this could be a legacy issue driven by previous data points.
4.29	In line with the recommendation the Board noted the progress being made on learning from deaths processes and the improvement work underway.

4.5 Health Inequalities	
4.30	This report was presented by the CMO. He reminded members that NHS Providers had 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 had been completed to check organisational maturity with respect to health inequalities. The Trust had recorded strong and consistent partnerships but there was work to do on health inequalities data evidence. This would inform the prioritisation of the NHSE actions.
4.31	The CMO continued that the recommended actions had been reviewed and prioritised. This exercise was summarised in this paper, and recommendations made to appropriate governance of the work necessary. If the Board agreed with the proposal presented then the next step would be to bring back a plan on how and when to complete the actions and to assign timeframes to those. He proposed an Annual Health Inequalities Report be presented to the Trust Board. He was looking for any comments and approval on the way forward.
4.32	The ATC responded that she very much welcomed traction at Board level on this.
4.33	NED-LB commented she was supportive of the approach. Her concern was the 'do now' list was huge so she asked for assurance this could be delivered given colleagues' competing priorities.
4.34	The CMO responded each individual action was fairly limited and actions would be divided up between the Executive team. Much of this could be done in parallel with existing work and some actions had most probably been achieved already.
4.35	NED-OA stated she also very much welcomed this including the proposal to bring an annual report. She asked whether QSC could receive a more regular update on this. The CMO confirmed that QSC could receive a regular update.
4.36	ANED-BM asked for assurance that over time PAHT could be part of the wider health inequalities work with the system so there was no gap in what the system and neighbourhoods were doing. The CMO responded that as the work delved deeper into the 'Core 20 plus 5' he would expect to leverage this through the Health & Care Partnership. He agreed the work needed to be done in the system and not separately.
4.37	The CEO acknowledged the question above and informed members the HCP Board had highlighted the need to secure public health management reporting expertise which was currently at risk with the cuts being made to ICBs.
4.38	The ATC acknowledged the assurance provided in the paper and in line with the recommendation the Board approved the proposal. .
05 People	
5.1 Report from People Committee (PC)	
5.1	<u>PC.24.11.25 – Chaired by Acting Trust Chair</u> The ATC presented her paper and the following key headlines were noted: • PC had supported the proposal to establish a Medical Workforce Group. This would strengthen oversight of medical staffing, aligning with safer staffing principles. • The Committee had supported the adoption of the Safe Learning Environment Charter and there was ongoing work to embed principles of safety, inclusion and support for trainees. • The FTSU self-assessment had been undertaken in July 2025 with no scores below 3 identified. • Workforce KPIs were reviewed and good progress was noted. Vacancy and sickness rates were above target, but turnover was at an historic low. Rostering improvements and bank/agency usage were under review. Diversity in senior roles was steadily improving. • Uptake of 'flu vaccination by staff was now at 40% with the Trust top in the country for performance. • Staff Survey response rate was improving at 55%. Appraisal compliance was below target with an action plan in place. Statutory training compliance was at 89% (improved from previous year).

	• PC had welcomed the plan to establish a Violence & Aggression working group with refreshed priorities. • Staff Engagement & Morale (BAF Risk 2.1) remained a risk with the score currently at 12.
5.2	The CEO highlighted that whilst 'flu and appraisal rates were up, and better than in the previous year, further improvement was required.
5.3	At this point the DCG flagged that the Internal Audit Report on People Deployment had been presented to both PC and Audit Committee with a conversation at PC on progressing the recommendations. The audit report had been assigned moderate and limited assurance so progress would be tracked through PC.
5.4	In terms of compliance with statutory/mandatory training NED-OA asked whether there could be a refresh of the training required by staff. The CPO responded there was currently some work underway around this given there were two requirements; nationally and locally mandated. There was recognition that nationally mandated training was only applicable to certain professional groups. She was pleased to report that as of that day compliance with statutory mandatory training was at 91% and for appraisals, 73%.
5.5	In response to a question from ANED-BM in relation to dedicated time to undertake training, the CPO confirmed there was work underway to ensure dedicated time for colleagues to undertake this, particularly nurses and medics.
5.2 Freedom to Speak Up (FTSU)	
5.6	This update was presented by the CPO. She informed members that a self-assessment had been undertaken in July 2025 on the Trust's FTSU arrangements which had identified areas of strength and areas of opportunity for further strengthening of the service and culture. The Trust demonstrated strong foundations and commitment to FTSU, with clear governance, leadership engagement and cultural integration, yet several principles required formalisation of processes, improved training coverage and stronger evidence of impact to achieve full maturity. The overall rating had been 'Developing to Strong – Positive trajectory with targeted actions needed to embed excellence across all principles'.
5.7	In response to the above ANED-BJ asked about the difference between whistle-blowing and raising concerns because she believed currently they were being grouped together which made the path unclear for colleagues. The CPO responded there had been training on this for a number of years to raise awareness and feedback was that the term whistle-blowing was not popular. Colleagues did not want to be seen as whistle-blowers but that did not mean they didn't want to raise concerns. She acknowledged the organisation must not create any barriers for people to raise concerns.
5.8	In line with the recommendation the Board approved the self-assessment and was assured of the actions in place to close the gaps identified within it.
5.3 Gender Pay Gap Report	
5.9	This update was presented by the CPO and the key headlines were as follows: Current workforce composition was 75% women and 25% men. The overall gender pay gap was: Mean gap: 23% (in favour of men, approx. £6.58) and median gap: 16% (in favour of men, approx. £3.69).
5.10	The gender pay gap within the Trust was not due to unequal pay for the same role but was driven by role distribution and progression disparities. Women dominated lower-paid AfC bands, while men held a greater share of senior clinical and managerial positions. Closing the gap would require targeted action on career progression, leadership development and flexible working opportunities, particularly for women in mid-bands and medical grades.
5.11	In response to a question from NED-DB, the CPO responded that historically it had been hard to recruit to senior managerial roles and candidates tended to be white males. That position was now changing and a higher calibre and an increased number of candidates were coming through, including more females. The CMO added this was a national picture with the disparity starting early on in schools.

5.12	ANED-BM asked about success measures and how those could be evidenced, particularly in terms of progression. The CPO responded there had been work to ensure roles were more flexible including part-time working and job shares. This had been underway for the last 18 months so was relatively new but the associated data would be the evidence of success.
5.13	NED-LB then asked about the Trust's policy on parental leave given women often took part-time roles because they had childcare commitments. The CPO responded this was currently being reviewed to ensure alignment with EDI requirements. She advised that an increasing number of male colleagues were requesting part-time working so the policy did require some review.
5.14	In line with the recommendation it was agreed that the report could be published in line with requirements and the Board noted the assurance provided on the associated action plan to address inequalities.
5.4 Ethnicity Pay Gap Report	
5.15	This update was also presented by the CPO and key headlines were as follows: 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) and median gap: -20.32% (in favor of ME, approx. £3.71). • Over-representation of ME on Band 5s with data suggesting a possible concern around promotion and progression. • Under-representation at entry level suggesting a possible labour market dynamic. • Over-representation of ME under Medical & Dental terms and conditions.
5.16	The CPO informed members the report was not mandated but was clear evidence of the Trust's commitment to bringing EDI to the forefront and its willingness to look beyond basic data.
5.17	The ICN then stated that in terms of nursing colleagues, the Trust's needed to support internationally educated nurses with levelling up in terms of knowledge and understanding of the system, so that when it came to applying for promotions there was a level playing field. There was a focussed piece of work therefore over the next year to support this.
5.18	In response to a question from the ATC it was agreed the work to address the ethnicity pay gap would continue to be overseen at PC.
5.19	In line with the recommendation the Board approved the report for publication.
5.5 Disability Pay Gap Report	
5.20	This update was presented by the CPO and the key headlines were as follows: • Workforce Composition: Disabled staff: 4%; non-disabled staff: 75%; not stated/not declared: 21%. • Overall Disability Pay Gap: Mean gap: 9% (in favor of non-disabled, approx. £2.17) and median gap: 4% (in favor of non-disabled, approx. £0.94). • The Electronic Staff Record (ESR) data indicated that 4% of staff had formally declared a disability. In contrast, findings from the 2024 Staff Survey suggested a significantly higher proportion, with 23% of respondents (based on a 49% response rate) identifying as having a disability or long-term condition.
5.21	In response to question from NED-OA a discussion ensued as to the difference between 'not known' and 'not stated'. The ATC requested this be picked up outside the meeting.
5.22	NED-LB then commented that colleagues not disclosing protected characteristics linked to FTSU in terms of psychological safety. NED-BJ agreed. It was challenging to get colleagues to disclose a disability so communication was key. The ATC agreed.
5.23	In response to the above the CEO stated that communication was a start, but not the ultimate solution. This needed to then be backed up with action to shift the culture, as had been the case in terms of the organisation's response to the Staff Survey leading to increased engagement in terms of responding in the following year.

06 Performance/Pounds/Places	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	PAF.27.11.25 – Chair NED-CM This update was presented by NED-CM and the key headlines were as follows: • The Trust had declared a surplus of £1.4m in M7 against a planned surplus of £1.4m and was on plan year to date. • Operating Plan submission for first draft plans was 17.12.25 with final submission on 12.02.26. • 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. • Q2 Procurement headlines were Baseline savings target for HWE ICS at £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. • Key performance 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. • In terms of Business Intelligence, and 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 would be presented to PAF in due course.
6.2	NED-OA queried why bank spend was not reducing despite recent recruitment. NED-CM responded this linked with the timing of recruitment. The bigger concern was agency spend which was creeping up and discussed at PC.
6.2 Finance Update	
6.3	This item was introduced by the CFIO and the paper was taken as read.
6.4	ANED-BM asked about the £15m income assumption based on delivery of system efficiencies (and required to break even). The CFIO responded this was a very live conversation with a series of meetings currently taking place and currently that plan had not been completely mitigated at system level.
6.5	The CEO commended the CFIO's leadership on the above.
6.6	ANED-BM asked a further question in relation to PQP. The CFIO responded that in the past when technical measures had been used to support the bottom line those had been declared as PQP. The organisation was now trying to move away from this and to be as purist as possible in terms of where PQP efficiencies came from.
6.7	As a final point the CCTO requested the Board note the significant progress on PQP at that stage in the year. End of year outturn remained a risk but the significant work to achieve the current position should be acknowledged.
6.8	The Board noted the M7 financial position and the potential challenges ahead through Q4.
6.3 Integrated Performance Report including Access Report	
6.9	This item was presented by the COO. She reminded members that the IPR itself was under review (revised version due in February) and the new format would start to draw attention to areas of variation.
6.10	M7 key concerning headlines were: • Increasing numbers of complaints, mainly due to delays/cancellations and booking capacity. • Ambulance handover performance had deteriorated. M7 waiting times were 40 minutes against a target of 37 minutes. There had been a 10% increase in ambulance arrivals at the front door so conversations were ongoing with NHSE around this.
6.11	In terms of improving variation there had been an improvement in cleaning due to better staffing and investment in domestic resource. There was an improving trend in terms of ED waits and the organisation was now middle of pack nationally for performance. RTT

	performance was also improving and if the organisation could improve its performance on elective targets then complaints should start to reduce.
6.12	In terms of the Access Report the COO drew members' attention to the current waits for scopes (Endoscopy). Performance had been quite low for a while predominantly due to data validation issues. In terms of long waiters there were challenging targets to year-end including zero 65 week waiters by the end of December. This would be hard to manage so robust demand and capacity planning would be a priority.
6.13	The COO continued there had been an improvement in 62 day cancer performance. M7 had seen performance at 48% and this was now at 61% in M8. The current October position was at 66.3%. Performance was also on track in terms of the revised RTT trajectory and the organisation was doing well on the 31 day standard for cancer and was at 77% for the faster diagnosis standard for cancer (3% off the national standard).
6.14	Going forward key actions included good demand and capacity planning, increased training, a robust winter plan and a revised surge plan.
6.15	In response to the above the CFIO commended the work to recruit into cleaning services. These positions were the gateway into healthcare support worker/nursing roles so were good development roles for colleagues.
6.16	At this point the CEO flagged a concern raised by the CQC that cleaning rotas in frontline staff offices were different to those in clinical areas. He emphasised the need for all colleagues to work in clean environments. The CFIO acknowledged the point and responded the audits had been reviewed and on occasion it appeared domestic staff were reluctant to enter corporate/management offices and also emphasised that it was incumbent on staff working in those areas to take personal accountability for basic levels of cleanliness; further updates would be provided in the future.
6.17	The ATC summarised that assurance could be taken from both the reports.
07 STRATEGY/GOVERNANCE	
7.1 Report from Audit Committee (AC)	
7.1	AC.08.12.25 – Chair NED-CM NED-CM reported key headlines as follows: • The Committee was assured on the progress of the 2025/26 audits with two reports finalised since the last meeting and those were 1) 25/26 Final Internal Audit Report – People Deployment (Rostering) - Moderate (Design) & Limited (Effectiveness) Assurance and 2) Divisional Governance (Surgery and Critical Care)- Substantial (Design) & Moderate (Effectiveness) Assurance. • In terms of the Internal Audit Follow-Up Report, 17 internal audit recommendations were due for follow-up; of these, 8 were fully complete, 6 were in progress, and 3 were overdue. AC had requested that recommendations from older audit reports not yet implemented were also included in the follow up report. • AC was assured in regards to the progress against the 2025/26 counter fraud plan. • In terms of clinical audit a review of the clinical effectiveness programme was underway, with a focus on enhancing the dissemination of lessons learned and aligning audit processes with patient safety and incident reporting mechanisms. • CQC Compliance: The Trust was undergoing a live CQC inspection and the action plan would be updated as new recommendations emerged.
7.2	The CEO informed members the organisation's response to Internal Audit recommendations had been discussed at an Executive team meeting the previous day. A proposal was now being developed by the CMO/CFIO in terms of a new way forward.
7.2 Report from West Essex Health & Care Partnership Board	
7.3	The CEO presented his report which was taken as read. He informed members the national dilemma across the country was how to fund the acute to community shift. The CFIO had been working with a leading local GP on this in terms of primary care incentivisation and keeping patients out of the acute setting. NED-OA commended this work.
7.4	The ATC thanked the CEO for his update.

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7.3 Report from Executive Board Meeting	
7.5	There were no comments on the paper.
Questions from the Public	
7.6	There were no questions from 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 and that it was now time to refresh this possibly at a future Board Development session.
ACTION TB1.11.12.25/18	**Undertake a review of the Board Charter as part of the Board Development Programme. Lead: Director of Corporate Governance/Acting Trust Chair**
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	The CSO informed members that Toni Coles (West Essex Place Director) would retire at the end of December after more than 30 years working within the local system. Her work and contribution over that time should be recognised.
8.6 Reflections on Meeting	
8.6	The CEO reflected on the detail discussed in the meeting and suggested the reports from the Sub-Committees could be used more effectively.
8.7	NED-LB reflected on the volume of papers and the used of the AI function in Diligent
8.8	The meeting closed at 13:29.

Signed as a correct record of the meeting:	
Date:	05.02.26
Signature:	
Name:	Darshana Bawa
Title:	Acting Trust Chair

ACTION LOG: Trust Board (Public) 05.02.26

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.02.10.25/15	Dermatology	Dermatology Showcase to be presented to the Board.	COO	~~TB1.05.02.26~~ TB1.02.04.26	Item not yet due.	Open
TB1.11.12.25/16	Corporate Risk Register	Corporate Risk Register: Review the wording and current risk score related to Risk 85 (Emergency Care Access Standard).	CMO	TB1.05.02.26	Risk review process underway and expected to come to RMG in due course	Closed
TB1.11.12.25/17	Nursing, Midwifery and Care Staff Levels	Meet to discuss care hours per patient day.	NED-CM ICN	TB1.05.02.26	Actioned.	Closed
TB1.11.12.25/18	Board Charter	Undertake a review of the Board Charter as part of the Board Development Programme.	DCG ATC	TB1.05.02.26	Board Development Programme being commissioned (likely to launch in March) which will include a review of the Board Charter.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 5 February 2026

Agenda item:	2.1							
Presented by:	Darshana Bawa, Acting Trust Chair							
Prepared by:	Darshana Bawa, Acting Trust Chair							
Date prepared:	30.1.26							
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 December 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:

Anne Wafula-Strike's term at PAHT ends in February so this is her last Board meeting. I would like to note our thanks and appreciation for her contributions and interventions at both Committee and Board meetings. Anne's perspective has been invaluable in championing the needs of our local population and for being a strong advocate for EDI.

Anne will continue to work closely with PAH as the lead Community Ambassador to support our initiatives in strengthening community integration - a key plank of our strategy.

Helen Howe (independent Chair of CFC) will be stepping down at the end of March. I would like to note our thanks and appreciation for her immense contribution and support, as she leaves the CFC in a strong position. We wish Helen all the best for the future.

3.0 Recent activity:

As the Trust's Wellbeing Guardian, I meet regularly with the organisation's Head of Staff Health & Wellbeing. This keeps me informed of issues affecting our people and the steps we are taking to address them. We know that some of our staff are feeling vulnerable following the recent divisional restructure so it was reassuring to know that we are providing support relevant to their needs.

In my last report, I mentioned my meeting with Mike Thorn, Chair of MSE ICB. He will be visiting PAH in February for a tour of the main hospital site and also St. Margaret's Hospital (if time allows).

HWE Chairs and Leaders meetings have been set up to start from February; this is still a key relationship for us going forward. As yet there is no news of a similar initiative from the Essex ICB as recruitment for the Chair gets under way.

I am now on the regional steering group, set up by the NHSE East regional director to improve non-executive directors' engagement. A Chair and Non-executive Regional meeting has been set for 8 April. The purpose is to align around the current strategic landscape and strengthen leadership capability, confidence, and connectivity during a period of great NHS national and regional change. The day will include guest speakers and development sessions. All regional chairs and non-executives have been invited to attend.

4.0 Board visibility:

We continue 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 in these challenging circumstances, to ensure that we provide the best possible health care for our patients.

I am very pleased to note that we have been de-escalated to tier 2 for our improved cancer and diagnostics performance in Q3. Well done to everyone who has worked hard to get us there.

The NEDs continue to do regular visits to our services including ED. We were pleased to see the opening of the new cohort area, which means that we no longer have corridor care. A summary of the last 2 scheduled visits 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 gives an invaluable opportunity for us to engage with staff and patients and receive direct feedback, which is very reassuring.

The Board is asked to note the report.

Author: **Darshana Bawa**
Acting Trust Chair

Date: 30.1.26

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

Chair's action matrix

Team: PAHT Chair and non-executive directors, updated 30 January 26

Non-Executive Directors initials:		Key for others
DB: Darshana Bawa (Acting Chair) CM: Colin McCready OA: Oge Austin-Chukwu LB: Elizabeth Baker (SID) DB: David Baines	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
01/12/2025	E Baker	ED (CC)	• Final corridor care visit undertaken on 1st December, after the new cohort area had gone live. Corridors 1 and 2 were both empty of beds. We noted the constraints and difficulty of putting beds in this area and the implications for patient safety. We have always maintained that this must never be normalised. • The cohort area is a significant improvement but the focus on flow though ED must be maintained to ensure sustainable improved patient care and safety. • In terms of ED staff wellbeing and morale, it was acknowledged that it is a challenging environment but the team felt supported, particularly by the new COO.	Jenny Abel, ADOP		To follow up with another visit to the cohort area in 4-6 weeks.
16/12/2025	DBawa DBaines	Estates	Postponed due to staffing and workload	CFIO / ADEF		To reschedule further as postponed again in January.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 5 February 2026

Agenda item:	2.2							
Presented by:	Thom Lafferty - CEO							
Prepared by:	Thom Lafferty - CEO							
Date prepared:	28 January 2026							
Subject / title:	Chief Executive Officer's Report							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Executive Summary	This report provides an update since the last Board meeting on the key changes, challenges and successes. The report is framed around our five strategic priorities: Patients, People, Performance, Places and Pounds.							
Recommendation:	The Trust Board is asked to note the update.							

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

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

Chief Executive's Report
Trust Board (Public)
5 February 2026

1.0 Our Patients

RISE Strategy

We continue to engage with our individual clinical specialties with regard to our new Trust Strategic Framework- 'RISE'.

The RISE Strategic Framework aims to restore hope and ambition to PAHT. It aims to feel fresh, different and distinct from other NHS organisational strategies. Deliberately, it suggests a journey of improvement, an upwards trajectory and strongly links to the proposed regeneration of our most proximate local community in Harlow.

RISE aims to capture the spirit of progress and resilience. It shows that the organisation is committed to overcoming past challenges and moving forward. The new Strategic Framework will challenge our organisation to 'rise' across three key areas:

1. Rising Hope (People): A renewed focus on staff-wellbeing, the enabling of clinical ambition/innovation and empowering people to operate at the very top of their licence.

2. Rising Communities: A focus on meeting population health need and community integration, working with partners to uplift our local populations and to improve our environmental credentials together.

3. Rising Standards: A focus on continuous service improvement and the delivery of excellent, acute care, working in collaboration with other acute and tertiary partners.

The initial strategic engagement sessions have been very positive, with our clinicians actively working through the implications of the new approach in the context of the development of their specialist clinical area.

Care Quality Commission (CQC) visit underway

Our Care Quality Commission (CQC) inspection, which began on 11 November, is drawing to a close.

As previously reported, the inspection team has assessed our Urgent & Emergency Care, Surgical and Medical Services. The inspections have involved observing care, speaking with staff and patients, and reviewing records to ensure services meet quality and safety standards. I am very proud of the positive manner in which all of our staff have responded to the CQC; they have genuinely allowed us to 'put our best foot forward'.
.
As you will be aware, the regulator checks that all hospitals are safe, effective, caring, responsive and well-led. The Well-Led aspect of the inspection has largely taken place across January and I expect to be able to share some informal feedback arising from this at the Board meeting. Of course, the inspectors have already provided some very helpful feedback during the course of the clinical services inspection and we have worked hard to quickly resolve any identified shortcomings.

We now await the CQC's formal response. We remain hopeful that, whilst the Trust still needs to develop and transform in order to fully meet the expectations of patients and staff, the CQC will see that the changes we have made to the organisation over the past 12 months have started to 'turn the dial' on the fortunes of the organisation.

2.0 Our People

Staff Survey: Engagement and Cultural Development

We continue to work hard to ensure that our organisational culture encourages staff at all levels within the Trust to speak up and to express their views and perceptions.

I am therefore pleased to report that we have received our highest response to the national NHS Staff Survey (c.64% of staff) for 5 years.

Whilst we are currently reviewing the themes and issues arising from the data, there will undoubtedly be some clear areas of concern in which we need to do more as an organisation to support staff wellbeing and improve working lives so that PAH can become the employer of choice within our local community.

However, I see the increased engagement as indicative of a more psychologically safe culture and a growing belief that concerns will be acted upon. Prospectively, we must ensure that we respond comprehensively and specifically to these issues and we will have the opportunity to further discuss our approach to this later in the Board meeting.

Organisational change update

Following the consultation that took place in 2025, our new Divisional structure came into effect from 1 February.

As a result, we have welcomed our new Divisional Directors to our executive leadership team:

- Planned Pathways: Monica Bose
- Families, Diagnostics & Community: Zowie Copeman
- Integrated Emergency & Medical Pathways: Gail De Souza

These appointments not only allow for a stronger clinical voice overall within the Executive team, it also means that doctors, nurses and AHPs are all represented within our Divisional leadership.

Over the months ahead, we will be asking each of the Divisional Directors to present their Divisional vision and strategy to the Trust Board as part of a 'Divisional showcase'.

4.0 Our Performance

Our operational performance

We have received written confirmation from NHS England that our 'tiering status' for Cancer and Diagnostics performance has been de-escalated to Tier 2 due to 'positive improvements in Q3'. Our elective performance also remains Tier 2.

In addition, our significantly improved Emergency Department 4-hour performance was highlighted at a national NHS meeting held on 27 January 2026.

These improvements will contribute positively to our National Oversight Framework (NOF) position and Anne Jebb, Chief Operating Officer, is currently pulling together some work to show the extent of change required on the NOF metrics to increase our NOF rating to 3.

We have a long way still to go; but I do think we are now seeing the green shoots of sustained operational performance improvement across the Trust.

Further detail with regard to our performance against the national operational standards can be found within the Integrated Performance Report (IPR).

5.0 Places and Partnerships

New Hospital Programme

The Trust Board continues to consider 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 and a recent announcement by the National Audit Office suggests that a new hospital would not be able to open its doors until 2039-2040.

In my last report to the Board, I commented that the risks associated with the Trust's deteriorating estate continue to grow, as has the understandable concern from local people and our staff. I have therefore been discussing with the national New Hospital Programme team and local stakeholders the idea of potentially redeveloping the existing PAH site amongst other alternatives.

In addition to the development of new, modern and fit-for-purpose acute facilities (mitigating our current estate risks), the New Hospital Programme also potentially provides a vehicle through which we can realise some of our 'acute to community' strategic ambitions; as we progress our plans to work with partners in moving some services into neighbourhood health hubs.

Community Diagnostic Centre (CDC) update

Work continues to progress on the CDC implementation as we come to the final weeks before implementation/opening of Phase 1a on 16 March 2026.

The CDC programme has four main workstreams – Operationalisation, Clinical Pathways, Estates and Infrastructure and Communications and Engagement. The CDC is a critical part of the Trust's strategy to bring care closer to home and integrate into the Neighbourhood Health Model across West Essex.

The focus of work for the last few weeks is around operationalising the new clinical pathways going into the CDC and making sure that we can report the activity correctly, digital pathways are set up and that all the final SOPs and procedures around the pathways and processes are in place. New exciting pathways going live in the CDC in March will be Breathlessness, Heart Palpitations, Rapid Access Chest Pain, Children and Young Person's (CYP) Asthma and Unscheduled Bleeding on HRT.

The CDC will have new CT, Ultrasound and MRI diagnostic capabilities.

6.0 Host Provider

The partnership approach to delivering health and care in West Essex continues to support the timely delivery of care closer to home. The Health & Care Partnership (HCP) developed collaborative plans for this winter which included a successful Multi-Agency Discharge Event that delivered significant available beds for the Christmas & New Year season and supported the Trust during the resident doctor strike. In addition, a pilot for the Community Assessment & Treatment Unit (CATU) at St Margaret's Hospital led by EPUT is delivering further local urgent care and the outcome of the pilot will propose future urgent care services for 26/27.

The National Neighbourhood Health Implementation Programme (NNHIP) is progressing well. In the coming year, the plan is to work across the partnership to support residents with long term conditions to maintain their health and prevent deterioration. We also agreed at the last HCP Board meeting to prioritise children and young people's care, recognising that services for the youngest of our local population are currently fragmented across West Essex.

West Essex has been invited by NHS Confederation to showcase its partnership achievements, challenges and future development at their national Care Closer to Home conference in February.

West Essex panellists comprise primary care, commissioner, PAHT, EPUT and the Patient Panel to illustrate the importance of multi-organisational working.

7.0 Our Pounds

Financial Performance

The Trust delivered a £0.2m surplus in Month 9 in line with plan, continuing the steady in-year financial performance. PQP delivery remains strong, with the full £2.4m Month 9 target achieved and the programme performing to plan year-to-date.

The Trust continues to forecast break-even for the full year and has secured extra funding to support additional activity focused on reducing long waits and improving performance standards. Capital expenditure has reached £19.3m against a £35.3m programme, and cash balances remain stable at £6.5m at the end of December.

2026/27 Business Planning

Planning for 2026/27 is underway and a separate item will be discussed by the Board on planning in line with the national timetable. To supplement this, we are having detailed conversations at our Performance and Finance Committee and across the Executive on how to deliver a compliant position. We submitted a deficit plan in December 2025 and are working with system colleagues (across both Greater Essex and Central East Integrated Care Systems) on a revised plan which will be submitted in February 2026.

Thom Lafferty
Chief Executive
January 2026

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

3.1

Agenda item:	3.1							
Presented by:	Andrew Kelso, Chief medical officer							
Prepared by:	Lisa Flack – Compliance and clinical effectiveness manager							
Date prepared:	07.01.2026							
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 07.01.26. **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 24. **Table 2** details the numbers of risks by category that breach the Trust appetite tolerance. **Section 3** - There are no risks scoring 20 **Section 4** - There are 2 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:	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 07.01.26.

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 24 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 (3)	0 (0)	0 (0)	**3 (3)**
Corp - Estates & Facilities	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Corp - IM&T	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
CHAWs Child Health	0 (0)	2 (3)	0 (0)	0 (0)	**2 (3)**
CHAWs Women's Health	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (0)	1 (0)	0 (0)	0 (0)	**1 (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)	7 (11)	0 (1)	0 (0)	**7(12)**
Totals	**7 (7)**	**17 (21)**	**0 (1)**	**0 (0)**	**24(29)**

The numbers of risks that exceed their risk appetite tolerance is recorded in table 2. This is detailed by risk category.
Divisions and services are able to submit those risks that breach appetite and score less than 15 by exception to the RMG if they consider they meet the criteria for recommending for inclusion onto the corporate risk register.

Table 2 – Number of risks by category that exceed appetite tolerance	Risk Appetite tolerance level	Risk Score					Totals
		10	12	15	16	20	
Quality – Safety	≥ 10	18 (20)	79 (74)	12 (8)	8 (9)	2 (2)	**117 (113)**
Quality – Patient Experience	≥ 12		11 (10)	0 (0)	1 (2)	0 (0)	**12 (12)**
Quality – Clinical Effectiveness	≥ 12		24 (18)	0 (0)	9 (6)	0 (0)	**33 (24)**
People	≥ 15			3 (1)	1 (1)	0(1)	**4 (3)**
Statutory Compliance & Regulation	≥ 12		10 (9)	3 (2)	0 (0)	0 (1)	**13 (12)**
Finance	≥ 12		5 (4)	0 (0)	0 (0)	0 (0)	**5 (4)**
Reputation	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**
Infrastructure	≥ 15			0(0)	0 (1)	0 (0)	**0 (1)**
Information and Data	≥ 10	0 (0)	8 (8)	0 (0)	0 (0)	(0)	**8 (8)**
Systems and Partnerships	≥ 15			0 (0)	1(1)	0 (0)	**1 (1)**

3.0 Summary of risks scoring 20 – there are no risks scoring 20

4.0 New risks scoring 16 added to the corporate risk register

Quality – clinical effectiveness risks

Id 801 Relates to ability to implant pacemakers and perform angiograms at PAH. Equipment used is at risk of downtime due to age, which could impact on operational performance and meeting quality standards for our patients.
Assurance: Purchase order raised and completing due process for upgrade and annual service agreement.

Id 838 Relates to the use of worklists on Cerner which could impact on the patient pathway when not followed correctly.
Assurance: Worklist steering group in place chaired by chief operating officer to ensure monitoring / visibility of action being taken.

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

Recommendation

The Board is asked to

- Review and discuss the contents of the corporate risk register

Author: Lisa Flack – Compliance and clinical effectiveness manager

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 February 2026

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 January 2026. There are no changes to the risk scores this month with the exception of BAF risk 2.1 which has been revised to reflect the risk of staff burnout following a review of the initial results from the staff survey. It is proposed to increase the risk score from 12 to 16. The new wording for the risk is: *Staff resilience and morale:* *There is a risk of 'burnout' and low morale in our staff base, resulting in an adverse effect on staff experience (and subsequently on patients) and a failure to sustain recent performance improvements*. BAF risk 3.2, System Pressures which is assigned to the Board for review is also included and has been updated by the CCTO however it is not proposed to change the risk score. The full BAF is available in Diligent for Board members.
Recommendation:	The Board is asked to: - Formally approve the wording for BAF risk 2.1 and the score of 16 - Review BAF risk 3.2 System Pressures - Note the remaining BAF risks

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

Previously considered by:	QSC, PC, and PAF in January 2026
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 2.1 and 3.2 and BAF summary

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

The Princess Alexandra Hospital Board
Assurance Framework 2024-25

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive/negative assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators** **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 risk 2.1		**Staff resilience 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.~~ **There is a risk of 'burnout' and low morale in our staff base, resulting in an adverse effect on staff experience (and subsequently on patients) and a failure to sustain recent performance improvements.**	**Causes:** Lack of leadership capability and capacity to support staff Divisional re-structure National directives - Trusts asked to reduce their corporate pay growth when compared with pre-pandemic levels by 50%. The need to formally incorporate PAH's lead/host provider arrangements for Place into divisional management structures	**5 X 4 =20**	CPO **People Committee**	1-Assessment centre process 2. People team and line managers in place to provide guidance and sign post colleagues to support networks and services 3. Different modes of communication in place to reach out to colleagues 4. Training in place for meaningful / difficult conversations 5. Communications Team supporting Trust awareness of change process ~~6.Staff survey actions and interventions including recognition awards~~ 7. Max& programme of work underway (culture and post re-structure support for divisional teams) 8.Awaiting 2025 Staff Survey validated and benchmarked data 9. Embedding of new structure from 1/2/26 10. Wellbeing offer being strenghtened 11. Health roster management to ensure safe working, i.e. breaks, annual leave	i) PC, Cabinet and Executive Board ii) People meeting iii) JSCC, JLNC iv) DRMs and divisional board meetings	Consultation reports to Cabinet, Executive Board, Trust Board. Staff survey reports to PC meetings SLF sessions (quarterly) Performance improvement KPIs cancer, ED reported to Executive Board, PAF and Board via IPR and Acces Report Workforce KPI metrics - retention, stability index reported to Executive Board, Pc and Board Wellbeing updates provided to PC People Deployment internal audit - moderate/limited assurance assigned	**4 x 4 = 16**	1. When assessment centre processes are complete feedback and learning to be reviewed and implemented (March 2026) 2. Not all staff are aware of how to access support in place 3. Not all line managers are equipped to manage difficult conversations 4. Capacity concerns within People Team and ability to delivery 5.Rostering management Actions: 1.Ready to manage training, OD support and employee support programmes to be promoted to staff 2. Graduates supporting People team during consultation/re-structure and assessment phase 3. Working group set up to implement recommendations from People Deployment audit (Rostering)	None identified.	16/01/2026	- **Increased risk score of 16 from 12 as the risk description has changed**	**4 x 3 = 12 December 2026**
			Effects: i) Low staff morale, high temporary staffing costs, poor patient experience and outcomes ii) Poor operational performance iii) Impact on Trust's reputation. iv) Staff vacancies in some areas v) Poor staff survey results											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2023-24**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership													
BAF 3.2		**System pressures:** Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	**Causes:** i) High levels of demand in Primary care and Mental health Services ii) Inability for all parts of system to meet demand impacting on PAHT services iii) Unmet demand post Covid iv) Resource constraints in primary care v) Long term sustainability of primary care and mental health services vi) Pressures on social care to meet needs of population vii) Community service and social care package and bed availabilityICB footprint change from Herts & West Essex (HWE) to Greater Essex creating transitional misalignments in commissioning, operating policy, and elective/UEC pathways	**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 arangemtns 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 PAHT host-provider arrangements—review and re-baselining with Greater Essex	Discussions at a range of meetings including: i) Trust Board meetings ii) Urgent care programme board iii) PRMs iv) Divisional board meetings v) QSC vi) PAF meetings vii) Local Delivery Board and ICS UEC meetings viii) HCP Board subcommittee of PAHT	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board 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) No formalised cross-border Access Equity KPI set or routine AEIR reporting yet v) Limited visibility of community capacity for Hertfordshire patients post-boundary **Actions:** 1) Establishing a PAHT–ICB Transition Cell covering contracting, finance, BI, and clinical ops to resolve cross-border issues quickly 2) Introducing an Access Equality Impact Review (AEIR) for any policy change affecting cross-border patients (Hertfordshire cohorts), with rapid escalation to Exec Board 3) Data conformance workstream (SUS/SLAM/BI) to protect reporting, HSMR, income and waiting list visibility during transition	i) ICB Boundary changes ii) New Governance framework not yet embedded iii) Place performance dashboard not in place	01/01/2026	**Risk score to remain at 16.**	**4x3=12** ~~**March 2026**~~ **October 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 v ICB footprint change from Herts & West Essex (HWE) to Greater Essex creating transitional misalignments in commissioning, operating policy, and elective/UEC pathways Divergent commissioning and access policies across ICBs leading to variable service availability ("postcode lottery") for Hertfordshire-registered patients using PAHT Contracting and data-flows (SUS, SLAM, BI extracts) not fully harmonised across ICB boundaries, increasing risk to income, performance reporting and assurance Potential re-prioritisation of investment across a larger ICB footprint delaying Estates, CDC, or community capacity programmes that relieve PAHT pressure Inequitable patient access across borders (e.g., Hertfordshire patients) leading to variation in waiting times, referral thresholds, and eligibility for community services												

Board Assurance Framework Summary 2025.26

Risk Ref. Committee	Risk description	Year- end score (Apr 25)	June 25	October 2025	December 2025	February 2026	April 2026		Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequities in our local population										
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16	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	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	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	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 resilience and morale: There is a risk of 'burnout' and low morale in our staff base, resulting in an adverse effect on staff experience (and subsequently on patients) and a failure to sustain recent performance improvements.			12 NEW RISK	12	**16**			↑	12	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	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	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	**Closed (included in BAF risk 3.1 Estate and Infrastructure)**					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) – 5 February 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.01.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.4 Action Log Appendices				<u>Request for Surgery Non-Access Complaints</u> Surgery & Critical Care have received 168 complaints this financial year. Non-access related themes were Medical Care (34), Nursing Care (12) and Privacy/Dignity (1). QSC requested an update on the outputs of the work around clinical communication (linked to complaints and thereby medical care) and also on the key aspects of communication cited in patient complaints. <u>Request for Mortality Coding Benchmarking</u> • Benchmarking was limited by differing mortality models across trusts. • Coding variation across trusts complicated interpretation as PAHT's coding issues were not consistently shared elsewhere. • Inconsistent use of mortality informatics further reduced the accuracy of comparisons.
2.1. M9 Integrated Performance Report	Y	Y	N	Concerning metrics at M9 were: • Proportion of ambulance handovers in less than 15 and 30 minutes. • Diagnostic times - patients seen within 6 weeks. • Appraisals – non-medical. • % patients under 18 weeks waiting for a first OPA.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.01.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Cancer 62 day - shared treatment allocation rules. • RTT over 78 week waiters. • Complaints – new. Metrics showing an improving variation were: • Proportion of patients treated within 4hrs in ED. • Bank spend, agency spend and voluntary staff turnover. • Catering food waste and Domestic Services (Cleaning) high risk. • Cancer 2 week waits. • Cost Improvement Plan and capital spend. • Estates responsiveness (Priority 2 - Urgent). Of note was that the Trust had been de-escalated to Tier 2 for Cancer & Diagnostics and that PAHT was currently 12th nationally for ED 4 hour performance (currently 80.3% for January).
2.2 Access Performance Report	Y	Y	N	Key headlines were: Performance Overview by Measure: Alert Measures • Diagnostic Endoscopy (DM01) Reporting – December performance accuracy and associated utilisation required.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**30.01.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• RTT Performance – 65-week and 52-week booked cohort at risk. • Cancer 62 day – Deterioration for November. • ED 12 hour – deterioration against plan. • Ambulance Handover <30min - Deterioration against plan. Advise Measures • RTT – risk to all metrics against year-end performance. • Cancer 28 day FDS – deterioration for November, mitigation in place for December. • Somerset Deployment – delay to 'go live'. Assured Measures • Cancer 31-day – performance maintained. • A&E 4 hour performance – performance maintained. PAF noted the Trust was now able to provide a full DMO1 report. Endoscopy performance was improving with a focus now on list utilisation.
2.3 Quarterly Progress Against Alex Health Reporting	Y	Y	N	Demand was outweighing the current capacity in the Informatics team. Dashboard building skills were lacking for the current tool resulting in a large backlog of requests, which are being prioritised by clinical need. Regular

BOARD OF DIRECTORS:	Trust Board (Public) – 5 February 2026			AGENDA ITEM: 4.1
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REPORT FROM:	Oge Austin-Chukwu			
DATE OF COMMITTEE MEETING:	30.01.26			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				reviews of the backlog were taking place to assess the organisational need. A business case was in progress and due for Executive Board review in February 2026. This would detail the requirement for new roles and new technologies to ensure the team can function efficiently. **QSC noted:** • Progress towards restoring timely quality and safety reporting. • The decision to source additional external support to address the backlog. • The Business Case for longer-term BI resourcing and sustainability. Outstanding Maternity Reports had now been agreed and would be added to the prioritisation list for the next iteration of the update.
2.4 Work List Update	Y	Y	N	There is an emerging risk around certain workflows in Alex Health not being followed / used by clinical and non-clinical teams (as intended) to administrate appointments for patients.

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				A high-priority validation exercise has commenced to review 'pending' follow-up patients and a 5% dip-sample has been completed to test data quality and inform a proportionate approach to management of the wider cohort. The dip-sample indication is: - 40% valid requests – requiring OPA - 58% invalid requests – remove from WL - 2% require further validation Output of dip-sample and associated recommendations were made to Clinical Cell 22.01.26. QSC: • Noted the patient safely and data integrity risks associated with unmanaged worklists. • Supported the governance structure and phased validation programme led by the Booking and Validation Cell. • Endorsed the risk-based prisonisation approach and resource allocation required to complete validation safely and effectively.
2.5 Auditory Brainstem Response (ABR) Look Back Update	Y	Y	N	This was a verbal update. SMEs had now been appointed by the ICS and the look-back would include up to 600 patients. There were no current concerns about the Trust's

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				service and indeed it was still supporting neighbouring organisations in terms of capacity.
3.1 Infection Prevention & Control (IPC) Updates	Y	Y	N	<u>Monthly IPC Update</u> Key headlines were: **Ventilation**: Agreement was still required on the design for the ITU pod upgrade but once confirmed that upgrade could take place in summer. The HDU side room upgrade was scheduled for completion by March, providing a new negative-pressure facility. **Water safety:** Point-of-use filters continued to protect patients on Winter Ward and a programme to address estates-related causes of Legionella would begin in March. The water safety group had also reviewed the risks associated with little-used outlets and the possibility of integrating partial flushing into domestic cleaning routines was welcomed as positive progress. **Alex Health and IPC data flow**: Work was ongoing to ensure reliable electronic transfer of C-diff, ESBL and other organism data, particularly in preparation for the laboratory's move off-site in the summer. This forms part of the Pathology IM&T work-stream and the CCTO has agreed to share the ongoing risk assessments with the Director of Corporate Governance to ensure line of sight of this

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				particular risk and its resolution. This would require significant changes in working practices for microbiology, stewardship and IPC teams. While off-site processing carried disadvantages, improvements in molecular diagnostics were highlighted as a major benefit. Efforts to implement norovirus PCR testing were still progressing and options such as moving to C. diff PCR were under consideration. <u>Report from IPC Committee</u> Key highlights were: • A concern there was currently no access to detailed information on individual prescribers, which allowed targeted discussions with clinicians about their prescribing practices. There was agreement that restoring these reporting capabilities was essential and the BI team was working to extract the necessary information from Alex Health. However the delay in accessing individual prescriber data was currently hindering some of the required one-to-one clinical conversations. • .

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3.2 Learning from Deaths Update	Y	Y	N	QSC discussed the drivers for the elevated mortality indicators. An increased number of consultant episodes and uncoded activity is negatively affecting SMR and HSMR indicators; the quality of coding remains a focus of improvement. Assurance was provided that no care or service delivery problems had been identified from reviews of patients who have died and the number of observed deaths has not changed.
3.3 Patient Safety & Quality Monthly Report	Y	Y	N	Key in-month headlines were: • Consistent incident reporting in-month. • Incidents open over 30 days – improved position with focused divisional trajectory. • Improved clinical compliance with overdue policies (71% to 76%) with agreed timeframes on remainder. • Friends & Family Test – slight deterioration from 83% to 79% but improved position in CHaWS, OPD and UEC. It was agreed an update would be circulated outside the meeting on an issue over the summer (since resolved) relating to patient letters not being sent out to GPs due to the decommissioning of an electronic system.

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				It was also agreed that QSC would receive an update in 3 months' time on the Trust's position in relation to Clinical Effectiveness following a review of this function.
3.4 Sharing the Learning 4 Monthly Update	Y	Y	N	The quarterly report outlined a summary of incidents/events from July-September 2025 with a focus on learning and any changes in practice as a result. Within the report were 9 patient safety incidents as follows: • 3 x patient safety incident investigations (1x MNSI) • 2 x medication incidents • 1 x inquest • 2 x complaints • 1 x after action review.
3.5 HWE Place Quality & Safety Update	Y	Y	N	The report detailed discussions held at the West Essex Health & Care Partnership (WE HCP) Quality & Transformation Group on 11.12.25. The group recommended four business cases to go to Finance & Commissioning and the HCP Board for approval, 3 for winter pilots/extension of services and one for 26/27 commissioning.

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				A detailed report on Stroke pathways in West Essex had highlighted areas of concern and actions that the partners agreed to support. The meeting also agreed to escalate to the WE HCP Board the issue of the ongoing lack of waiting list performance reporting for Children's ADHD/ASD waiting lists in the community.
3.6 Quality & Transformation Update	Y	Y	N	The paper summarised Q3 outcomes of quality improvement and transformation work, maintaining a strong focus on integration and enabling care closer to home, while advancing divisional alignment, strengthening governance, and building improvement capability to support sustainable change and delivery of PAHT2030 objectives. QSC noted the Quality First Team's progress in delivering quality improvement and transformation, focusing on integration and care closer to home, while strengthening divisional alignment, governance, and improvement capability for information and assurance purposes.
3.7 Update from Patient Panel	Y	Y	N	The report summarised the Patient Panel's recent activities in support of the Trust's Quality and Safety agenda. Key work included patient engagement through public meetings, collaboration with Patient Participation Groups,

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				and support for educational initiatives such as Lunch & Learn sessions on priority clinical topics. The Panel continued to contribute to improvement work through involvement with CQC processes, NHS Confederation events and task & finish groups focused on long waiting times and GP referrals. Patient experience remained a priority, with planned surveys on telephone access and regular ward visits to provide feedback to senior nursing leadership. The Panel was commended at the meeting for the very positive initial verbal feedback it had received from the CQC Well-Led inspection that week.
3.8 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	The risk rating remained at 16. Controls and assurances had been reviewed and a review of the clinical effectiveness function was underway and would be reported to QSC in March 2026. It was agreed however to undertake a more detailed review of the risk/risk score and a timeline for completion of that work would be provided at the next meeting.

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4.1 Reports from Feeder Groups	Y	Y	N	Reports were taken from the following feeder groups, with no escalations highlighted: • Patient Safety Group • Strategic Learning from Deaths Group • Clinical Effectiveness Group • Patient Experience Group It was agreed there was limited assurance on compliance with NICE guidelines with the risk that outdated guidance could affect clinical decision-making and the Committee further discussed the need for a structured plan for this. It was agreed that a prioritised review of NICE guidelines would be produced within one month, focusing first on those most critical to patient care.
4.2 Horizon Scanning Update	Y	Y	N	QSC noted the following: • HSSIB investigation report – how electronic patient records systems still contribute to patient care being missed: The report emphasised how electronic patient record (EPR) systems still contribute to patient care being missed, delayed or recorded incorrectly.

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				• MHRA Call for evidence on AI regulation: The MHRA had launched a Call for Evidence to support the work of the National Commission into the Regulation of AI in Healthcare.

BOARD OF DIRECTORS: **Trust Board 05.02.256** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Oge Austin-Chukwu, Acting Committee Chair/ Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 January 2026**

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. • A summary of the newly implemented Maternity Outcomes Signal System (MOSS) • Booking Targets: The target is for 90% of women to have bookings by 10 weeks. Current performance is 83%, with improvements for Black, Asian, and mixed ethnicity women having plateaued. Work with the MNVP and community engagement is ongoing to identify and address barriers, with further events planned. • Triage Improvements: Telephone triage has started, but no significant improvements are yet evident • Obstetric Sphincter Injury Lead: There is currently no formal obstetric lead for perinatal pelvic health; the gap in leadership was acknowledged and is being considered by the new Divisional Director, with recent leadership changes noted.

BOARD OF DIRECTORS: **Trust Board 05.02.256** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Oge Austin-Chukwu, Acting Committee Chair/ Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 January 2026**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.2 Maternity Monthly Report	Y	Y	N	Highlights included: • Staffing and Culture: A significant reduction in midwife vacancies (bands 5–7) to 0.24%, with ongoing efforts to improve community midwifery staffing and expand continuity of care. Cultural improvement initiatives included staff recognition, festive activities, and the Civility Saves Lives project. • Acuity and Red Flags: Compliance with the birth rate plus acuity tool on Labour Ward was slightly down but remained high; red flag events, which had increased earlier in the year, had returned to average levels. • Delays and Transfers: The main delay in care continued to be transfers from antenatal to labour ward for women on induction pathways, consistent with previous months. • Workforce Planning: 25 of 28 newly recruited band 5 midwives had started, with plans to rotate more senior staff to improve skill mix in triage and Labour Ward. • Triage and Day Assessment Unit: The triage and maternity day assessment units remained challenged by estate limitations, with both areas described as not fit for purpose. A new ward manager had been appointed, positively impacting staff morale and resilience to change. • Triage Improvement Initiatives: The implementation of the BSOTS triage system within Alex Health was planned for March, expected to streamline processes and improve data capture. • . • Bank and Agency Use: Despite low vacancy rates, agency and bank usage remained above target due to new staff being supernumerary and the need to reduce staff burnout. • Birth Centre Compliance: Compliance with the acuity tool in the birth centre fluctuated due to redeployment of staff to Labour Ward and frequent closures; a workshop was planned to improve pathways and increase eligible women's access.

BOARD OF DIRECTORS: **Trust Board 05.02.256** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Oge Austin-Chukwu, Acting Committee Chair/ Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 January 2026**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.3 Home Births	Y	N	N	The Committee was updated on the national Prevention of Future Deaths (PFD) report, which prompted a review of the home birth service. The team met with community midwives to address concerns and developed an action plan based on gaps identified in the coroner's report and national recommendations. The home birth rate remained low (around 2%), resulting in infrequent practice for midwives and challenges in maintaining skills. The current on-call model meant midwives could be called out after working a full day, raising fatigue concerns. The action plan focused on enhanced training, regular drills (including collaboration with paramedics), and improved risk assessment, especially for remote locations and transfer times. There was an increase in women requesting home births outside clinical guidance, mirroring national trends. The guideline for out-of-guidance births was under peer review. The proposed workforce model would require an additional 5.37 whole-time equivalents, subject to governance approval. The Committee agreed to endorse the action plan, with a full plan to be presented in March for further review.
2.4 Birthrate Plus Establishment Review	Y	Y	N	The findings of the latest Birthrate Plus review were received, which analysed staffing needs based on increased complexity and activity in maternity services. The review identified a deficit of 13.7 whole-time equivalent midwives, primarily due to a rise in women requiring higher-acuity care (categories 4 and 5), and highlighted the need for an extra midwife on labour ward 24/7. The report included detailed breakdowns for each area, clarifying gaps in headroom and service improvements, such as triage and antenatal ward staffing. The Committee discussed the historic shortfall in meeting the recommended 22% headroom, noting that neighbouring trusts operate at 25%. The current request aims to reach the 22% baseline, with additional asks for specialist posts and home birth support. It was confirmed that the recommendations would be incorporated into capacity planning and risk assessment for the next year, with mitigation plans to be developed if full funding is not secured. The Committee supported the recommendations in the Birthrate Plus review which will now be taken through the governance approval route prior to submission to the Board.

BOARD OF DIRECTORS: **Trust Board 05.02.256** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Oge Austin-Chukwu, Acting Committee Chair/ Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 January 2026**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.5 PMRT (Perinatal Mortality Review Tool)	Y	Y	N	It was reported that the service maintained compliance with all PMRT standards for the incentive scheme, with three cases reviewed and completed in the quarter. All actions and learning from these cases were summarized in the submitted papers. The Committee noted the improvements and ongoing work to strengthen PMRT compliance.
2.6 Maternity Assurance (Oversight) Report	Y	Y	N	A significant reduction in the number of open maternity incidents was noted, with the team on track to meet the target of fewer than 30 open incidents over 30 days old, supported by a process of closing about 60 incidents per week while reviewing historic cases. All open incidents had actions progressing, with immediate learning already implemented, and daily data meetings provided oversight to prioritise cases of concern. A challenge with maternity complaints was highlighted, noting an increase in new complaints and a total of 28 open maternity complaints (over 60 across women's health), with resource constraints impacting timely resolution. An action plan was being developed with the patient experience lead. The Committee recognised the positive trend in reducing incidents and acknowledged the trust-wide increase in complaints, commending the team's efforts to address these issues.
2.7 Maternity Patient Safety Incidents	Y	N	N	There are currently three ongoing maternity patient safety incident investigations, with all showing good progress and clear action plans being developed. The retained swab case's final report had been completed, the paediatric case involving biparietal fractures was expected to be finalised next month, and the MNSI report had been submitted, with cross-divisional meetings planned to formulate actions. The team was prioritising preparation for the upcoming inquest related to a maternal death, scheduled for the end of March. The Committee noted the positive progress in closing the oldest investigations and the ongoing focus on timely completion and learning from these cases.

BOARD OF DIRECTORS: **Trust Board 05.02.256** **AGENDA ITEM: 4.1**

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

REPORT FROM: **Oge Austin-Chukwu, Acting Committee Chair/ Non-Executive Director**

DATE OF COMMITTEE MEETING: **30 January 2026**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.8 Neonatal Workforce Report	Y	Y	N	The neonatal workforce review highlighted a significant increase in acuity and activity on the neonatal unit over the past 18 months, which had exposed gaps in the current establishment. The report identified the need for an uplift of 7.5 whole time equivalent nurses to meet BAPM standards, ensure adequate bedside nurse cover, and provide a supernumerary nurse in charge. The team had a trajectory to achieve BAPM compliance through ongoing training, with low reliance on bank staff, but emphasised that the uplift would need to be phased over several years. Additional workforce would also be required to meet new neonatal outreach standards and to support transitional care, with further modelling needed for the latter. The Committee supported the uplift in principle, noting that the proposal would proceed through financial and governance approval processes, and that current non-compliance with BAPM standards was being reported for assurance and MIS requirements.
2.9 Maternity Incentive Scheme	Y	Y	N	An update on the Maternity Incentive Scheme (MIS)was noted, confirming that the Trust remained compliant with all safety actions except for one episode of non-compliance related to Safety Action 1, which was being addressed with NHS Resolutions. It was reported that the Trust had received written confirmation from the NHS digital team that, for MIS year 7, only data quality would be assessed, and the Trust's submission was considered compliant despite challenges with data uploads during the transition to Alex Health. The Committee agreed to seek delegated authority from the Board to the CEO, Chief Nurse and Committee Chair for final sign-off.
2.10 Maternity Safety Champions Update	Y	Y	N	The maternity safety champions reported on their recent visit, noting positive staff feedback during visits in December and January, especially regarding morale and teamwork over the busy winter period. Estates issues were highlighted, with some quick-fix housekeeping improvements identified and actioned. The champions planned further listening events to support staff and maintain oversight of culture, teamwork, and patient care, with CQC also focusing on these areas during their inspection.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

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:	18/01/2026							
Subject / title:	Overview of Patient Safety Incidents within maternity services (Q3 summary)							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues:	There have been no new maternity PSII declared in quarter three. One PSII was closed in quarter three. Maternity services currently have 3 PSII investigations ongoing: PSII - 2 MNSI - 1							
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents and Patient Safety Incident Investigations.							

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

Previously considered by:	CHAWS Governance CHAWS Divisional Board PSG (Jan 2026)
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) Perinatal quality oversight model (2025)
Appendices:	n/a

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

2.0 Background

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

3.0 Analysis

The maternity service currently has 3 open PSIIs, 1 of which is being investigated by Maternity and Neonatal Safety Investigations (MNSI. There have been no new PSIIs declared in maternity in the last 6 months.

The remaining three PSIIs are expected to be closed in quarter four. Learning actions have been completed and are in progress for all three investigations.

The final MNSI report relating to an incident in January 2025 has now been received, and an inquest is scheduled for March 2026. As the case involved input from multiple specialties, a cross-divisional meeting is being organised to review the safety recommendations and determine which actions remain outstanding.

4.0 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.

5.0 Recommendation

It is requested that the Board accepts 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: 18/01/2026

The Princess Alexandra Hospital NHS Trust

4.2

Trust Board (Public) – 5 February 2026

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery
Prepared by:	Emma Rose – Head of Women's Health Governance & Assurance
Date prepared:	20/01/2026
Subject / title:	Maternity & Perinatal Incentive Scheme (MIS) Year 7 Update

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

Key issues:	1. One non-compliant safety action (SA): SA1 - PMRT. 2. Digital issues impacting SA2 which could change compliance assessment by NHS Resolution.
Recommendation:	1. To note the following: SA4 workforce compliance and the separate Nursing Workforce paper and progress against the action plan to achieve compliance with the British Association of Perinatal Medicine (BAPM) staffing framework; 1:1 labour care compliance and actions (SA5); frequency of safety champion meetings (SA9). 2. To note that the MIS year 7 evidence is planned to be reviewed by an extraordinary meeting planned for 12 February 26 against the Board declaration form. Invitees include Board Exec, Safety Champions and ICB. The Board is asked to grant delegated authority to the Chair of QSCII and the CEO to sign-off the final submission. 3. To note that the Board will then need to give permission to the Chief Executive Officer (CEO) that they are satisfied the service is able to demonstrate compliance against all 10 safety actions as set out in the MIS guidance and technical guidance and therefore that the CEO can sign the Board declaration form. 4. To note that the CEO must also request the Accountable officer sign the declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

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

Previously considered by:	CHAWS Divisional Governance (verbal update 19/01/26) CHAWS Divisional Board (paper 27/01/26) – QSCII.30.01.26
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) Perinatal quality oversight model (2025)

Appendices:	None

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 were at risk.

3.0 Maternity & Perinatal Incentive Scheme Year 7 position prior to final Board evidence review in February

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	Non-compliant	Standard a not met (100% compliance required). 19/20 (95%) cases reported within 7 working days. Breached in Jan 2025. Mitigations and learning at the time have meant that no further incidents have occurred since this episode of non-compliance (.12 hours). Evidence submission to Board will include narrative around steps taken to prevent further non-compliance. All other standards within SA1 met compliance.
2. MSDS data quality	Met	July 2025 data for birthweight and valid ethnicity category passed the data quality standards. However, the data submission was incomplete – only a third of births were submitted (105 v 334), and not all bookings were submitted (350 vs 377). There is a risk that NHS Digital might challenge our submission and amend the current data quality pass to a fail. Improvement work has been undertaken to improve completeness of MSDS data submissions and evidence of this will be submitted at the final evidence review.

3. Transitional care and ATAIN quality improvement	On track	The QI project for early respiratory distress (ERD) which was commenced in year 6 has been continued but as yet evidence of the required progress reporting at 6 months (Summer 2026) has not been identified. Progress was reported to safety champions and the Local Maternity and Neonatal System (LMNS) as per end of reporting period requirements.
4. Clinical workforce planning – medical and neonatal nursing	Met	Evidence for the nursing workforce progress towards BAPM recommendations is being presented in a separate paper. This is also being notified to the LMNS and Operational Delivery Network (ODN).
5. Midwifery workforce planning	Met	
6. Saving Babies Lives implementation	Met	The service was signed off as achieving 90% compliance by the LMNS in November 2025, which meets the requirements for safety action 6.
7. Listen to women, parents and families, and coproduction of services with users	Met	Due to the LMNS not being able to meet the service requirements for a fully operational MNVP, Route 1 is being followed. This has been appropriately escalated by the LMNS and updates by the service have previously been presented to Safety Champions and Board.
8. Evidence 3 elements of local training plans in in-house, one day multi-professional training	Met	>90% compliance was achieved for all maternity across all training requirements. Update awaited regarding neonatal compliance but was on track for >90% in October 2025.
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 and the service commenced use of SPEN as of 20 October 2025, (the new “submit a perinatal event notification” portal).

Overall compliance was assessed by the LMNS as 90%, with improvement plans in place to increase compliance across the partially implemented elements.

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%

SA8: Training compliance breakdown

The deadline for 90% or above compliance is 30 November. Compliance must be reported by each professional group and role.

Group	Training element	Compliance as of end Nov [%] (target >90%)
Midwives	FMSD and assessment	97
	PROMPT	92
	Newborn resus	98
	SFH	92
MCAs	PROMPT	98
Obstetric consultants	FMSD and assessment	94
	PROMPT	100
Obstetric registrars	FMSD and assessment	100
NICU Nurses	Newborn resus	100
NICU Consultants	Newborn resus	92
NICU Registrars	Newborn resus	92
NICU SHOs	Newborn resus	100
Anaesthetic consultants	PROMPT	100
Anaesthetic registrars	PROMPT	100

4.0 Recommendations

The Board are requested to note the following:

Safety action 4a: Obstetric medical workforce compliance
The service meets all requirements of SA4 for obstetric medical workforce:

1) 100% compliance for short-term locum use (2 locums used and both have their Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility (CEL) to undertake short-term locum posts.
2) No long-term locums are used and therefore audit isn't required.
3) An audit was undertaken for April-June 2025 of consultant attendance in person against the clinical situations listed in the RCOG workforce document: "Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology" and the service was 100% compliant.

Safety action 4c: Neonatal medical workforce compliance
The service remains compliant against British Association of Perinatal Medicine (BAPM) national standards of medical staffing for a level 2 neonatal unit.

Also to note:

1. The separate Nursing Workforce paper and progress against the action plan to achieve compliance with the BAPM staffing framework (SA4).
2. To note that the MIS year 7 evidence is planned to be reviewed by an additional Board meeting planned for 12 February against the Board declaration form.
3. To note that the Board will then need to give permission to the Chief Executive Officer (CEO) that they are satisfied the service is able to demonstrate compliance against all 10 safety actions as set out in the MIS guidance and technical guidance and therefore that the CEO can sign the Board declaration form.
4. To note that the CEO must also request the Accountable officer sign the declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.
5. Final submission of the Board declaration form is **by 12 noon 3 March 2026.**

Safety action 5: 1:1 care in labour compliance
During the reporting period there were 3 months where the service reported 99% compliance with 1:1 care in labour. Target compliance for MIS is 100%. Over the reporting period this non-compliance represented four episodes out of 1,135 reporting touch-points on Birthrate Plus. The midwifery staffing workforce paper presented in November outlines the actions taken (additional funding for more midwives) and the planned actions (template review against the latest Birthrate Plus report, November 2025). This will support reduce the likelihood of non-compliance due to staffing with 1:1 care in labour. There is also an escalation policy within the service to support prompt redeployment of staff or use of the manger on call to resolve when 1:1 labour care cannot be provided.

Safety action 9: Frequency of perinatal leadership team meetings with the Board safety champions

The perinatal leadership team meet with the Board Safety Champions bi-monthly and this took place four times over the reporting period (Apr, June, July and November).

5.0 Oversight

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

Author: Emma Rose
Date: 20 January 2026

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery, Gynaecology, and Assistant Chief Nurse
Prepared by:	Linda Machakaire
Date prepared:	22 January 2026
Subject / title:	Home birth Prevention of Future Deaths and PAHT plans

Purpose:	Approval		Decision		Information	X	Assurance	X

Key issues:

- National PFD findings have highlighted important opportunities to strengthen safety in home birth services and to enhance the consistency of national guidance.
- At PAHT, the review has identified areas for improvement around workforce variation, escalation processes, risk assessment, and clinical exposure — providing a clear focus for development and future investment.
- Work is already underway to strengthen governance, SOPs, and audit processes, with several actions progressing well and creating a strong foundation for safer home birth care.

Recommendation:

The Board is asked to:

- Note the national PFD findings and implications for PAHT additional investment of **5.37wte** required to support community service and home births
- Endorse the PAHT Home Birth Action Plan and associated timelines.
- Support the development of the PAHT Home Birth Strategy.
- Agree quarterly progress reports to QSC Part II.

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:	QSCII.30.01.26
Risk / links with the BAF:	BAF 1.1 Clinical Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	This report highlights the national gaps in home birth guidance, and it reinforces the Trust's duty to dignity by providing safe, informed, and consistently governed home birth services for all women
Appendices:	1. **Home Birth Services Review letter** from Chief Midwifery Officer for England, and East of England 26.11.25

1.0 Purpose

This paper provides the Quality and Safety Committee (QSC) with a comprehensive summary of the national Prevention of Future Deaths (PFD) report concerning the deaths of a mother and her newborn baby in an NHS Trust in England after a home birth and outlines the actions undertaken by Princess Alexandra Hospital NHS Trust (PAHT) in response. It seeks approval and assurance regarding progress made and planned improvements.

2.0 Background

The PFD report published in November 2025 identified multiple systemic concerns surrounding home birth services, risk assessment, midwifery competencies, national guidance gaps, and emergency response capacity. PAHT has undertaken a review of current processes, workforce capability, governance, and safety structures to align with national expectations.

The home birth rate currently at PAHT is 2.1%, year to date for 25/26. For the previous 3 years it has been:

22/23 – 2.4%
23/24 – 1.3%
24/25 – 2.2%

This rate is comparable to other services in the country meaning that community midwifery workforce is not attending births regularly to maintain their skills. Some of the core midwifery staff attend one ‘present’ midwifery shift in the hospital per 4-week rota to maintain their skills but the uptake varies amongst staff.

Nationally, there has been an increase in requests for a home birth from women who would be recommended to give birth in hospital where medical oversight and emergency care can be provided swiftly, with the support of laboratory services and theatres. These “out of guidance” births need good governance and oversight to ensure that choices are well-informed, that continual risk assessments throughout the pregnancy journey truly reflect existing and evolving risks, and that attending staff are supported as much as possible in the way of adequate training, equipment, oversight, and roster management.

The home birth rate is not currently regularly reported to the Board, and the maternity leadership intends to do so via quarterly reports to QSC, and to the Board.

2.1 Key factors contributing to deaths

- Lack of informed decision-making: No senior midwifery review or “out of guidance” care plan completed; emerging risks were not discussed with the woman.
- Poor antenatal risk recognition: changing specimen results not escalated or considered in relation to a home birth
- Inadequate intrapartum care:
  - Infrequent and incorrect monitoring of fetal heart rate.

- Equipment failures (Entonox, split bag-valve-mask for resuscitation).
- Delay in identifying perineal trauma and postpartum haemorrhage.
- Delay in Syntometrine administration.
- Poor communication with ambulance service and delayed escalation

- Midwives attending were not involved in antenatal care and had limited intrapartum experience.

2.2 Coroner's national concerns

The PFD identified **10 systemic risks** nationally:

1. No national home birth guidance.
2. Increasing number of high-risk requests without clear frameworks.
3. Inconsistent models of care and no national commissioning specification.
4. Lack of discussion with women about small but real risk of maternal death.
5. NICE intrapartum guidance does not include maternal death risk.
6. Risk terminology (high/low pregnancy) misleading for women.
7. No minimum requirement for midwife delivery numbers to maintain competence.
8. No national training needs analysis for home birth midwives.
9. No national dataset on home birth outcomes.
10. No national staffing/training/competence model for home birth providers

3.0 PAHT position - summary of current risks and gaps

The senior midwifery leadership met with community midwives and leaders on 2 December 2025 to discuss the PFD findings and its implications. This meeting helped to identify local risks aligned with the national PFD themes.

3.1 Operational & workforce concerns

- Availability of senior multidisciplinary practical support for out-of-guidance births not well understood, and that senior presence can be sought and obtained if needed.
- Variable home birth skills in the workforce and equipment sometimes sourced from different places.
- Requirement for improved rest periods for midwives on -call so that not working for an extended period. **This will require an additional investment of 5.37wte registered midwives**
- Need for clear transfer and extraction pathways, and communication of these when completing a home birth risk assessment.

3.2 Care planning and risk assessment

- Need for improved MDT assessment, especially for "out of guidance" requests.
- Home birth risk assessment documentation requires overhaul.
- MDT communication with ambulance services requires strengthening.

3.3 Governance, oversight and audit

- Home birth service oversight to Trust Board needs establishing.
- Audit programme for clinical and operational outcomes to be expanded.
- Guidance and SOPs require full revision.

4.0 Action plan progress

Action Area	Progress (Jan 26)
1. Publicising senior midwifery manager on-call availability	Communicated at Maternity Unit Meeting (MUM), Band 7/8 meetings; community forum scheduled.
2. Home birth letter (CMidO) and PFD gaps analyses	Work underway and aligned with governance review.
3. Revised SOP for home birth pathway	Draft requires refinement; work ongoing.
4. Documentation study day	Booked with Trust solicitors for March 2026.
5. Community and senior midwifery attendance at (planned) home birth meetings	Senior presence implemented, monitoring ongoing
6. Business continuity packs for home births	Contents agreed, awaiting distribution
7. 'Birth Rights' training for all staff	Prioritising community midwives and medical teams; already commenced
8. Emergency drills in home or home-like environment	Engagement with EEAST and Harlow College; planning in progress
9. Workforce model review	Consultation planned for March 2026; aims to improve rest periods, intrapartum experience, and safe staffing; additional investment required
10. Home birth strategy	Draft due March 2026; to be co-produced with Maternity and Neonatal Voices Partnership and partner providers and to include Board oversight

5.0 Recommendation

The Board is asked to please:

- Note the national PFD findings and implications for PAHT, including proposed investment.
- Endorse the PAHT Home Birth Action Plan and associated timelines.
- Support the development of the PAHT Home Birth Strategy.
- Agree quarterly progress reports to QSC Part II.

Author: Linda Machakaire – Director of Midwifery and Gynaecology
Date: 22 January 2026

Classification: Official

To: Trust Chief Nurses
Trust Directors of Midwifery

cc. ICB Chief Nurses
ICB Directors of Midwifery

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 November 2025

Dear colleagues,

Urgent review of homebirth services following Prevention of Future Deaths report

We are writing to bring to your immediate attention the Prevention of future deaths report issued by the Senior Coroner for Manchester North after the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth. The report raises a number of concerns and we are asking you to urgently review the safety and quality of your homebirth services.

We would like you to consider the following issues which were highlighted in this case:

The operational running of your service: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multi-disciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.

Care planning and risk assessment: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.

Publication reference: PRN02255

Governance and oversight: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

Trusts have a continuing responsibility to offer homebirth as a choice for women. Where this review identifies concerns, please take prompt action to address them to ensure your homebirth service remains safe and high quality. While no formal response is required, we expect that the outcome of the review be reported to your Trust board and that you contact your regional NHS England team immediately if you identify any safety concerns requiring urgent attention.

Yours sincerely,

Kate Brintworth
Chief Midwifery Officer for England

Wendy Matthews OBE
Regional Chief Midwife/Director of Nursing, East of England,
NHS England

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

Agenda item:	4.3
Presented by:	Jo Ward - Interim Chief Nurse
Prepared by:	Charlotte Collings – Lead Nurse for Safe Staffing and Workforce Polly Read – Interim Deputy Chief Nurse
Date prepared:	19 December 2025
Subject / title:	Safe Staffing Monthly report – November 2025

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

Key issues:	• A sustained overall registered staffing fill rate of >95% has been maintained. • No wards recorded an overall fill rate below 75% during the reporting month. • The continued increase in overall fill rates is multifactorial, including a rise in enhanced care requirements. • The full year nursing and midwifery establishment review was completed in September 2025 and is progressing through the agreed governance processes, with submission to the People Committee in January 2026 and the Trust Board in February 2026.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	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:	**Diligent Resources:** **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

The Princess Alexandra Hospital NHS Trust

4.3

Executive Summary

Safe staffing was maintained in November with reasonable assurance, supported by daily safety huddles, redeployment, and use of temporary staffing. Registered fill rates remained strong, and no wards fell below the minimum threshold. However, the position remains safe but fragile.

Persistent pressures include high enhanced care demand, an increase in Red Flags, and CHPPD remaining below national benchmarks, reflecting sustained acuity-driven workload. These pressures correlate with upward trends in harm, particularly falls and pressure ulcers, and with patient experience themes relating to delays and communication, most notably within the Emergency Department (ED). Maternity and Paediatric ED continue to demonstrate fragility in HCSW cover, mitigated through Birthrate Plus deployment and targeted shift adjustments.

Positive actions provide assurance that risks are being actively managed. These include improved redeployment practices, proactive escalation via Datix, strong mandatory training compliance, and implementation of targeted improvement plans. Recruitment of newly qualified nurses and the completion of the establishment review will further strengthen workforce resilience. However, immediate priorities remain enhanced care workforce planning, red flag closure compliance on SafeCare, and focused support for maternity and ED.

Overall judgement: Staffing was safe in November; however, continued close oversight and proactive workforce planning are required to sustain assurance.

1.0 Introduction

This paper outlines how nursing and midwifery staffing at the Princess Alexandra Hospital Trust (PAHT) was deployed during November 2025, demonstrating how safe staffing levels were achieved and maintained**.** It also sets out how this position has been supported through targeted recruitment, effective deployment, and workforce management arrangements**.**

2.0 Background

The National Quality Board (NQB, 2016) recommends that monthly actual staffing data is compared with expected staffing levels and reviewed alongside indicators of quality of care, patient safety, and patient and staff experience. The Trust remains committed to ensuring that improvements are identified, learned from and celebrated, and that emerging risks are recognised and addressed promptly.

This paper presents nursing and midwifery staffing data and associated actions for November 2025. The sections that follow set out the governance, assurance and operational processes in place to demonstrate how the Trust proactively manages nursing and midwifery staffing in support of safe, high-quality patient care.

3.0 Inpatient wards fill rate

The Trust's safer staffing submission for November 2025 was submitted to NHS Digital within the required data submission timeframe. Table 1 presents a summary of the overall fill rate for the month, while Table 2 provides the overall fill rate percentages across a rolling 12-month period.

Appendix 1 sets out a ward-by-ward breakdown for the same period.

3.1 Wards with < 75% average fill rate

No wards recorded an average fill rate below 75% during November 2025.

The Princess Alexandra Hospital NHS Trust

3.2 Wards with > 100% average fill rate

Henry Moore Ward continues to report an increased fill rate, reflecting fluctuating capacity, the opening of additional surgical beds, and the establishment of a Level 1 post-operative care area. The Level 1 bay is funded through the ITU establishment, and the additional staffing therefore reflects the workforce required to safely meet increased activity and acuity. Board-approved establishment changes have been applied to the roster from 22 December 2025 and will be reflected in future reports.

Healthcare Support Worker (HCSW) fill rates exceeding 100% remain primarily attributable to high patient acuity and enhanced care requirements.

3.3 Mitigation and Governance

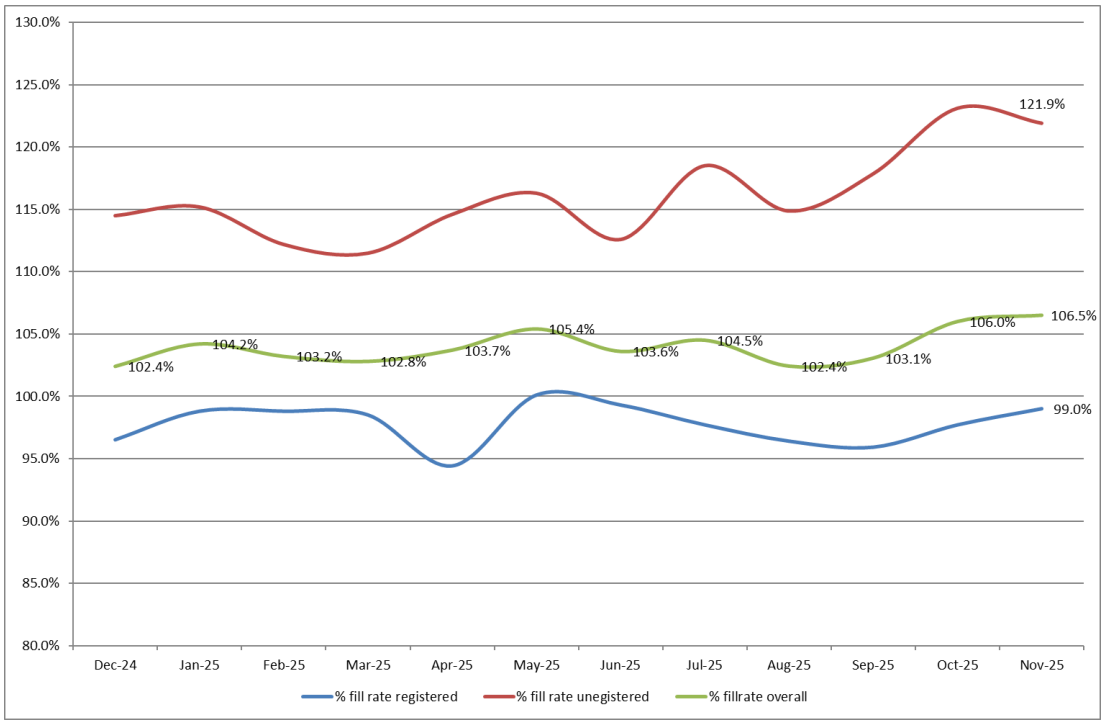
To maintain safe staffing during November, the Trust applied a range of controls underpinned by robust governance arrangements:

- **Real-time oversight:** Daily SafeCare huddles and three-times-daily acuity and dependency reviews ensured continuous oversight of staffing and safe, informed redeployment decisions.
- **Senior clinical support:** Senior nurses and midwives provided direct clinical support to areas of need when required.
- **Temporary staffing:** NHSP filled vacant shifts, including RMN's used appropriately to support patients with assessed mental health needs.
- **Enhanced care oversight:** A local Red Flag for unmet enhanced care and Level 3 patient tasks was introduced to improve visibility and assurance, with data shared through the Enhanced Care Collaborative.
- **SafeCare governance:** Red Flags are reviewed daily and actively inform deployment decisions. Training on reporting and closure is embedded within preceptorship and Band 6 development programmes.
- **Redeployment governance:** In November, 158 substantive redeployments were recorded (1.06% of substantive hours), with oversight maintained through daily huddles and monthly reporting.
- **Escalation and assurance:** Staffing risks are escalated via divisional leadership and monitored through twice-daily compliance checks, weekly SafeCare reports, and monthly Board reporting.

Table 1. Overall fill rate

Average day fill rate - registered nurses/midwives	Average day fill rate - care staff	Average night fill rate - registered nurses/midwives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
95.9%	111.0%	103.0%	134.8%	99.0%	121.9%	106.5%

Table 2. Inpatient fill rate including Maternity Wards Trend



4.0 Care Hours Per Patient Day (CHPPD)

Care Hours Per Patient Day (CHPPD) enables comparison and benchmarking of staffing levels within the Trust and against similar wards in other organisations. It supports the identification of variation between comparable wards, helping to ensure the right staff are deployed, in the right numbers, and in the right skill mix.

CHPPD is calculated by adding the total hours worked across day and night shifts by registered nurses, midwives and healthcare support workers, and dividing this by the number of patients at midnight to give the total care hours per patient day.

CHPPD should not be interpreted in isolation. While it provides a useful indicator of staffing input, it does not directly measure the quality, safety or effectiveness of care. It must therefore be considered alongside other quality, safety and patient experience indicators to provide meaningful assurance.

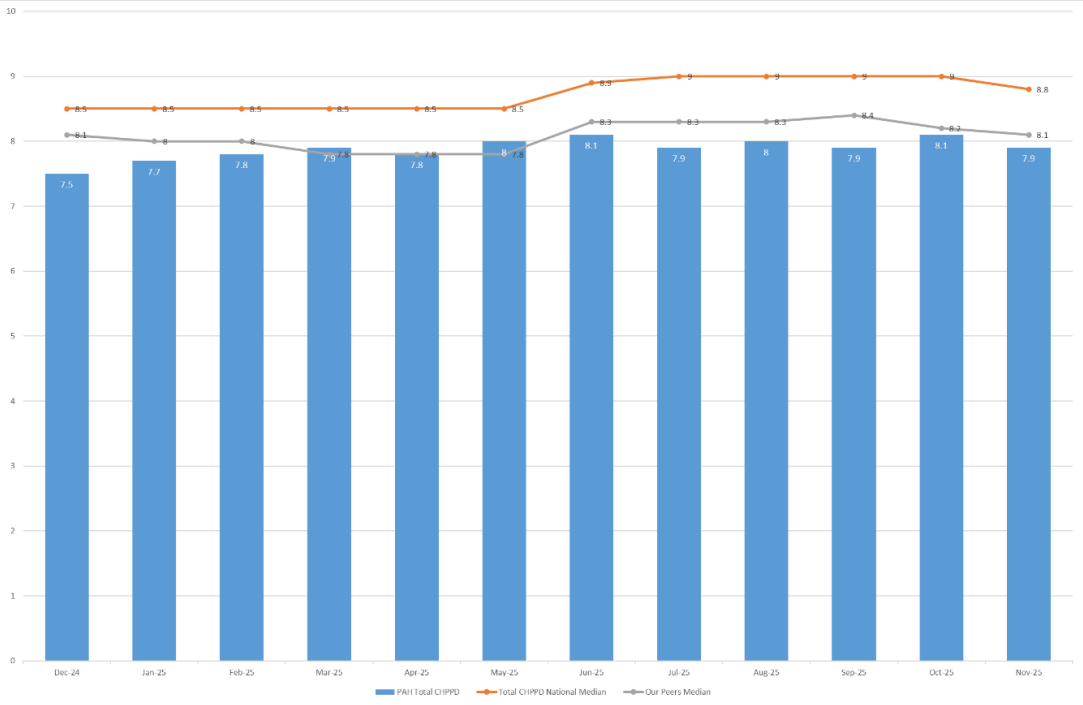
Table 3. Overall Care Hours Per Patient Day (CHPPD) November 2025

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.0	3.0	7.9

Model Hospital data (November 2025) indicates that the Trust's CHPPD is 7.9, compared with a national median of 8.8. Table 4 also presents the Trust's total CHPPD benchmarked against peer organisations, which have a median CHPPD of 8.1 (East and North Hertfordshire NHS Trust and West Hertfordshire Teaching Hospitals NHS Trust). The Trust's CHPPD therefore remains below both peer and national median benchmarks.

Appendix 2 provides a detailed breakdown of CHPPD by ward and division for November 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. This may include the deployment of additional nursing staff or other appropriate mitigating actions to manage risk. **Appendix 3** sets out the NICE (2014) definition of Nursing Red Flags, including the number of occasions where registered staffing fell below 75% of the standard template, with associated trend data, and the number of Red Flags recorded in SafeCare.

The number of Red Flags recorded in SafeCare is increasing. This reflects improved awareness and training in the use and purpose of the SafeCare tool, leading to better identification and escalation of risk. Despite this improvement, under-reporting is still likely, and continued focus remains on embedding consistent use of the system to strengthen assurance.

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

November data shows a slight increase in falls (80 compared to 78 in the previous period), with Winter and Lister wards the highest contributors. Pressure ulcers increased to 41 from 30; however, professional review indicates that these were largely unavoidable, providing assurance on care quality. Two wards remain under quality surveillance, both associated with high enhanced care demand, while nine wards reported zero hospital-acquired pressure ulcers (HAPUs), one of which has sustained this position for over 12 months.

Complaints and PALS activity were highest in the Emergency Department (ED) and Lister Ward, with recurring themes relating to delays and communication. Compliment data continues to be inconsistently captured, limiting opportunities to share positive patient experiences and celebrate good practice.

Nursing Red Flags increased to 133 (from 120), predominantly related to registered nurse shortfalls and unmet enhanced care needs, with Tye Green and Penn wards reporting the highest numbers.

A detailed review of quality and safety indicators is provided in **Appendix 4.**

6.0 Conclusion

The Trust continues to maintain a sustained overall registered fill rate of >95%**,** providing assurance that staffing levels remain safe**.** However, acuity-driven pressures persist**,** evidenced by ongoing high enhanced care demand, and continue to place pressure on workforce resilience.

7.0 Recommendation

The Board is asked to note the contents of this report, which provide assurance on the daily management and mitigation of nursing and midwifery staffing risks**.**

Trust Board (Public) – 5 February 2026

Agenda item:	4.4							
Presented by:	Jo Ward – Interim Chief Nurse							
Prepared by:	Charlotte Collings - Lead Nurse for Safer Staffing and Workforce Polly Read – Interim Deputy Chief Nurse							
Date prepared:	December 2025							
Subject / title:	Full year nursing establishment review							
Purpose:	**Approval**	**x**	**Decision**	**x**	**Information**	**x**	**Assurance**	**x**
Key issues:	• A full-year nursing and midwifery establishment review (Sept 2025) confirmed safe staffing across inpatient wards in line with NQB, NICE, and SNCT guidance. • Data quality and methodology are robust, with no additional funding required for most inpatient areas. • Funding is needed outside core SNCT establishments to address increased Enhanced Care demand (Level 1C/1D) and the ambulance cohort area (£1.3million into budgets majority offset against current temp spend). • Sustained rises in demand and acuity, particularly during PM and night shifts, have created a gap between enhanced care needs and workforce capacity. • Significant reliance on temporary staff and evidence of unmet need (Red Flags) for patients with a high enhanced care need pose ongoing patient safety risks. • Approval is sought for investment in substantive Healthcare Support Workers (HCSWs) for Enhanced Care to reduce risk, improve continuity, and reduce bank usage while full demand is validated. • A Task & Finish Group will restart in Jan 2026 to strengthen assessment, deployment, and governance for enhanced care. • The ambulance cohort area has opened as additional capacity within the emergency department that requires substantive staffing as currently using temporary staff. • Interim review due Mar 2026, report to Board June 2026; Maternity Birthrate+ review paper expected February 2026.							
Recommendation	The Board is asked to note the information within this report and support the outcome and recommendations.							

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

Previously considered by:	NMAHP SLT – 12.1.26 Executive Board – 20.01.26 and PAF.29.01.26

Risk / links with the BAF:	All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18 There are no ED&I implications identified from this report
Appendices:	**Diligent Resources:** Appendix 1 Regulatory requirements and best practice guidance Appendix 2: SNCT process and methodology Appendix 3: Nurse sensitive indicators September 2025 Appendix 4: Full SCNT results compared to March/September 2024/5 full review and areas not incorporated within SNCT Appendix 5: Refreshed SNCT levels and descriptors Appendix 6: Average daily number of Level 1c and 1d enhanced care patients

Executive Summary

The September 2025 full-year nursing and midwifery establishment review was undertaken in line with National Quality Board and NICE guidance to assure safe staffing across inpatient wards and key clinical areas. The review confirms compliance with methodology and data quality standards, with an average acuity accuracy of 98.45%.

Key Findings:

- Overall SNCT establishment requirement: 703.95 WTE (March 2025) vs 696.50 WTE (September 2025), against a funded establishment of 739.14 WTE which includes the Enhanced Care team establishment and Supervisory Ward Managers.
- No immediate changes recommended for most inpatient wards; however, professional judgment highlights emerging demand in areas such as Tye Green, OPAL, and Emergency Department escalation spaces.
- Enhanced Care (ETOC): Demand for Level 1C/1D patients has increased significantly. Historical modelling of 40 WTE is no longer sufficient; current estimates suggest 56 WTE to meet safe coverage for AM and Night shifts using a blended care model.
- Specialist areas pending review outcomes: Endoscopy, Critical Care, Oak Unit, Maternity (Birthrate+) and Neonatal. These will inform future workforce planning and business cases.

Risks:

Workforce capacity remains a key risk on the Board Assurance Framework (BAF 2.1). Enhanced care demand poses a patient safety risk if not addressed.

Next Steps:

- Complete outstanding reviews for specialist areas and report in March 2026.
- Progress the Enhanced Care working group to define the ETOC model (central pool vs hybrid approach) and align with NHS England's Enhanced Care Collaborative.
- Review headroom allowance for specialist areas (recommendation: increase from 22% to 27%).

Recommendation:

The Board is asked to note the findings, endorse the ongoing workstreams, and support the development of a revised workforce plan for enhanced care and specialist services.

1.0 Background and National Context

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

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

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

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

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

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

2.0 Process and Methodology

The process and methodology for completing the establishment review can be found in **Appendix 2**

A full breakdown of the nurse sensitive indicators that were reviewed when considering the SNCT results are available in **Appendix 3.**

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

3.0 Data Quality

To ensure accuracy and validity of the SNCT data a matron or senior nurse should complete a twice weekly audit. This audit should be done alongside the ward staff. To ensure accuracy of SNCT a minimum of 1 audit per ward per week should have been undertaken over the 30-day census period.

Thirteen wards managed to achieve eight or more audits, with no wards having less than six undertaken. This is the same as March 2025 where 145 audits in total were undertaken compared to 137 in this period. There is an on-going training programme which continues to increase the number of ward-based assessors which has facilitated the matrons to undertake a more reliable external validation. The average acuity accuracy was 98.45%. This is an improvement from previous establishment reviews, and we will continue to focus on sustaining this improvement in subsequent reviews.

For this review we are confident that the SNCT data collected is accurate as all the staff that gathered the data have been trained, assessed and passed their PAHT interrater reliability assessment for SNCT.

4.0 Findings

No changes to an establishment should take place until there are two consecutive reviews demonstrating an increasing or decreasing trend in nursing and midwifery staffing. In addition,

this should be triangulated with patient and staff outcomes and professional judgment of the senior nursing and midwifery team.

	Ward or Department	SNCT Change/Establishment review Change	Final Recommendation
Urgent and Emergency Care	Emergency Department	The Adult ED SNCT tool does not adequately reflect the supervisory role of the nurse in charge, nor does it capture the additional workload associated with caring for patients in Temporary Escalation Spaces (TES), patients experiencing waits more than 12 hours for an inpatient bed, or the complexities arising from the physical layout of the department.	It is recommended to secure funding for the new escalation ambulance cohort space within the Emergency Department (ED), which will require the allocation of 10.73 WTE to ensure appropriate staffing levels and operational effectiveness.
	Adult Admission Unit (AAU)	No change	No change
	Charnley	No change – indicates the staffing is accurate, however concerns have been raised through professional judgement due to the high flow of admissions and discharges which aren't captured through AIPW SNCT.	No change - a review and comparison of methodologies will be undertaken to inform which tool is adopted from March 2026. Benchmarking indicates that other hospitals are applying assessment multipliers.
Surgery	Harvey	No change	No change
	Henry Moore	No change	No change – establishment and funding now moved as per prior plan.
	John Snow Unit	No change – The SNCT consistently indicates a reduction in staffing. However, this is driven by the size of the department and the low WTE calculated by the tool, which would be insufficient to support the mandatory minimum establishment of two registered nurses per shift. As such, the SNCT output is not considered operationally safe or deliverable in this context.	No change
	Penn	No change	
	Saunders	No change	No change
	Critical Care	No change	No change

Medicine	Fleming	No change	Reduction in unregistered establishment to support an increase in HCSW's on Tye Green.
	Harold	No change	No change
	Kingsmoor	No change recommended by SNCT, professional judgement indicates the staffing does not match demands, consistent need to add additional shifts for HCA's and high volume of ETOC patients direct from UEC.	No change
	Lister	No change	No change
	Locke	No change	No change
	OPAL	Typically using AIPW SNCT for bedded area only, this does not factor in demands for the assessment area which has been in use consistently since March 2025 – applying AAU SNCT to the assessment area and AIPW to the bedded area indicates an increase of 6 WTE to the establishment.	No change to the current establishment is proposed at this stage. However, there is a recommendation to increase WTE by 1 Band 6 Registered Nurse to provide dedicated day-shift assessment capacity in support of patient flow. This will be reviewed following a repeat SNCT assessment in March 2026, applying the assessment multipliers to determine the resulting impact on establishment requirements.
	Nightingale	Not reviewed in this period due to temporary closure.	No change - plan to collect data once re-opened.
	Ray	No change	No change
	Tye Green	Emerging trend from SNCT to increase WTE from 53.93 to 56.78, professional judgement indicates very high dependency and would benefit from establishing an RNA workforce.	Recommendation to increase Healthcare Support Worker (HCSW) provision by 1 per shift on both day and night shifts to better support patient dependency. This will be funded through a transfer of 5.37 WTE establishment from Fleming Ward, with no net increase to the overall workforce establishment.
	Winter	No change	No change
Child Health and Women's Services (CHAWs)	Paediatric ED	The ED SNCT tool does not account for the supervisory responsibilities of the nurse in charge. When this is factored in, alongside the application of professional judgement, the current Paediatric ED	Since data collection, the department has introduced a middle shift (10:00–22:00) and a twilight shift (18:00–02:00). The effectiveness of these changes will be reviewed as part of the March 2026 data collection.

		staffing establishment is assessed as meeting existing service demand and does not require further investment currently. However, there is a recommendation to review shift profiling to ensure staff availability aligns with periods of peak departmental activity.	
	Dolphin	No change – Dolphin Ward experiences significant seasonal variation in both bed demand and patient acuity. The current census periods of March and September do not capture peak activity or highest acuity levels. In addition, the census did not include patients attending the ward for day-case procedures or treatments, meaning overall workload is not fully reflected.	No change to the staffing establishment**;** however, it is recommended that data on day-case attendees, including volume, level of care and duration of stay is routinely recorded to ensure activity and workload for these patients are appropriately captured.

A full breakdown of the findings from the establishment review can be found in **Appendix 4** alongside wards and departments that are not included in the SNCT establishment review

Workforce Intentions

At times of peak demand, the Emergency Department is required to open additional clinical areas to support the timely offloading of ambulances. Going forward, this must be considered alongside the SNCT findings, as the physical geography of the Emergency Department necessitates additional staffing to ensure safe clinical oversight across multiple areas.

In response, the Trust has taken a proactive decision to cease the use of corridors within the Emergency Department. As part of the revised Trust surge plan, the discharge lounge has been relocated, and a newly refurbished area within the Emergency Department has been designated as a formal escalation space for ambulance cohorting.

This approach directly responds to CQC feedback regarding corridor care and strengthens assurance around patient safety, dignity and clinical oversight. However, to ensure this model is safe, compliant and sustainable, additional funded staffing is required to provide appropriate supervision and meet regulatory expectations.

The establishment for Henry Moore has formally changed and now incorporates the establishment previously held within the ITU/HDU budget. Plans are in place to recruit additional nursing staff into this area, supported by intensive staff development programmes to enable the safe care of higher-acuity patients. These programmes are being delivered by the Surgical and Critical Care Division teams.

As specialist services within each division undertake reviews of their clinical pathways, the requirements for specialist nurses and advanced clinical practitioners will be reassessed. Workforce recommendations will be developed and presented by each division as part of their demand and capacity reviews, informed by a robust job-planning process undertaken in partnership with clinical leads, operational leaders and workforce colleagues. This will ensure roles, responsibilities and job plans are clearly defined, aligned to patient pathways and clinical guidelines, and deliver safe, efficient and sustainable service models.

Enhanced Care

Within the refreshed SNCT tool **(Appendix 5)** the patient classification levels have been revised, with clearer alignment between levels of care and the staffing required to safely meet patient need. This adjustment has not yet been applied to the CYP or Emergency Department SNCT tools.

The refreshed tool now explicitly incorporates enhanced care requirements, including two additional levels of care recently introduced. The layout provides two methodological options, allowing wards and departments to select the most appropriate approach depending on whether the clinical area comprises a mix of side rooms and bays, or side rooms only. Professional judgement is applied to account for environmental nuances that may influence staffing requirements. The revised multiplier values represent the whole-time equivalent (WTE) nursing workforce required to safely deliver care for patients assessed at each SNCT acuity level.The tool also takes account of the impact of an ageing population on inpatient acuity and dependency, single-room ward design, care hours per patient day (CHPPD), distribution of care across day and night shifts, and the increasing need for enhanced care to support patients at risk of falls, confusion and mental health-related needs.

Using the new multipliers for level 1c and 1d patients there has been an overall increase in CHPPD when compared to the multipliers used in the previous version of the SNCT (**Appendix 6**).

The Trust is part of NHS England's national programme reviewing the provision of enhanced therapeutic supervision and care (ETOC), which includes the provision of registered mental health nursing support; and the best use of resources to support our most vulnerable patients and improve the unpredictable demand of enhanced care requirements. There is also an internal working group led by the deputy chief nurse for enhanced care to support how this workforce will be deployed across the organisation, this could be a central pool of enhanced care staff, or a hybrid approach where some areas maintain this service from their funded establishment. We have also recruited 2 newly registered nurses who trained with us who are dual registered nurses (adult/mental health) and are hoping to increase this workforce and develop additional competencies moving forward.

Appendix 4 presents a comparison of full SNCT results across three review points: the September 2024 full review, the March 2025 interim review, and the September 2025 full review. For each period, the table sets out the SNCT whole-time equivalent (WTE) nursing establishment including enhanced care**,** excluding enhanced care, and the associated 1c and 1d enhanced care requirement.

The data demonstrate relative stability in overall SNCT demand over time, with fluctuations reflecting changes in patient acuity, enhanced care need, and ward configuration rather than structural shifts in baseline staffing requirements. The March 2025 interim review shows the highest total requirement (703.95 WTE including enhanced care), aligning with increased enhanced care demand during that period.

The September 2025 full review identifies a total requirement of 696.50 WTE including enhanced care, representing a reduction compared to March 2025 and broadly consistent

with September 2024 levels. This indicates that enhanced care demand remains a significant and persistent component of staffing need, while underlying SNCT acuity-based requirements remain relatively stable.

The table also highlights variation at ward level, reinforcing the importance of using professional judgement alongside SNCT outputs to account for environmental factors such as side rooms, cohorting capability, and patient dependency. These comparisons provide assurance that the establishment review recommendations are evidence-based, triangulated over time, and reflective of both acuity and enhanced care demand.

The September 2025 data (including enhanced care) indicates that the recommended nursing establishment for the Trust is 696.50 WTE. This represents a variance of –7.45 WTE compared with the previous full-year establishment.

The Trust's funded SNCT establishment is 721.14 WTE, which includes 18.0 WTE for supervisory ward managers (excluding the Adult and Paediatric Emergency Departments). Although this may give the impression that the funded establishment is sufficient, supervisory ward managers do not routinely provide direct patient care and therefore cannot be counted within the workforce available for day-to-day safe staffing at ward level.

When we exclude these supervisory posts, the number of staff available for direct care is reduced accordingly. Additionally, when the enhanced care team is included, the total establishment rises to 739.14 WTE (inc. WMS), which is significantly higher than the SNCT recommendation of 696.50 WTE.

It is important to emphasise that SNCT is only one component of the safer-staffing triangulation method. Nursing quality indicators and professional judgement carry equal weighting and must be considered alongside the SNCT data to determine whether staffing levels are safe in practice.

5.0 Going Forward

A mid-year interim establishment review will be undertaken in March 2026.

Continued training will be undertaken with matrons, ward managers and band 6 nurses to support understanding of the updated tool and consistency of data collection. The guidance states, that a minimum of 3 senior ward nurses (Band 6 or above) have undertaken and passed the Trust's SNCT training and assessment. Inclusion of other areas not included within this paper, including the methodology applied, will continue to be included in the establishment reviews moving forward in 2026.

The SNCT calculation is based upon a funded headroom allowance of 22% and this has been incorporated within the reviews for inpatient wards. This headroom allowance is insufficient, particularly for specialist areas such as critical care, the emergency department and maternity services, which have greater training requirements for staff which may inflate the headroom required, the recommendation for these areas is between 24 - 27%.

NHSE and SNCT guidance requires validation of patient acuity and dependency levels to be undertaken by matrons or senior nurses (for example, nurse consultants, advanced practice nurses or nurse educators) from departments other than the one being assessed. This approach strengthens objectivity and rigour and will be implemented locally from 2026 to enhance the robustness of the validation process.

In addition, guidance recommends that a maximum of three pre-designated staff per department are responsible for SNCT data collection and are rostered accordingly to undertake this activity. This arrangement will be reviewed and confirmed in advance of the March 2026 data collection.

The SNCT tool used within the Emergency Department was updated in December 2025 to include the care requirements of patients remaining in the department for more than 12 hours, which had not previously been captured. The Trust is now collecting this data to formally recognise the presence and care needs of patients staying in the Emergency Department for over 12 hours and to support the application of professional judgement when determining additional WTE required to meet those needs.

This enhancement strengthens the evidence base underpinning workforce decisions and provides greater assurance in relation to safe staffing, patient oversight and quality of care.

6.0 Maternity Services

Birthrate+ is the evidenced based tool used to inform midwifery and maternity support worker establishments with a recommendation that it is undertaken every three years. The previous Birthrate+ review was in 2021. A new review is in progress, and the report is expected by February 2026. Early indications from the review include a need to invest in maternity triage and specialist midwifery roles and this will be discussed once the full report is published.

Birthrate plus recommends that the service should be funded to a midwife to birth ratio of 1:23.

7.0 Recommendations

The board are asked to note the requests for additional funding outside the areas that use the SNCT tool based on demand and capacity for services. These will be reviewed by divisions in the next six months.

UEC:

- It is recommended that the ambulance cohort escalation space within the Emergency Department is substantively funded, reflecting its consistent daily utilisation and its role in maintaining patient flow and safety.
- A review and comparison of methodologies will be undertaken to inform which tool is adopted for Charnley Ward from March 2026. Benchmarking indicates that other hospitals are applying assessment multipliers.

SCC: No recommendations.

Medicine:

- To review the data collection methods in OPAL ward and apply to AIPW and AAU tool in each identified area. In March 2026, we will be able to review any emerging trend data formally and re-assess the establishment needs.

- Tye Green ward has been highlighted across 3 separate SNCT data collections as needing to increase WTE. In addition to patient outcome and professional judgement, it is felt it would benefit the department to consider an additional 5.2 WTE to cover 1 additional HCA per shift to their current template.

CHAWS:

- Within Paediatric ED, it is recommended to review the effectiveness of shift profiling measures in the March 2026 audit that have commenced post September 2025 audit.

- Dolphin Ward will review the day attendees' and will aim to capture these in the March 2026 audit period to evidence the additional care requirements these patients need when in the department.

- Additionally, the formal review of maternity staffing using the Birthrate+ methodology will be available in December 2025, for workforce considerations.

Enhanced Care:

Since April 2025, the Trust has implemented the nationally mandated Enhanced Care reporting methodology. Analysis of data from April to November 2025 demonstrates a sustained and recurrent requirement for unregistered Enhanced Care, rather than short-term or episodic demand. Over this period, 59,425 hours of unregistered Enhanced Care were delivered, with an average of 85.5% provided by NHSP bank staff and only 14.5% by substantive staff, confirming a structural reliance on temporary workforce.

Despite high bank utilisation, significant numbers of Enhanced Care hours remained unfilled, peaking at 8,353 hours in October 2025, with 309 hours still unfilled in November 2025. These unfilled hours represent unmet patient need and increase risks associated with deterioration, falls, pressure damage and reduced therapeutic engagement, highlighting that the current model does not provide sufficient resilience or safety.

Delivery of unregistered Enhanced Care currently requires approximately 3,900–4,000 NHSP bank hours per month at charge rates of £17.87–£29.20 per hour, equating to £18k–£63k per month or £220k–£750k per annum. Modelling demonstrates that recruiting 25–30 WTE unregistered staff, inclusive of headroom, would significantly reduce reliance on temporary staffing and provide a more cost-effective and sustainable solution. While final costs require confirmation by Finance, substantive recruitment represents better value for money than continued NHSP usage, alongside improved continuity and quality of care.

It is therefore recommended that the Trust approves recurrent funding to recruit 25–30 WTE unregistered staff for Enhanced Care, delivered through a hybrid model comprising a central Enhanced Care team and locally embedded roles within services with consistently high demand. Approval of this proposal will reduce unfilled care hours, improve patient safety, support national temporary staffing reduction objectives, and provide a sustainable workforce solution for inclusion in the Trust's 2026/27 establishment and workforce plan

Financial Implications of recommendations:

Recommendation on ward establishments

Budgeted changes proposed	WTE change	Financial Impact £
TYE Green	(5.37)	(225,798)
Fleming	5.37	225,798
Ambulance cohort space	(10.73)	(451,175)
Total SNCT changes	(10.73)	(451,175)

The recommended changes result in a proposed increase in budget of £451k per annum for the Ambulance cohort staff (currently spending on these so there is no change in run rate). We have explored the potential to fund this increase from within nursing given the difference between budgeted nursing establishments and SNCT scores (budgeted 739.14 versus SNCT results suggesting required established of 696.50) however this has been explained not to be viable due to the SNCT results not taking account of ward layout.

Recommendation on Enhanced care establishment:

Budget changes	WTE change	Financial Impact £
Budget	35.67	1,592,342
Proposed substantive	(25.00)	(1,051,200)
Proposed bank	(31.45)	(1,403,957)
Budget changes	(20.78)	(862,815)

The recommended changes would require an increase to budgets of £0.9m per annum. The increase comes from the fact that despite currently having a demand of 56.45 WTEs for enhanced care, only 35.67 WTEs are currently budgeted. There is a minimal saving from converting from bank to substantive.

We have explored the potential to fund this increase from within nursing given the difference between budgeted nursing establishments and SNCT scores (budgeted 739.14 versus SNCT results suggesting required established of 696.50) however this has been explained not to be viable due to the SNCT results not taking account of ward layout.

Some of the above costs are being incurred currently therefore the run rate change resulting from this proposal would be an increase in run rate of £0.5m as per table below. The increase in run rate comes from the fact that currently despite there being a requirement for the equivalent of 56.45 WTEs for enhanced care we are only filling a proportion of these shifts with bank, with the remainder left unfilled. The substantive staff would cover the unfilled element in the first instance with the remainder then being in the place of bank staff.

Run rate changes	WTE change	Financial Impact £
Actual substantive	8.00	336,384
Actual bank	35.35	1,578,057
Proposed substantive	(25.00)	(1,051,200)
Proposed bank	(31.45)	(1,403,957)
Run rate changes	(13.10)	(540,716)

The above calculations assume 25 WTEs are substantive (which includes posts within the enhanced care team, 8 of which are already in post substantively).

Summary Financial Impact:

The total financial impact of the request to fund the Ambulance cohort support and substantiate 25 WTEs of Enhanced Care support is a required increase to budgets of £1.3m.

Summary below of differences in budget and SNCT results:

Ward	Total Funded WTE	SNCT Data WTE	Difference between budget and SNCT
AAU	56.03	52.05	3.98
Charnley	40.06	34.57	5.49
Dolphin	36.18	26.2	9.98
Fleming	36.04	31.6	4.44
Harold	53.87	51.87	2.00
Harvey	31.47	26.87	4.60
Henry Moore	44.97	41.01	3.96
John Snow	19.90	15.67	4.23
Kingsmoor	47.23	47.25	-0.02
Lister	42.60	51.68	-9.08
Locke	43.09	45.63	-2.54
Nightingale	30.64	19.52	11.12
OPAL Beds Only	28.74	20.83	7.91
Penn	41.09	46.88	-5.79
Ray	39.47	42.63	-3.16
Saunders	42.00	40.63	1.37
Tye Green	53.93	56.78	-2.85
Winter	42.60	44.82	-2.22
Enhanced Care team	14.76		14.76
Less apprenticeship backfill	-5.52		-5.52
	739.15	696.49	42.66

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

4.5

Agenda item:	4.5
Presented by:	Andrew Kelso – Chief Medical Officer
Prepared by:	Nicola Tikasingh – Lead Nurse for Quality & Mortality Andrew Kelso – Chief Medical Officer
Date prepared:	20 January 2026
Subject / title:	Learning from Deaths and Mortality Update

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

Key issues:	Uncoded activity is negatively affecting SMR and HSMR indicators Quality of coding remains a focus of improvement No care or service delivery problems are identified on reviews of patients who have died
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.

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

Previously considered by:	January 2026 Strategic Learning from Deaths Group and QSC.30.01.26
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

1 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 Background

PAHT has a learning from death process that meets the national requirements. The Strategic Learning from Deaths Group (SLfDG) was held on 20 January 2026.

3 Mortality Indicators

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

3.1 Headline statistics

3.1.1 Hospital standardised mortality ratio (HSMR) overview

HSMR+ for Aug-25 is 135.72 and “higher-than-expected”, based on 1390 superspells and 61 deaths (crude rate 4.39%)Figure 1.

HSMR+ for the period Sep-24 to Aug-25 is 110.03 and “higher-than-expected”, based on 18,822 superspells and 767 deaths (crude rate 4.08%) Figure 2.

3.1.2 Standardised Mortality Ratio (SMR)

SMR for Aug-25 is 121.4 and “within expected”, based on 5514 superspells and 74 deaths (crude rate 1.3%) Figure 3.

SMR for the period Sep-24 to Aug-25 is 113.18 and “higher-than-expected”, based on 67,851 superspells and 976 deaths (crude rate 1.44%) Figure 4.

3.1.3 CUSUM Alerts

There is one new CUSUM alert for the latest period: coronary atherosclerosis and other heart disease.

3.1.4 PAH Emergency Weekend HSMR+

Emergency Weekend HSMR+ and Emergency Weekday HSMR+ values have risen correspondingly, while maintaining the same banding as last month Figure 5.

3.2 Narrative analysis

3.2.1 Coding Backlog & Impact

- Aug-25: ~25% of inpatient admissions coded as ‘residual codes, unclassified’ (ICD-10 R69), indicating incomplete coding.
- Deaths remain valid (0 in Jul-25; 8 in Aug-25 with R69), but survivals lack casemix adjustment, lowering expected mortality and inflating SMR/HSMR+.
- Result: High single-month SMR and HSMR+ values for Jul-25 and Aug-25 are pulling rolling averages upward.

3.2.2 Outliers & CUSUM Reviews

- Three new HSMR+ outliers: acute bronchitis, fluid and electrolyte disorders, other gastrointestinal disorders.
- One new non-HSMR+ outlier: other nervous system disorders.
- Reviews confirm no care or treatment issues; flags driven by episode structure and incomplete coding.

- Coronary Atherosclerosis & Other Heart Disease CUSUM alert reviewed—coding affected by vague documentation and multiple episodes before confirmed diagnosis.

3.2.3 Context

Elevated values are primarily due to data quality issues from incomplete coding at SUS+ submission. Despite this, the Trust is not statistically significantly higher than regional or national peers (99.8% control limit). Emergency weekday/weekend HSMR+ values have risen but remain in the same banding.

3.2.4 Conclusion

Mortality indicators remain elevated, but the underlying cause is data quality rather than clinical care. The backlog in coding—linked to changes in episode recording under AlexHealth—continues to distort expected mortality calculations. Observed deaths are accurately coded, but survivals lack full casemix adjustment, inflating SMR and HSMR+ values.

A dedicated working group is actively addressing these issues, focusing on improving coding completeness and documentation clarity. Reviews of flagged outliers and CUSUM alerts have found no patient safety concerns, reinforcing that current mortality performance does not reflect deficiencies in care.

4 Mortality Programme Updates

4.1 Learning from Deaths

90 deaths recorded in December 2025. 13 cases were referred for Structured Judgement Reviews (SJRs). 108 SJRs remain outstanding (>6 weeks post-death). Divisional Directors receive monthly reports on outstanding SJRs.

4.2 Themes from Reviews

- Early Recognition & Management: Timely identification of deterioration and senior review.
- Family Communication: Clear, regular updates, especially for end-of-life care.
- Multidisciplinary Approach: Inclusion of palliative care and geriatrics.
- Documentation Accuracy: Essential for safe, continuous care.
- Resuscitation Planning: Clear, timely CPR/DNAR discussions aligned with patient wishes.

4.3 Cases Awaiting Second Review Panel

Medical Division: *PAweb162747* – Over-anticoagulation on prior admission, returned with bleed. Rapid review downgraded harm to minor; second panel to review avoidability.

4.4 Patient Safety Incident Response Framework

Surgical Division: *PAweb162146* – Post-biopsy bleeding. Investigation pending.

5 Medical Examiner

- 100% were scrutinised by 6 Medical Examiners.
- 73.3% of MCCDs were issued within 72 hours in December 2025; national target is 95%.

6 Learning from Inquests – Reporting period June 2025 – Dec 2025

- The Trust were notified of 54 new Inquests.
- One Regulation 28 notice was received in December 2025.

7 Escalations to QSC from Strategic Learning from Deaths Group 20th January 2026

- Increase in the number of R69 codes deaths partly due to vacancies and the need for an establishment review in the Coding Team
- Reduction seen in palliative care coding – the reason for this is being investigated.
- Investigation taking place into the increased number of FCEs which particularly affect Medicine
- Zero NACEL quality survey completion for 2025. This issue is being addressed.
- Improvements in the number of completed SJRs from Surgery and Critical Care division.
- Risk of patients being inappropriately resuscitated due to issues with uploading the RESPECT form on the computer on wheels in some clinical areas

8 Risks

There were no changes made to the risk register.

9 Recommendation

To note the work of the Learning from Deaths programme.

10 Figures

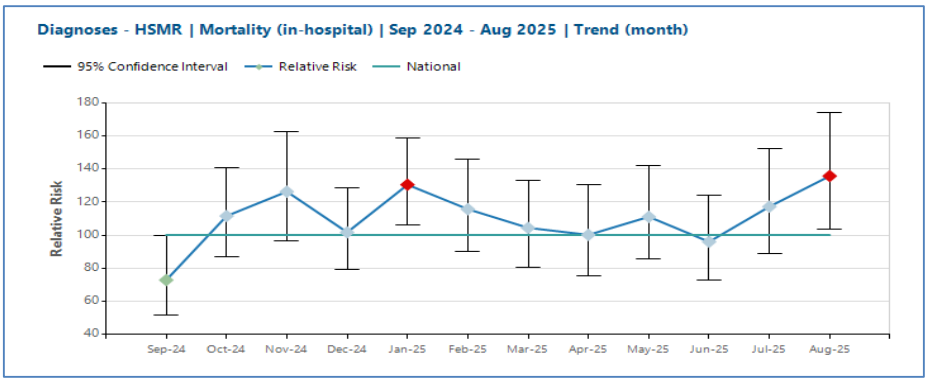


Figure 1 HSMR Monthly Trend Sept 24 – Aug 25

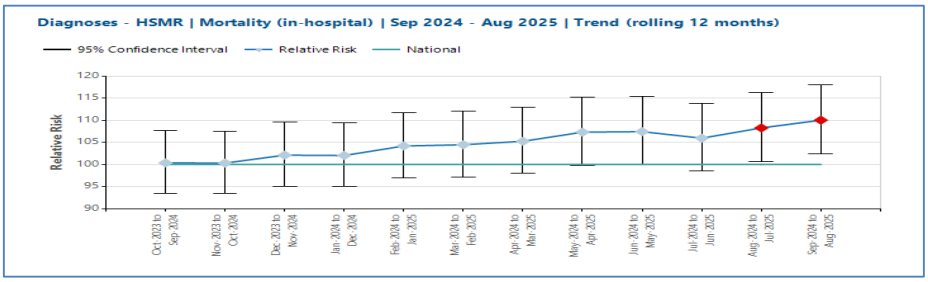


Figure 2 HSMR 12 month rolling trend Sept 24 – Aug 25

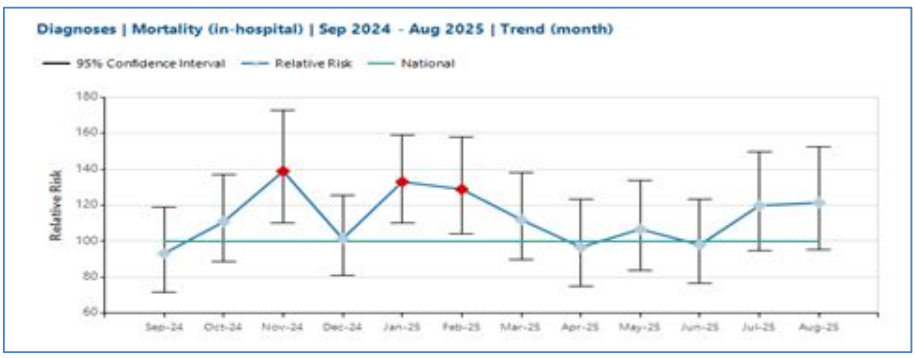


Figure 3 SMR Monthly Trend

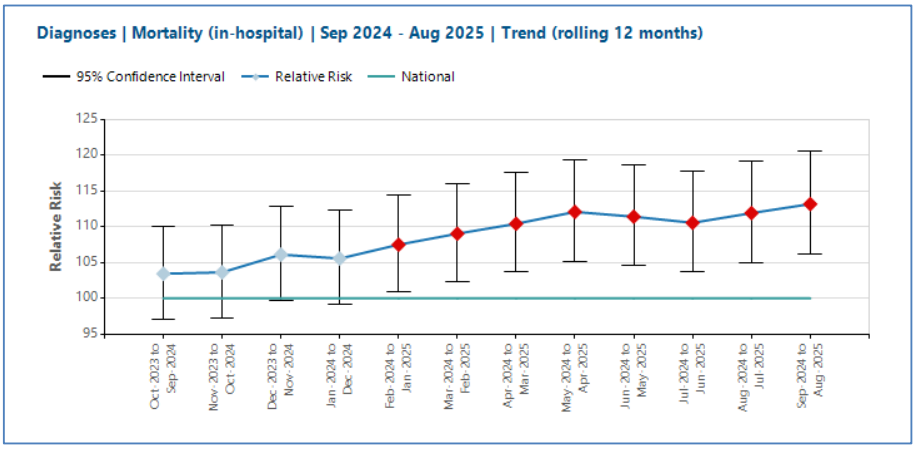


Figure 4 12 month rolling SMR

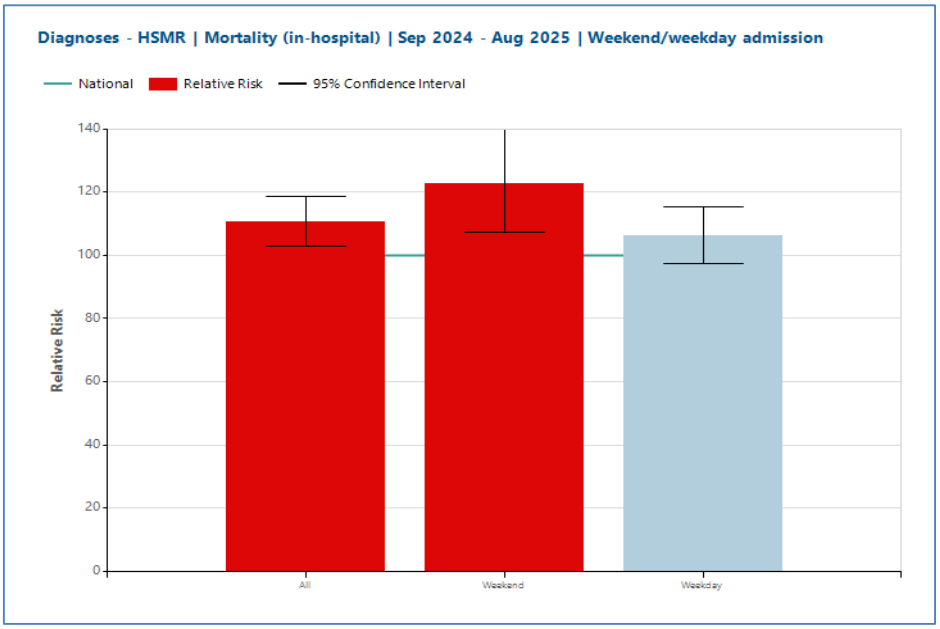


Figure 5 HSMR Weekend/Weekday Admissions Emergency only

11 Appendix

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: Cumulative sum

A CUSUM is a type of control chart used to monitor small shifts in the process mean. It uses the cumulative sum of deviations from a target. The CUSUM chart plots the cumulative sum of deviations from the target for individual measurements or subgroup means.

A cumulative sum statistical process control chart plots patients' actual outcome against their expected outcomes sequentially over time.

The charts help identify patterns and deviations from expected mortality, allowing for timely interventions to improve patient outcomes.

The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered.

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 People Report	Yes	Yes	No	The Committee were assured on the good progress being made on the People KPIs. Key highlights included: • Staff engagement and wellbeing metrics remained positive, with KPIs generally strong. • The reported vacancy rate appeared artificially high due to roles held back during the divisional restructure; the adjusted rate was estimated at approximately 7%. • Sickness absence increased, primarily driven by cold and flu during winter, but a robust flu prevention campaign led to a 5% increase in vaccination uptake, meeting NHS England targets. • Bank and agency spend was elevated, mainly due to enhanced care needs and mental health presentations; strategies are in place to address this, including recruitment of enhanced care health care assistants and dual trained Mental Health nurses • Freedom to Speak Up processes are being strengthened, with a new review group established to triage and address concerns more robustly. • Employee relations case durations are being targeted for reduction, with training planned to expedite resolution and improve staff confidence in processes.

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.2 Divisional Restructure and 2.3 Culture Update	Yes	No	No	**Divisional Restructure:** The clinical divisional restructure has been successfully completed, with three new clinical divisions and senior leadership teams appointed. Most vacancies are filled, and temporary measures are in place to ensure service safety where needed. The assessment centre process used for appointments has been recognised as a regional model of best practice. All candidates received structured feedback, which will inform their appraisals and career development. **Culture Update:** The partnership with Max& is supporting leadership capability, focusing on leadership, change, culture building, and governance, with strong engagement from staff. The next phase includes a diagnostic of organisational culture and embedding a consistent leadership culture across the Trust, strengthening clinical governance, and ensuring continuous improvement. Max& is providing external perspective and building blocks for sustained improvement. The restructure is seen as a positive step, with staff expressing support in the process and outcomes. There is recognition of the need to support those not appointed to their desired roles, with wellbeing, coaching, and development opportunities provided.
2.4 Baseline Rostering Action Plan	Yes	Yes	No	An internal audit identified key risks in roster management, particularly around hours owed to staff and the Trust. The People team working with the Corporate Nursing team have

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				developed and begun implementing a robust action plan addressing all audit recommendations, including improved validation of hours, enhanced communications to staff, and refreshed rostering policy and training. Nursing, midwifery, and AHP teams are the initial focus, with standardised processes being rolled out and regular scrutiny meetings in place to ensure compliance and sustainability. Medical rostering is under review, with plans to procure a more suitable system that integrates with payroll and ESR, ensuring alignment across all staff groups. Progress will be closely monitored, with regular updates to the Committee, and the initiative is expected to improve workforce planning, reduce reliance on temporary staffing, and support safer staffing levels.
2.5 Learning & OD Update	Yes	Yes	No	Key highlights included: • Mandatory training compliance remains above 90% for eight consecutive weeks, marking a significant achievement. • Appraisal rates continue to improve, with targeted communications, automated reminders, and increased training and drop-in support for managers and staff. • Medical and dental appraisals also showed positive progress, supported by collaboration with clinical leaders.

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				• A coaching and mentoring network was established, with 12 trained coaches and a system for easy access launching in the new financial year. • Community engagement initiatives included onboarding healthcare support workers, T-level students, and apprentices in partnership with Harlow College, and gifting £343,000 to local organisations to support employment and apprenticeships. • The Oliver McGowan training programme faced challenges with attendance, particularly for off-site sessions, and national funding for this training will end in March, prompting ongoing discussions about future provision. • The team continued to address environmental and operational factors affecting appraisal completion, with a focus on supporting staff through change and linking development plans to the new divisional structure.
2.6 Staff Survey	Yes	Yes	No	Staff survey engagement reached a record high of 64%, a 15% increase from the previous year, indicating strong confidence in the insights gathered. Positive results were seen in line management behaviours, role clarity, meaningful work, appraisal quality, and access to learning and development, reflecting targeted improvement efforts. Areas identified for further improvement included confidence in care quality, workload fatigue, harassment from the public, access to nutrition, reasonable adjustments, and

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				autonomy. Five-year trends showed progress in staffing perceptions, psychological safety, reporting of violence and aggression, and access to equipment. Next steps included divisional deep dives, rollout of team-level dashboards, and integration of survey findings into the cultural leadership programme, with a focus on maintaining engagement and acting on staff feedback
2.7 Equality Delivery System Report	Yes	No	No	The EDS report covered progress from 2024 to 2025, noting that while the overall grading remained at "developing," significant actions had already been implemented to address health and wellbeing and health inequalities, particularly in domains 2 and 3. Improvements included strengthened staff networks, increased executive visibility, and the implementation of quality impact assessments. Governance was strengthened by amalgamating EDS actions with other equality-related plans (e.g., WRES, WDES) into a single delivery plan, monitored by a steering group and reported to the People Committee and Board. The report acknowledged that while the formal grading had not yet moved to "developed," there was clear evidence of progress, with actions now more targeted, cross-referenced, and regularly monitored
2.8 Safer Nurse Staffing	Yes	Yes	No	Registered nurse fill rates sustained above 95%. No wards below 75%. The only exception was John Snow Ward (orthopaedics), where a lower fill rate was appropriate due to reduced patient numbers. Some wards showed fill rates

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				above 120% overnight, primarily driven by enhanced care needs. Future reports will benchmark care hours per patient day against funded establishment to clarify these variances. Safety metrics, including red flags, staffing incidents, pressure ulcers, and falls, were triangulated. No correlation was found between lower fill rates and adverse patient safety outcomes. The maternity staffing review (Birthrate Plus review) has been completed and will be presented to the Quality and Safety Committee in January, then to the People Committee in March.
2.9 Nursing Establishment Review	Yes	No	No	The nursing establishment review confirmed that most ward areas have adequate staffing levels, with no additional requests for staff in core areas. Some clinical areas require slightly more staff than recommended by the SNCT due to ward layout and patient needs, but this is supported by evidence. A new cohort area in ED has been opened and is currently staffed with temporary or redeployed staff; a request was made to substantively fund 10.2 WTE posts for this area. Enhanced care demand remains high, with an average of 65–70 WTE healthcare support workers used monthly, mostly via temporary staffing. A request was made to substantively fund 16 additional posts for the enhanced care team to improve reliability and training. Risks include potential recruitment challenges for healthcare support workers, but ongoing work with Harlow College and apprenticeships aims to strengthen the workforce. All

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				requests have been through executive board and will proceed to Trust Board for approval, with further requests for maternity and neonatal staffing expected. The Committee recommended the report to Board for approval.
2.10 Voluntary Services Report	Yes	Yes	No	An update was received on the progress to date against the voluntary service strategy. The voluntary services team continued to expand, with 40 new volunteers being onboarded to support winter pressures and an additional 50 on a waiting list. Volunteer roles were increasingly aligned with clinical needs, including new placements in audiology and enhanced gardening roles to support estates, as well as involvement in the Fundamentals of Care project. Community engagement remained strong, with ongoing partnerships with NHS services, local authorities, charities, and Harlow College. Initiatives such as Volunteering for Health and Volunteer to Career provided career pathways for local people, including a successful case of a volunteer progressing to a healthcare assistant role. The team identified administrative bottlenecks in volunteer onboarding (DBS, occupational health, references), which could delay placements by up to three months. Offers of support from the Committee and system partners were noted, with ongoing efforts to streamline processes while maintaining legal compliance. Strategic focus included developing a volunteer readiness programme with system partners,

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				enhancing patient flow, supporting staff, and improving patient experience.
2.11 Improving Resident Doctors Lives - 10 point plan	Yes	Yes	No	An update on the Improving Resident Doctors Lives 10 point plan was received. The Trust achieved a significant increase in completion of the 10 Point Plan, rising from 65% to 88% at the 12-week review. The initiative received regional recognition as best practice, with the Trust invited to present its approach at an NHS performance meeting. Key successes included improvements in estates (notably parking and hot food provision for all staff). Outstanding actions relate to formalising the annual leave policy for resident doctors, developing a policy for less than full-time doctors, and finalising self-development time arrangements; these are progressing through governance and consultation. Ongoing monitoring and oversight are provided by the Improving Working Lives group, with all remaining actions on track for completion.
2.12 Guardian of Safer Working Hours Report	Yes	Yes	No	There were 95 exception reports received between October and December 2025, mainly related to working hours. Exception reporting by senior doctors had increased, indicating improved engagement with the process. Immediate patient safety concerns were raised during industrial action and in trauma and orthopaedics, where weekend staffing was found to be insufficient. Actions are underway to review rotas and address staffing gaps, with divisional leadership involvement. The exception reporting

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REPORT TO THE BOARD FROM: People Committee

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

DATE OF COMMITTEE MEETING: 26 January 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				process is being strengthened, with additional administrative support identified and process changes going live in early February. Recruitment for a new GoSW is in progress.
2.12 Report from Medical Workforce Group	Yes	No	No	The group met on the 15 January 2026 and reviewed progress on additional session management, HealthRoster adoption, and key financial controls, noting continued agency and bank spend pressures and divisional overspends. Divisions will report on safe staffing work, alternative pay elements, and drivers of pay errors, with strengthened oversight through the Payroll Improvement Group. Culture and behaviours remains a standing focus with planned input from OD. Overall, improvement actions are in progress with clear divisional accountability.
2.13 BAF Risk 2.1 Staff Engagement and Morale	Yes	Yes	No	The Committee noted that the original risk focused on poor staff engagement amid organisational instability and had been set during a period of significant change. It was explained that recent staff survey results show engagement has improved, and the key risks have now shifted to staff burnout and low morale, prompting a revision of the risk description to reflect this. The score had been reviewed and has been increase to 20, 16 with mitigations. The Committee approved the revised risk description and increased score.
2.17 Horizon Scanning	Yes	No	No	Highlights included: • Workforce Supply and Labour Market Pressures - National shortages persist across nursing, midwifery,

BOARD OF DIRECTORS: Trust Board - Public 5 February 2026				**AGENDA ITEM: 5.1**
REPORT TO THE BOARD FROM: People Committee				
REPORT FROM: Committee Chair – Darshana Bawa, Acting Trust Chair				
DATE OF COMMITTEE MEETING: 26 January 2026				
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				AHPs, diagnostics, and medical specialties and growing reliance on temporary staffing remains a financial and operational risk. • Digital Transformation - Digital literacy is now a core competency to all staff groups and there is demand for ethical and safe use of AI as well. • Changing workforce expectations - With the new structures in place from 1 February and the roll out of the new clinical strategy, there will be a need for role-redesign on services as well as the expectation of our People to be supported with their learning, development, flexible working and reasonable adjustments.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**David Baines - Committee Chair**	
DATE OF COMMITTEE MEETING:	**29 January 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M9 Integrated Finance Report	Y	Y	N	The Trust declared a surplus of £0.2m in M9 of 25/26 against a planned surplus of £0.2m. This was a positive continuation of achievement of the plan from the start of the financial year, with PQP delivering in-month and YTD. The forecast outturn position for 25/26 was to deliver the break-even plan. The Trust had secured additional funding to support additional activity to reduce long waiting patients and achieve performance metrics. The capital plan for 25/26 was £35.3m with expenditure to date of £19.3m and cash at the end of December was £6.5m. It was requested that PAF receive the outputs of a deep dive into the utilisation of the Vanguard Theatre and whether there were opportunities for it to be used by specialties other than Ophthalmology. This was subject to Business Planning which is being run in parallel.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 January 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Operating Plan Update	Y	Y	N	The plan submitted prior to Christmas had been for a £28.6m deficit. A further meeting around the assumptions would take place on 02.02.26 (including PAF members) with the next submission then signed off by the Board later that week ahead of the next submission on 12.02.26. The indicative plan presented showed a £17.6m deficit plan albeit subject to a number of caveats. Discussions were still ongoing with both ICBs around activity/contracts. Requests had been made to both for the Trust to remain on a block contract for 26/27 to mitigate some of the activity capture risk.
2.3 PQP Update	Y	Y	N	The £26.1m PQP target for 2025/26 represented a significant delivery challenge. Despite this challenge, YTD to M9 the Trust had achieved its PQP target (£18.12m delivered against a YTD target of £18.12m). M9 had a partial over-delivery of £70k. PAF requested some future assurance on the recurrency of PQP schemes/savings and the £2.6m of unidentified schemes. It was agreed this would be presented in March once the planning process had concluded.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 6.1**
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REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 January 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 Nursing Establishment Review	Y	Y	N	Funding was needed outside core SNCT establishments to address increased Enhanced Care demand (Level 1C/1D) and the ambulance cohort area (£1.3million into budgets majority offset against current temp spend). PAF endorsed (for Board approval) the requested additional investment of: 1) Ward establishments – 451,175 and 2) Enhanced care establishment: 862,815, subject to some assurance being provided on relative benchmark levels to peers, the phasing was appropriate and all avenues had been explored to mitigate costs through repurposing existing bank budgets.
2.5 IMS Project Post-Implementation Review	Y	Y	N	The IMS project was coming to its last phase of deployment as per the IMS Business Case with two remaining departments to go-live and ward rollouts planned: Endoscopy on the 9th of February 2026 and Cath Labs 25th of February 2026. The IMS Project to date had saved the Trust more than £744k. This fell under cost avoidance, stock wastage write-off and reduction of overstock. This was showing as non-cash recurring (over a two-year forecast). PAF welcomed the practice of post-implementation reviews.

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REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 January 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.6 MSK Community Sub-Contract Direct Award	Y	Y	N	PAF endorsed, for Board approval, the recommendation to direct award the MSK community services contract to EPUT under the Procurement Selection Regime, Direct Award Process C. The contract would be five years with an option to extend by two years as per the lead provider contract arrangements. This recommendation would allow for continuity of care and to build on the improvements that were underway. The intention was that the contract would be at current financial values, plus national uplifts. It was noted that due to the tight timeframe for awarding the contract it had not been possible to consider alternative options for provision of this contract but due to the one year get out clause within the contract, the longer term options could be considered.
2.7 BAF Risk 5.1 (Finance – Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.

3.1 M9 Integrated Performance Report (IPR)	Y	Y	N	Concerning metrics at M9 were: • Proportion of ambulance handovers in less than 15 and 30 minutes. • Diagnostic times - patients seen within 6 weeks. • Appraisals – non-medical. • % patients under 18 weeks waiting for a first OPA. • Cancer 62 day - shared treatment allocation rules. • RTT over 78 week waiters. • Complaints – new. Metrics showing an improving variation were: • Proportion of patients treated within 4hrs in ED. • Bank spend, agency spend and voluntary staff turnover. • Catering food waste and Domestic Services (Cleaning) high risk. • Cancer 2 week waits. • Cost Improvement Plan and capital spend. • Estates responsiveness (Priority 2 - Urgent). Of note was that the Trust had been de-escalated to Tier 2 for Cancer & Diagnostics and that PAHT was currently 12th nationally for ED 4 hour performance (currently 80.3% for January). It was agreed the finance metrics in the IPR would be reviewed as it was not always appropriate to have finance presented in an SPC format.
3.2 Access Performance Report	Y	Y	N	Key headlines were: Performance Overview by Measure: Alert Measures • Diagnostic Endoscopy (DM01) Reporting – December performance accuracy and associated utilisation required. • RTT Performance – 65-week and 52-week booked cohort at risk. • Cancer 62 day – Deterioration for November. • ED 12 hour – deterioration against plan. • Ambulance Handover <30min - Deterioration against plan.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 January 2026**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				□ Advise Measures • RTT – risk to all metrics against year-end performance. • Cancer 28 day FDS – deterioration for November, mitigation in place for December. • Somerset Deployment – delay to 'go live'. □ Assured Measures • Cancer 31-day – performance maintained. • A&E 4 hour performance – performance maintained. PAF noted the Trust was now able to provide a full DMO1 report. Endoscopy performance was improving with a focus now on list utilisation.
3.3. Bi-Annual Emergency Preparedness and Business Continuity Update	Y	Y	N	PAF endorsed the Core Standards Submission (substantial compliance) for approval by the Trust Board.
3.4 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.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 January 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.5 BAF Risk 1.4 (EHR)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
3.6 BAF Risk 1.5 (Cyber)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.
4.1 New Hospital Programme Update	Y	Y	N	PAF discussed the Trust's strategy for the new hospital programme. This would be discussed further at February's Trust Board.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 February 2026**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 January 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.2 Health & Safety Update	Y	Y	N	Key headlines included: • The fire safety risk had reduced to 15 after steady improvement work. • Interim Fire Safety Officer cover was in place while recruitment continued. • Training on fire awareness, evacuation equipment and drills had also im proved and work on AE fire actions and cause-and-effect documentation was progressing. • Sharps and needlestick incidents remained the most common reported issue, despite training, and this had been escalated to the Chief Nurse. • Training compliance for manual handling, H&S and fire remained high at over 88%, although fit testing was at 14% which was being reviewed.
4.3 BAF Risk 3.1 (Estate and Infrastructure)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 February 2026

Agenda item:	6.2								
Presented by:	Tom Burton, Chief Finance and Infrastructure Officer and Interim Deputy CEO								
Prepared by:	Beth Potton, Interim Operational Director of Finance								
Date prepared:	27 January 2026								
Subject / title:	Month 9 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 £0.2m in month 9 of 25/26 against a planned surplus of £0.2m, this is a positive continuation of achievement of the plan from the start of the financial year, with PQP delivering in month and YTD. The Trust had a PQP target of £2.4m in month 9 which was delivered, the PQP plan is delivering YTD. The capital plan for 25/26 is £35.3m with expenditure to date of £19.3m. Cash at the end of December was £6.5m.								
Recommendation:	The Board is asked to note the month 9 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:	PAF – 29 January 2026
Risk / links with the BAF:	BAF risk 5.1.
Legislation, regulatory, equality, diversity, and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached.

December - Month 9

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a surplus of £0.2m in month 9 of 25/26 against a planned surplus of £0.2m, this is a positive continuation of achievement of the plan from the start of the financial year, with PQP delivering in month and YTD.

- Industrial costs of £0.4m were incurred in month which were mitigated by the release of a provision relating to prior year additional sessions and Anaesthetist backpay with the majority now having been paid. Payments made were lower than expected providing a YTD benefit this month and last month.

- Non-pay costs remain high, with a £0.4m adverse variance in month, despite recoding £0.4m of EHR invoices to capital. Pass through drugs costs were high on non pay but are offset with income, electricity costs also remain high due to being out of contract with our supplier (work is ongoing to resolve) and aged debt linked to Pathology invoices also contributed to the in month over spend.

- 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, this has not been achieved to date. Whilst there had been a small reduction in the last quarter, M9 costs have crept back up (potentially linked to Industrial action). Agency costs have also increased in the last three months.

- The Trust had a PQP target of £2.4m in month 9 which was delivered, the PQP plan is 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 £35.3m with expenditure to date of £19.3m.

Summary financial results

The Princess Alexandra Hospital NHS Trust

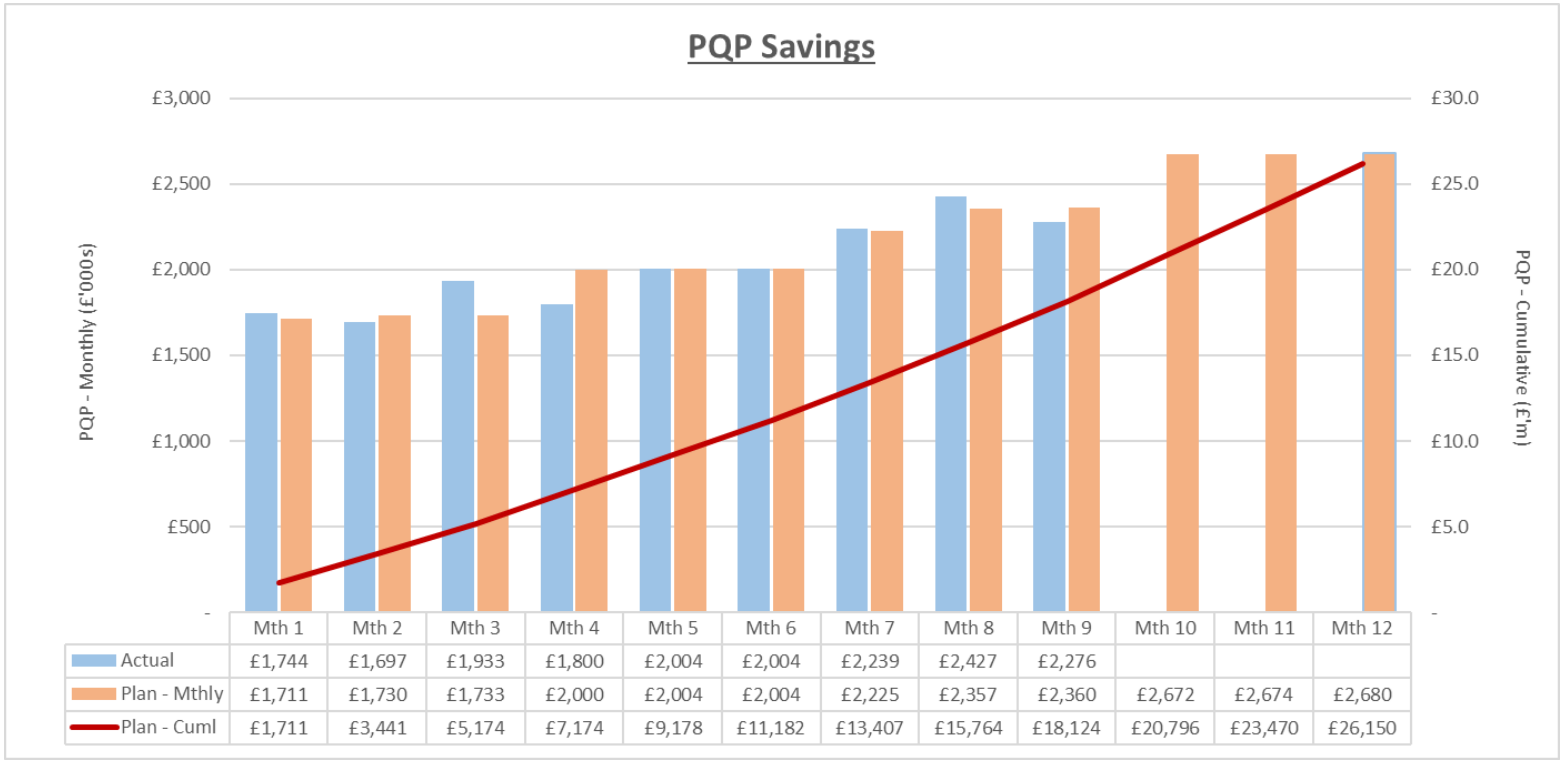
	FY Budget	Dec-25			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS & non-NHS Income	411.1	34.2	34.6	0.3	307.7	310.4	2.7
Pass through Income	20.3	1.7	1.9	0.2	15.2	15.2	0.0
Income Total	**431.4**	**35.9**	**36.4**	**0.5**	**322.9**	**325.6**	**2.7**
Pay							
Substantive	(276.0)	(23.1)	(20.8)	2.3	(207.4)	(186.8)	20.6
Bank	(7.1)	(0.6)	(2.4)	(1.8)	(5.3)	(21.6)	(16.3)
Agency	(3.3)	(0.2)	(0.7)	(0.5)	(2.5)	(3.7)	(1.1)
Pay Total	**(286.4)**	**(23.9)**	**(23.9)**	**0.0**	**(215.3)**	**(212.0)**	**3.2**
Non-Pay							
Drugs & Medical Gases	(11.5)	(1.0)	(0.9)	0.0	(8.4)	(7.7)	0.7
Pass through expenditure	(20.7)	(1.7)	(2.0)	(0.3)	(15.5)	(15.6)	(0.0)
Supplies & Services - Clinical	(14.3)	(1.2)	(1.7)	(0.5)	(10.7)	(13.8)	(3.1)
Supplies & Services - General	(6.3)	(0.5)	(0.5)	0.1	(4.7)	(3.9)	0.8
All other non pay costs	(69.3)	(5.5)	(5.2)	0.3	(52.5)	(56.7)	(4.2)
Non-Pay Total	**(122.0)**	**(9.9)**	**(10.3)**	**(0.4)**	**(91.7)**	**(97.6)**	**(5.9)**
Financing & Depn							
Depreciation	(17.8)	(1.5)	(1.7)	(0.2)	(13.4)	(13.8)	(0.4)
PDC & Interest	(5.5)	(0.5)	(0.5)	0.0	(4.1)	(3.7)	0.4
Financing & Depn Total	**(23.3)**	**(1.9)**	**(2.1)**	**(0.2)**	**(17.5)**	**(17.5)**	**(0.0)**
Total	**(0.3)**	**0.1**	**0.1**	**(0.0)**	**(1.6)**	**(1.5)**	**0.0**
Technical Adjustment	0.3	0.0	0.0	0.0	0.2	0.2	0.0
Grand Total	**0.0**	**0.2**	**0.2**	**(0.0)**	**(1.4)**	**(1.3)**	**0.0**
Non recurrent system transformation funding	(15.1)	(1.3)	(1.3)	0.0	(11.3)	(11.3)	0.0
Non recurrent deficit support funding	(5.3)	(0.4)	(0.4)	0.0	(3.9)	(3.9)	0.0
Non recurrent efficiency	(12.1)	(1.0)	(1.0)	0.0	(8.3)	(8.3)	0.0
25/26 Underlying position	**(32.4)**	**(2.5)**	**(2.5)**	**(0.0)**	**(24.9)**	**(24.9)**	**0.0**

PQP

The Princess Alexandra Hospital NHS Trust

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

In month 9, the Trust delivered £2.3m PQP against a plan of £2.4m, 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	£2,427	£2,276			
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	Nov-25	Dec-25	Movement In Month	Movement YTD
	£'m	£'m	£'m	£'m	£'m
Non-current assets					
Property, plant & equipment	189.1	192.7	197.2	4.5	8.1
Right of use assets	43.1	41.2	40.8	(0.4)	(2.3)
Intangible assets	32.1	34.3	31.7	(2.6)	(0.4)
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**265.4**	**269.4**	**270.8**	**1.5**	**5.5**
Current assets					
Inventories	4.2	4.2	4.2	-	-
Trade & other receivables	10.5	24.9	27.1	2.2	16.6
Cash & cash equivalents	28.6	11.1	6.5	(4.6)	(22.2)
Current assets	**43.3**	**40.2**	**37.8**	**(2.4)**	**(5.5)**
Total assets	**308.7**	**309.6**	**308.6**	**(1.0)**	**(0.1)**
Current liabilities					
Trade & other payables	(46.1)	(47.3)	(46.4)	0.8	(0.4)
Provisions	(1.2)	(1.2)	(1.2)	-	-
Borrowings	(2.7)	(3.2)	(3.2)	-	-
Current liabilities	**(50.0)**	**(51.7)**	**(50.8)**	**0.8**	**(0.4)**
Net current assets/ (liabilities)	**(6.6)**	**(11.5)**	**(13.0)**	**(1.6)**	**(5.9)**
Total assets less current liabilities	**258.7**	**257.9**	**257.8**	**(0.1)**	**(0.5)**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.0)	(0.9)	(0.9)	-	-
Borrowings	(40.2)	(38.5)	(38.3)	0.2	1.9
Total non-current liabilities	**(41.2)**	**(39.4)**	**(39.2)**	**0.2**	**1.9**
Total assets employed	**217.5**	**218.5**	**218.6**	**0.1**	**1.5**
Financed by:					
Public dividend capital	384.6	387.2	387.2	-	3
Income and expenditure reserve	(172.6)	(182.5)	(182.4)	0.1	(9.8)
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**	**218.5**	**218.6**	**0.1**	**1.1**

Non-Current Assets: PPE has increased by £4.5m due to in year additions. A decrease of £0.4m in ROU assets is mainly due to ROU depreciation charge during the year. A decrease of £2.6m in intangible assets relate to in year amortisation.

Trade and Other Receivables have increased by £2.2m and this is mainly driven by outstanding invoices for HWE ICB of £1.3m, HSL of £0.7m and others of £0.2m

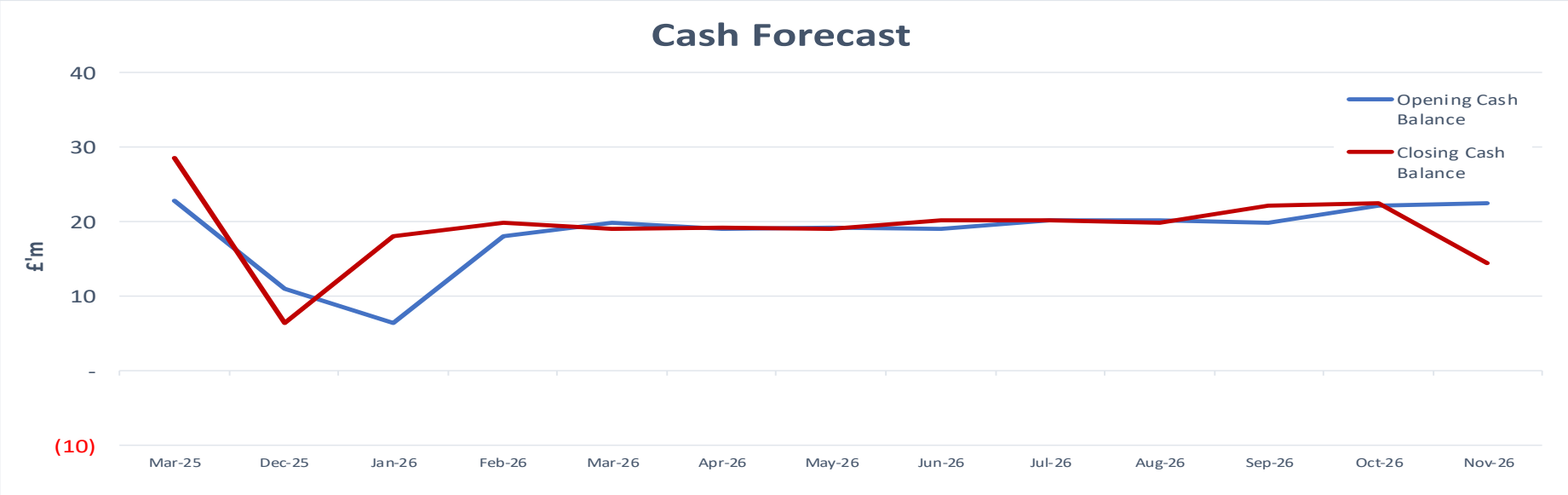
Cash balances decreased by £4.6m, primarily due to the rescheduling of a £4.8m Capital PDC drawdown from December2025 to January 2026. This was partially offset by a net increase in receipts over payments of £0.2m.

Trade and Other Payables decreased by £0.8m, primarily driven by a £1.7m release of deferred income, comprising £1.0m of NHSE education funds, £0.4m from other sources, and £0.3m of CDC funding. This was partially offset by a £0.9m increase in invoices payable to NHSP.

Cashflow

The Princess Alexandra Hospital NHS Trust

	<----Actual---->		<----------Forecast----------										
	Mar-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
Opening Cash Balance	22,934	11,072	6,473	18,080	19,825	19,116	19,184	19,150	20,150	20,224	19,952	22,212	22,558
Closing Cash Balance	28,628	6,473	18,080	19,825	19,116	19,184	19,150	20,150	20,224	19,952	22,212	22,558	14,568



Cash balances decreased by £4.6 million, primarily due to the rescheduling of a £4.8m Capital PDC drawdown from December to January. This was partially offset by a net increase in receipts over payments of £0.2m. The forecast closing cash balance for the 2025/26 financial year has been revised to incorporate the confirmed £8.7m system support payment from the ICB which was previously assumed as non-cash backed for cash forecasting in 25/26.

Capital Analysis 25/26

The Princess Alexandra Hospital NHS Trust

	Month 9			YTD			Forecast		
	In-month Actual £'m	In-Month Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m	Plan & profile £'m	FY FoT	Variance £'m
Internally Funded Schemes									
Estates									
Estates Schemes	223	223	0	1,133	1,133	-	1,259	1,281	(22)
Estates BLM Schemes	323	323	-	1,680	1,680	-	1,738	1,738	-
HDU Works	-	-	-	-	-	-	-	200	(200)
Phlebotomy to Harvey refurb	39	39	0	54	54	0	-	600	(600)
CDC									
CDC	377	377	(0)	7,132	7,132	0	11,029	10,047	982
EHR, ICT & Info									
ICT & Information Schemes	67	67	-	551	551	0	-	802	(802)
EHR	584	584	(0)	1,649	1,649	-	770	2,294	(1,524)
Corporate									
IFRS16 Leased Assets	-	-	-	-	1,025	1,025	3,300	1,034	2,266
Medical									
Medical Equipment (Surgery)	1	1	(0)	52	52	(0)	-	53	(53)
Medical Software (Medicine)	-	-	-	-	-	-	21	185	(164)
Refurbishment - UTC Works Phase 1 (Medicine)	-	-	-	77	77	-	-	77	(77)
Refurbishment - SMH (CSS)	-	-	-	91	91	-	-	91	(91)
Medical Equipment (CHAWS)	-	-	-	66	66	-	-	90	(90)
Equipment (General)	-	37	37	37	37	-	-	37	(37)
YTD Total	**1,614**	**1,652**	**36**	**12,521**	**13,547**	**1,025**	**18,117**	**18,528**	**(412)**
Externally Funded Schemes									
Fire-CIR- Compartmentation & Fire Doors	87	87	-	246	246	-	1,500	1,500	-
Electrical CIR IPS/UPS and Distribution	9	9	0	519	519	-	1,083	1,083	-
Chidrens ED	500	500	-	743	743	-	2,336	2,336	-
Phase 2 UTC Corridor Refurbishment	4	4	-	572	572	-	2,000	2,000	-
CDC	-	-	-	3,000	3,000	-	3,000	3,000	-
CDC Pathways Funding	-	-	-	-	-	-	2,385	2,385	-
NHP	129	129	(0)	500	500	-	910	910	-
Gamma Probe - Surgery	-	-	-	36	36	-	36	36	-
Image Intensifier - Surgery	-	-	-	65	65	-	66	66	-
Olympus Keymed CF-Q260DL ADU Endoscopy	808	808	0	808	808	(0)	920	920	-
Flexible Nasal Endoscopy	-	-	-	-	-	-	86	86	-
Redirooms, canopies and Proxide HPV systems	-	-	-	211	211	-	211	211	-
Wayfinder PEP NHS App - ICT	-	-	-	-	-	-	200	200	-
Estates Safety Fund	4	46	42	46	46	-	2,492	2,492	-
YTD spend on External Schemes	**1,541**	**1,583**	**42**	**6,746**	**6,747**	**(0)**	**17,225**	**17,225**	**-**
Total - Internal and External	**3,155**	**3,235**	**78**	**19,267**	**20,294**	**1,025**	**35,342**	**35,753**	**(412)**

Plan

Total capital funding approved by the ICS is £35.3m. Included within this is £17.2m of external funding.

Actual and Forecast

Year-to-date capital expenditure totals £19.3m, in line with the approved financial plan.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

Agenda item:	6.3							
Presented by:	Anna Jebb							
Prepared by:	Informatics Team							
Date prepared:	22nd January 2026							
Subject / title:	Integrated Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	X
Key issues	The metrics falling into the concerning variations at month 9 are: • Proportion of Ambulance Handovers less than 15 minutes & 30 minutes • Diagnostic times -Patients seen within 6 Weeks • Appraisals – non-medical • % Patients Under 18 Weeks Waiting for a 1st OPA • Cancer 62 day - Shared treatment allocation rules • RTT over 78-week waiters • Complaints - New The metrics which are showing an improving variation are: • Proportion of Patients treated within 4hrs in ED • Bank Spend • Staff Turnover Voluntary • Catering Food Waste • Cancer two week waits • Domestic Services (Cleaning) High Risk • Cost Improvement Plan • Capital Spend • Agency Staffing Spend • Estates Responsiveness (Priority 2 - Urgent) • Domestic Services (Cleaning) Very High Risk							
Recommendation:	The Board is asked to note that 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.							
Trust strategic objectives: please indicate which of the five Ps is relevant to	**Patients**		**People**		**Performance**		**Places**	**Pounds**

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

the subject of the report	X	X	X		X

Previously considered by:	PAF.29.01.26 and QSC.30.01.26
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:	M9 IPR

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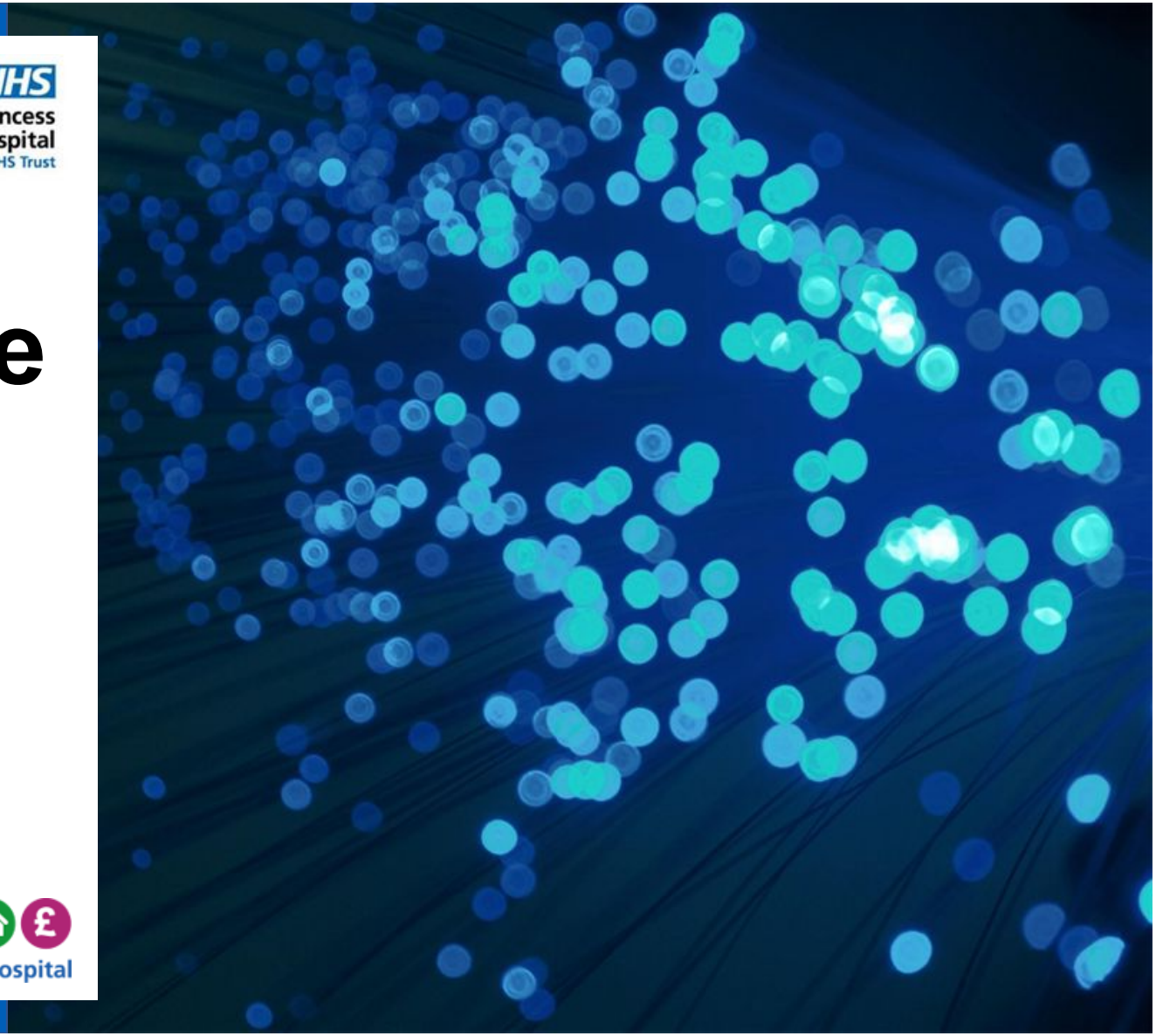
Integrated Performance Report:

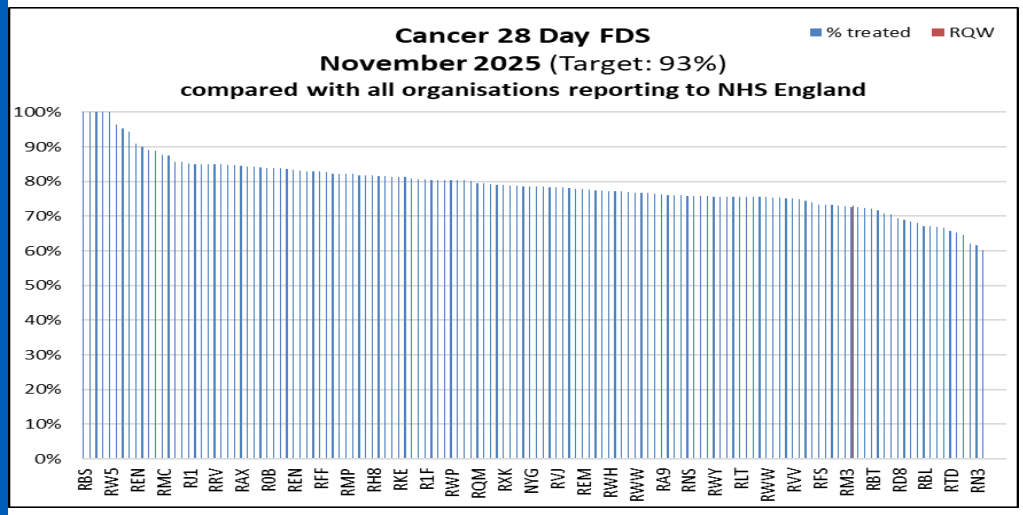


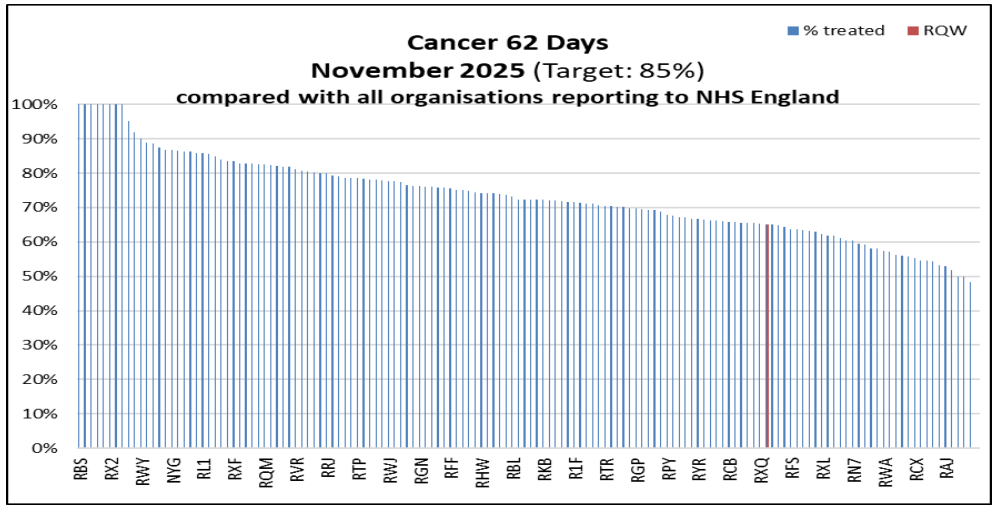
December 2025

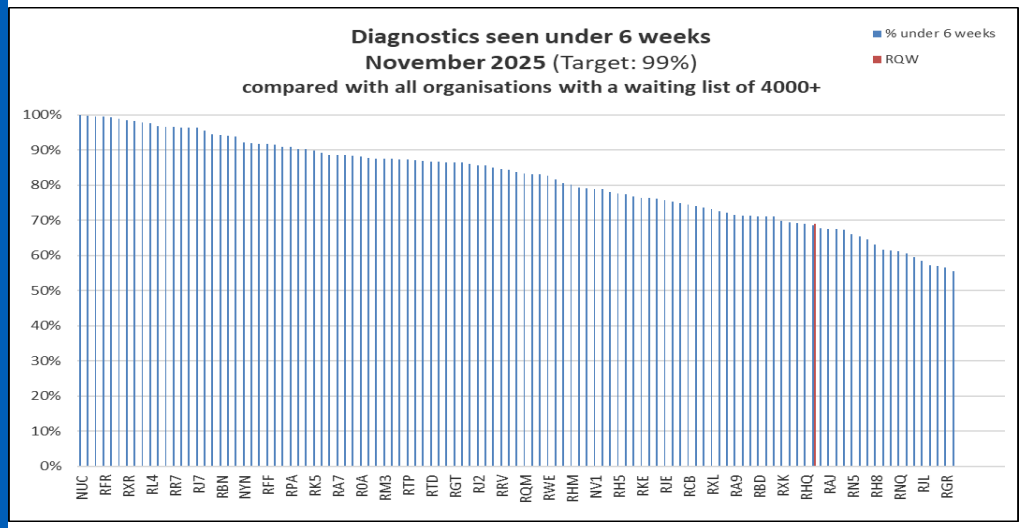
As at 20/01/2025

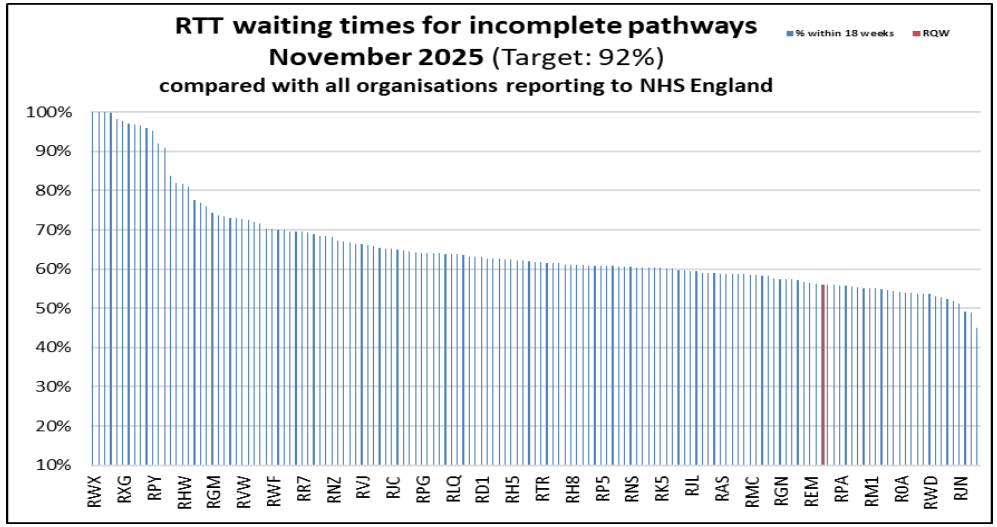
Your future • Our hospital

NATIONAL BENCHMARKING

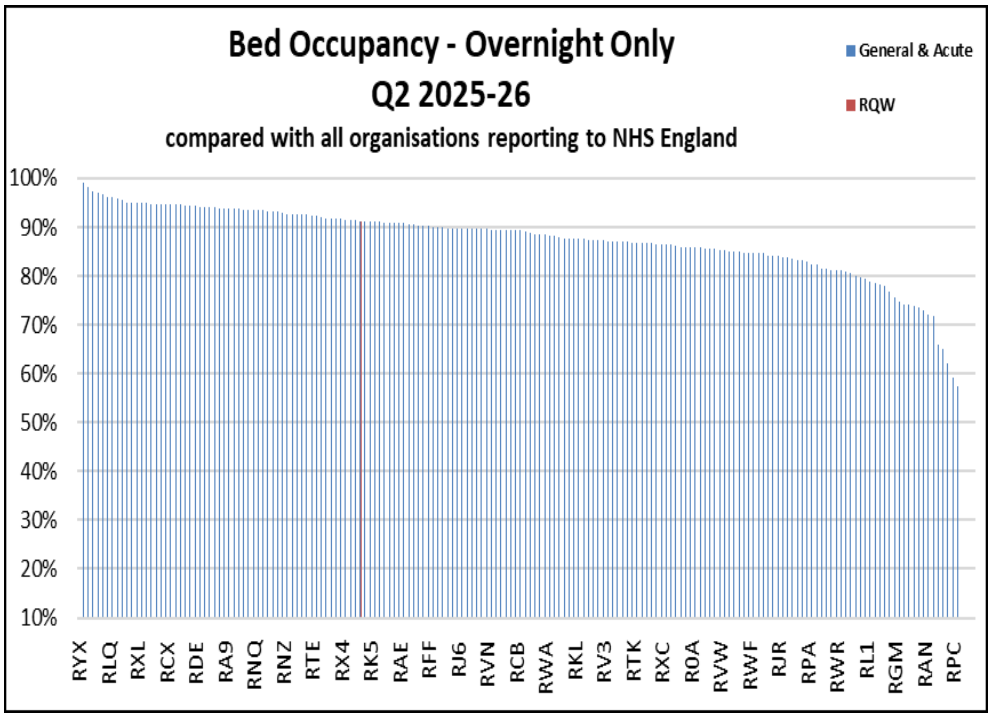


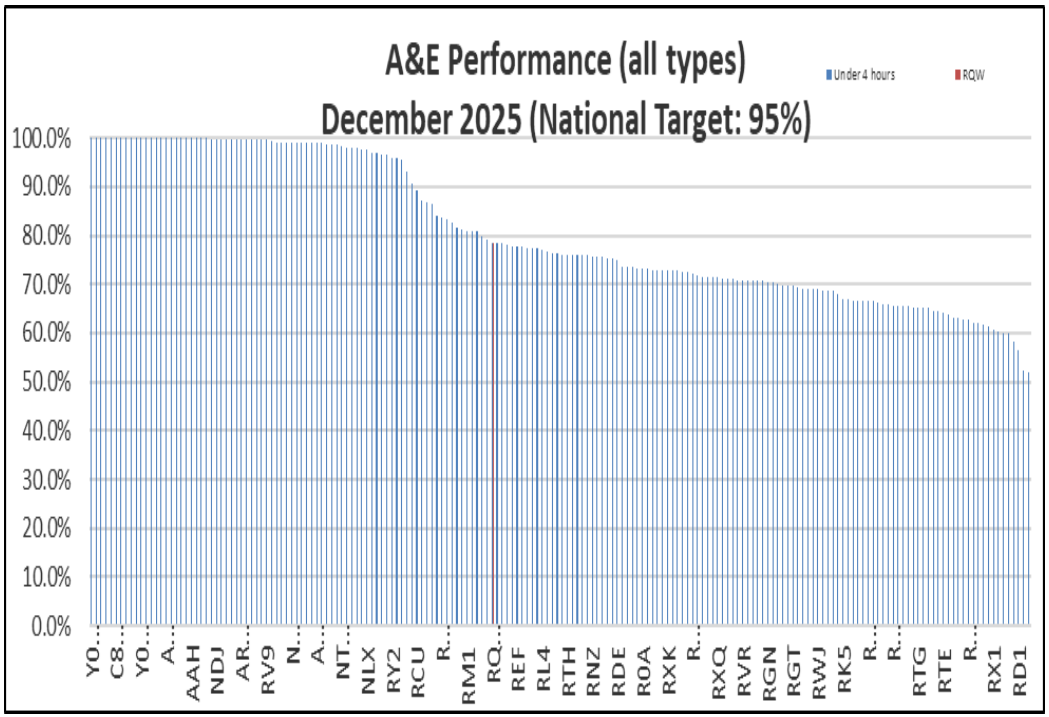






NATIONAL BENCHMARKING





Pillar	KPI	Performance for last reporting month	SPC Trend	Variation	Assurance
Patients	C-DIFF Hospital onset Healthcare Associated	2	Common cause variation		
Patients	C-DIFF Community onset healthcare associated (Acute Admission within last 4 wks)	0	Common cause variation		
Patients	Tissue Viability - (Pressure Ulcers) per 1000 bed days	2	Common cause variation		
Patients	Total grade 3, 4 & unstageable pressure Ulcers	9	Common cause variation		
Patients	Complaints - New	43	Special cause variation-cause for concern(indicator where high is a concern)		
Patients	Falls - total of Minor, Moderate & Severe	11	Common cause variation		
Patients	FFT Patient Satisfaction	85.10%	Special cause variation-improvement(indicator where high is good)		
Patients	Mortality - HSMR	1	Common cause variation		
People	Appraisals - non medical	73.80%	Common cause variation		
People	Statutory & Mandatory training	90.50%	Special cause variation-improvement(indicator where high is good)		
People	Staff Turnover Voluntary	7.40%	Special cause variation-cause for concern(indicator where low is a concern)		
People	Sickness Absence	4.70%	Common cause variation		
People	Agency Staffing Spend	2.90%	Special cause variation-improvement(indicator where low is good)		
People	Bank Staffing Spend	10.10%	Special cause variation-improvement(indicator where low is good)		
Places	Estates Responsiveness (Priority 2 - Urgent)	95.00%	Special cause variation-improvement(indicator where high is good)		
Places	Domestic Services (Cleaning) Very High Risk	99.00%	Special cause variation-improvement(indicator where high is good)		
Places	Domestic Services (Cleaning) High Risk	96.10%	Special cause variation-improvement(indicator where high is good)		
Places	Meals Served	33,807	Common cause variation		
Places	Catering Food Waste	10.30%	Special cause variation-improvement (indicator where low is good)		
Performance	Proportion of Patient treated within 4 hours in ED	78.50%	Special cause variation-cause for concern(indicator where low is a concern)		
Performance	Proportion of Ambulance Handovers less than 15 minutes	16.50%	Common cause variation		
Performance	Proportion of Ambulance Handovers Between 15 & 30 minutes	23.30%	Common cause variation		
Performance	RTT Incomplete Performance	56.10%	Special cause variation-improvement(indicator where high is good)		

Pillar	KPI	Performance for last reporting month	SPC Trend	Variation	Assurance
Performance	Over 12Hrs ED	875	Common cause variation		
Performance	Incomplete 52+ Under 18s PTL	9.00%	Special cause variation-improvement (indicator where low is good)		
Performance	ASIs	7824	Special cause variation-improvement (indicator where low is good)		
Performance	% Patients Under 18 Weeks Waiting for a 1st OPA	53.30%	Common cause variation		
Performance	ED Admitted Percentage	20.30%	Special cause variation-cause for concern(indicator where high is a concern)		
Performance	ED Non - Admitted Percentage	79.70%	Special cause variation-cause for concern(indicator where low is a concern)		
Performance	Diagnostic times - Patients seen within 6 weeks	68.60%	Common cause variation		
Performance	Daily SDEC attendance	87	Common cause variation		
Performance	Average los	6.90%	Common cause variation		
Performance	Cancer two week waits	77.60%	Common cause variation		
Performance	Cancer 28 Day Faster Diagnosis	72.70%	Common cause variation		
Performance	Cancer 62 Day - Shared treatment allocation rules	65.10%	Special cause variation-improvement(indicator where high is good)		
Performance	RTT over 65 week waiters	44	Special cause variation-improvement (indicator where low is good)		
Performance	RTT over 78 week waiters	12	Common cause variation		
Pounds	Cost Improvement Plan	£2,276.00	Special cause variation-improvement(indicator where high is good)		
Pounds	Income	£36,444.00	Common cause variation		
Pounds	Operating Expenditure	-£34,172.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Capital Spend	£3,152.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Bank Spend	-£2,408.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Agency Spend	-£684.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Surplus	£150.00	Common cause variation		
Pounds	Cash Balance Actual	£6,473.00	Common cause variation		

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The Princess Alexandra Hospital
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Variation		Assurance: Will consistently pass if nothing changes	Assurance: Neither pass or fail consistently	Assurance: Will consistently fail if nothing changes	Assurance: No Target set to measure
H / L	**Improving Variation**	**Performance:** Proportion of Patients treated within 4hrs in ED **Pounds:** Bank Spend **People:** Staff Turnover Voluntary	**Places:** Domestic Services (Cleaning) High Risk **Pounds:** Cost Improvement Plan **Pounds:** Capital Spend **People**: Agency Staffing Spend **Places:** Estates Responsiveness (Priority 2 - Urgent) **Places:** Domestic Services (Cleaning) Very High Risk	**Places:** Domestic Services (Cleaning) High Risk **Pounds:** Cost Improvement Plan **Pounds:** Capital Spend **People**: Agency Staffing Spend **Places:** Estates Responsiveness (Priority 2 - Urgent) **Places:** Domestic Services (Cleaning) Very High Risk	**Places:** Domestic Services (Cleaning) High Risk **Pounds:** Cost Improvement Plan **Pounds:** Capital Spend **People**: Agency Staffing Spend **Places**: Estates Responsiveness (Priority 2 - Urgent) **Places:** Domestic Services (Cleaning) Very High Risk
	No Significant Variation	**Places:** Catering Food Watse **Pounds**: Surplus **Performance**: Cancer two week waits	**Patient:** C-DIFF Community onset Healthcare associated (Acute Admission within last 4 weeks) **Patient:** Tissue Viability - (Pressure Ulcers) Per 1000 bed days **Patient:** Total grade 3, 4 & unstageable pressure Ulcers **Patient:** Falls - total of Minor, Moderaate & Severe **People:** Sickness Absence **Places:** Meals Served **Performance:** Average LOS **Performance:** Cancer 28 Day Faster Diagnosis **Pounds:** Income **Pounds:** Cash Balance Actual **Patients:** Mortality HSMR **Performance:** Proportion of Ambulance Handovers less than 15 minutes	**Performance:** Proportion of Ambulance Handovers less than 15 minutes & 30 minutes **Performance:** Diagnostic times -Patients seen within 6 Weeks **People:** Appraisals - non medical **Performance**: % Patients Under 18 Weeks Waiting for a 1st OPA **Performance**: Cancer 62 day - Shared treatment allocation rules **Performance**: RTT over 78 week waiters	**Patient:** C-DIFF Hospital onset Healthcare Associated **Performance:** Over 12hrs ED **Performance:** Daily SDEC attendance
H / L	**Concerning Variation**		**Patient:** Complaints - New		**Performance**: ED Admitted Percentage **Performance**: ED Non - Admitted Percentage

PATIENTS PILLAR
SPCs

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

The Princess Alexandra Hospital NHS Trust

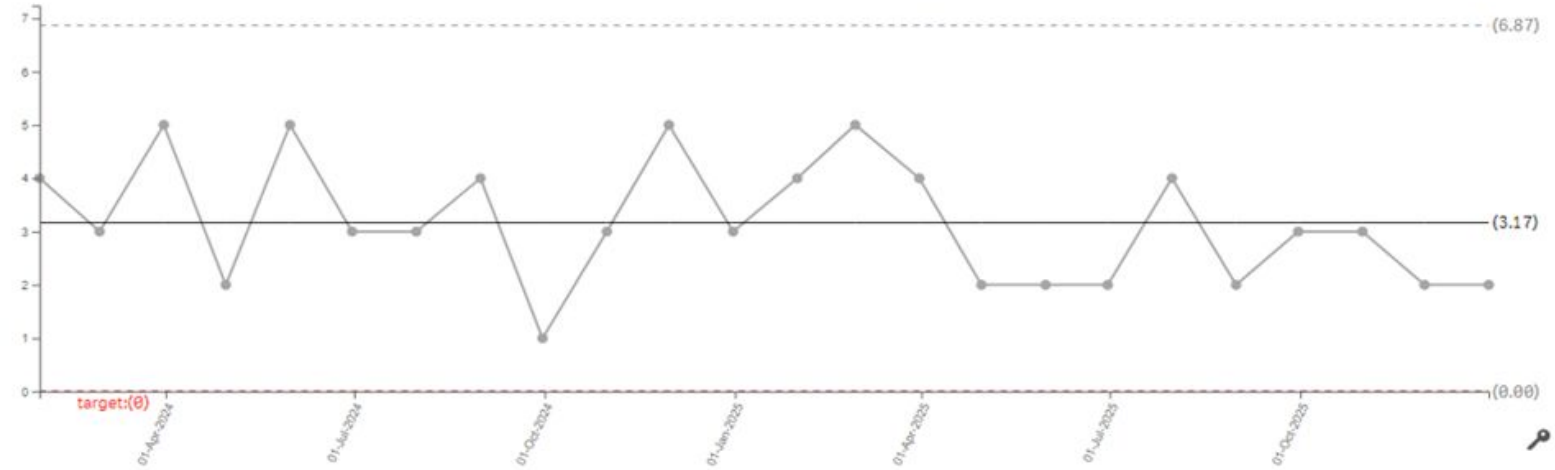
Previous month ...
November-2025

2

Month to date v...
December-2025

2

Target
December-2025
Target is at Trust-wide level



Latest
2
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for C.4 - C-DIFF Community onset healthcare associated (Acute Admission within last 4 wks)

The Princess Alexandra Hospital NHS Trust

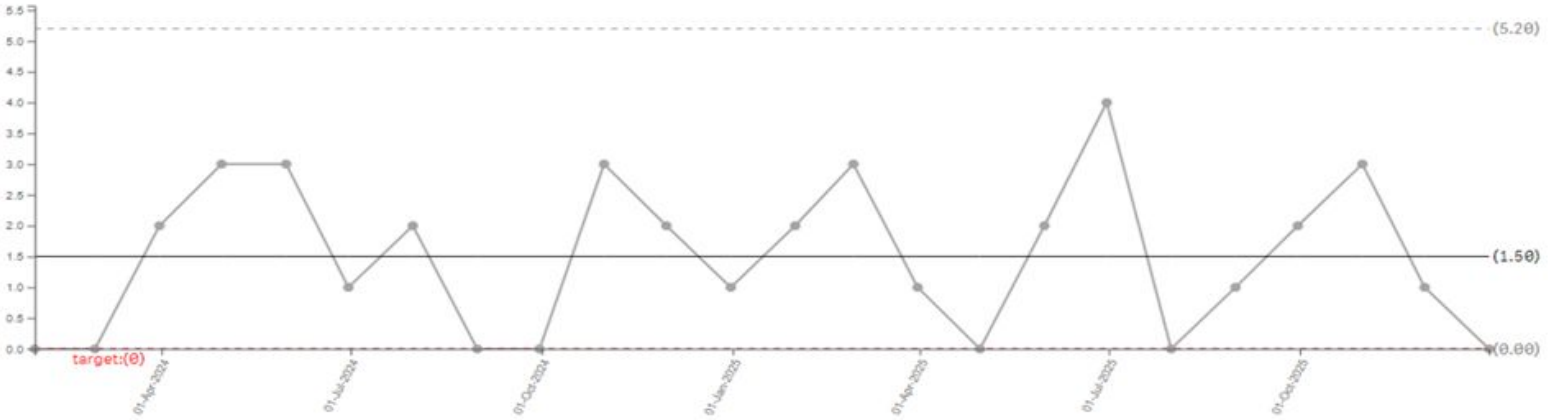
Previous month ...
November-2025

1

Month to date v...
December-2025

0

Target
December-2025
Target is at Trust-wide level



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

SPC for C.14 - Tissue Viability - (Pressure Ulcers) per 1000 bed days

NHS The Princess Alexandra Hospital NHS Trust

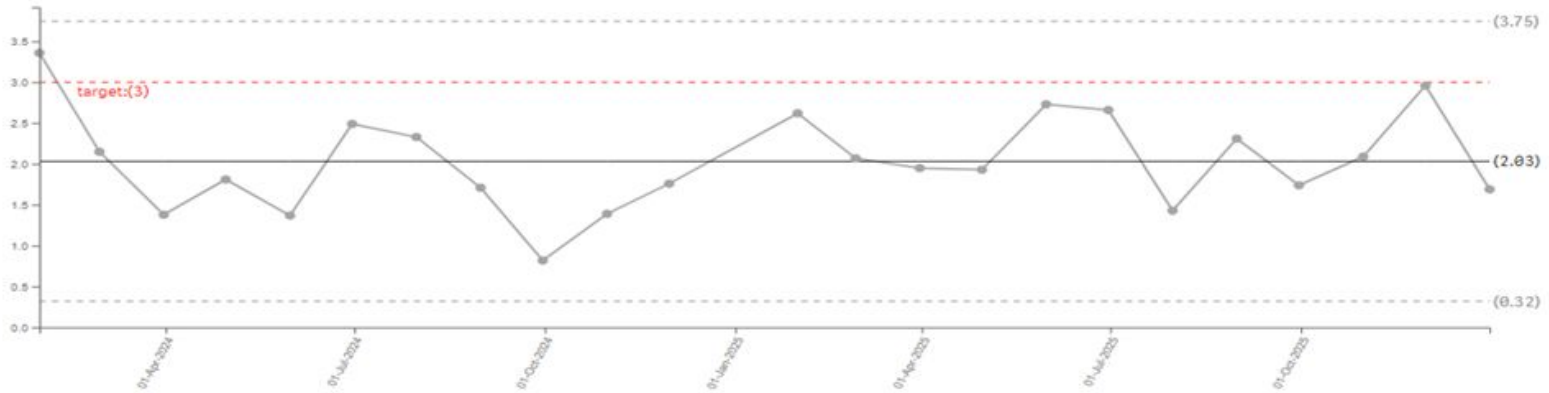
Previous month ...
November-2025

3

Month to date v...
December-2025

2

Target
December-2025
Target is at Trust-wide level



Latest
2
Variance Type
Common cause variation
Target
3
Target Achievement
The system may achieve or fail the target subject to random variation

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

NHS The Princess Alexandra Hospital NHS Trust

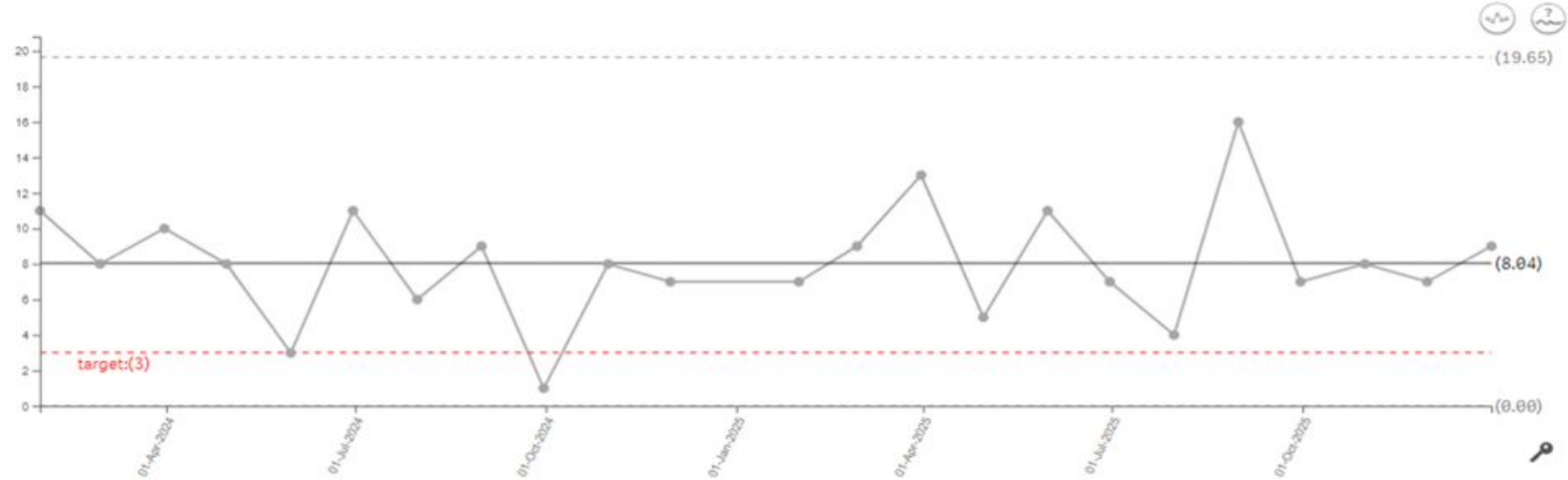
Previous month ...
November-2025

7

Month to date v...
December-2025

9

Target
December-2025
Target is at Trust-wide level



Latest
9
Variance Type
Common cause variation
Target
3
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.11 - Complaints - New

The Princess Alexandra Hospital NHS Trust

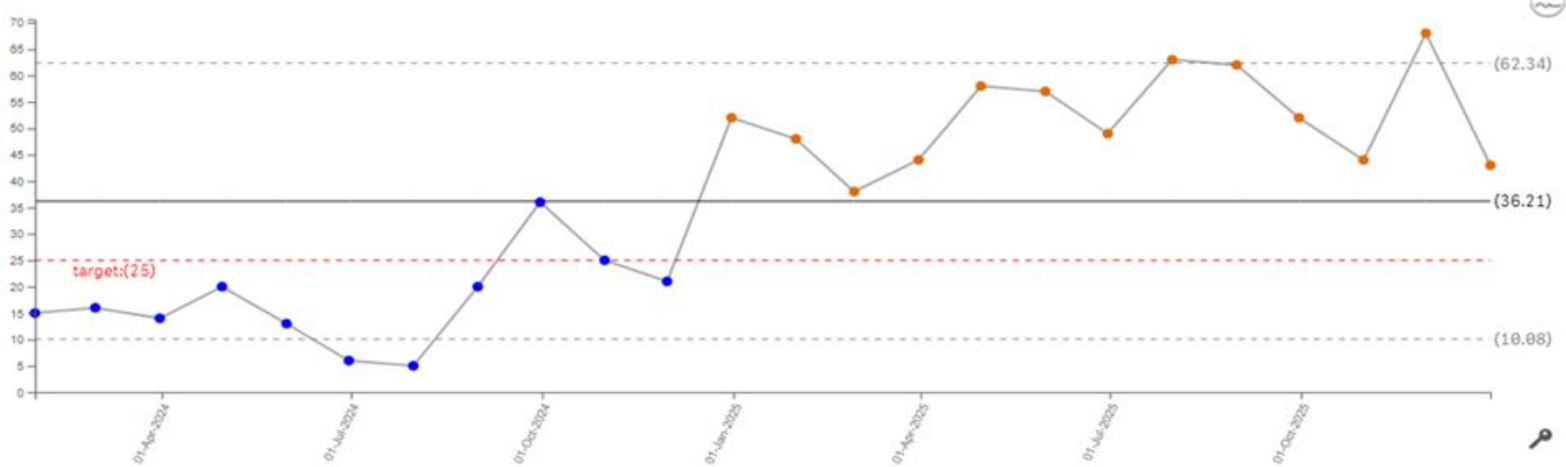
Previous month ...
November-2025

68

Month to date v...
December-2025

43

Target
December-2025
Target is at Trust-wide level



Latest
43
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.2 - Falls - total of Minor, Moderate & Severe

The Princess Alexandra Hospital NHS Trust

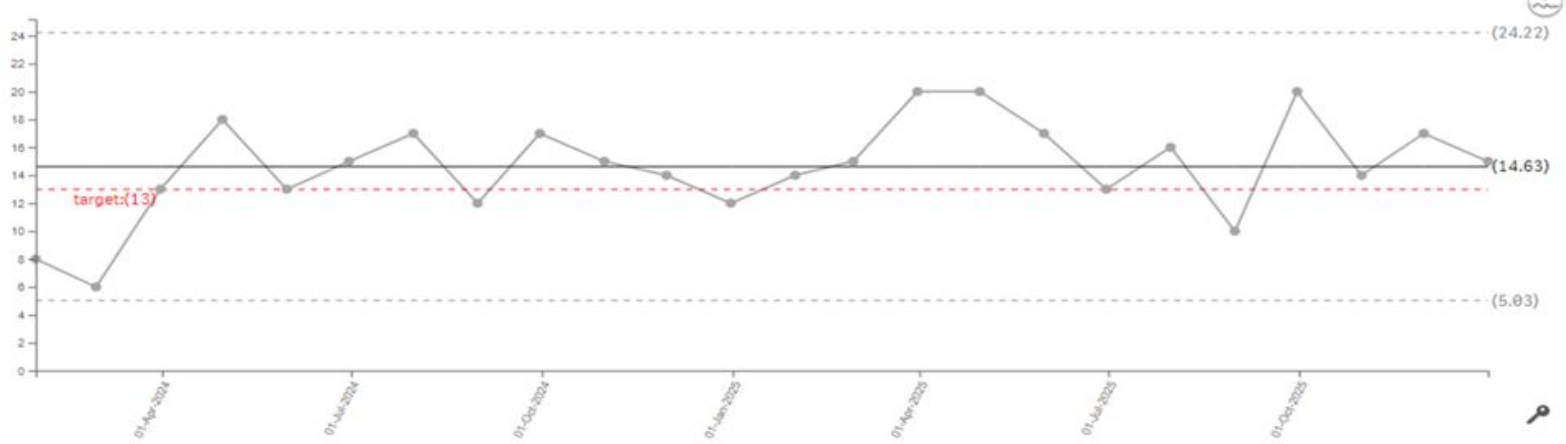
Previous month ...
December-2025

15

Month to date v...
January-2026

11

Target
December-2025
Target is at Trust-wide level



Latest
15
Variance Type
Common cause variation
Target
13
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.54 - FFT Patient Satisfaction

NHS The Princess Alexandra Hospital NHS Trust

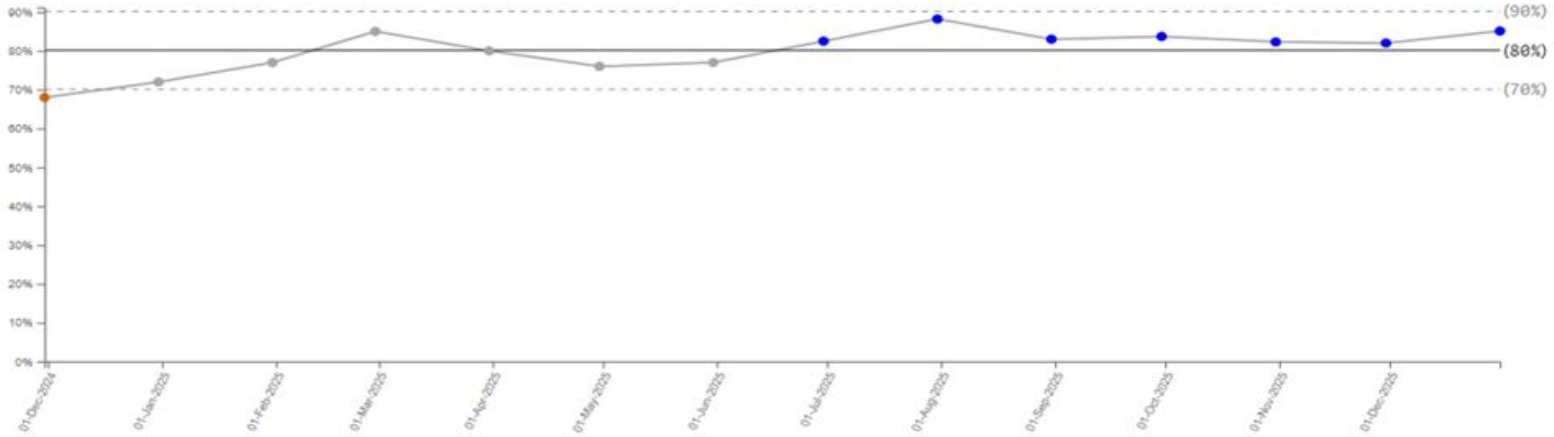
Previous month ...
November-2025

82.0%

Month to date v...
December-2025

85.1%

Target
December-2025
Target is at Trust-wide level



Latest
85.1%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
N/A
Target Achievement
N/A

SPC for D.36 - Mortality - HSMR

NHS The Princess Alexandra Hospital NHS Trust

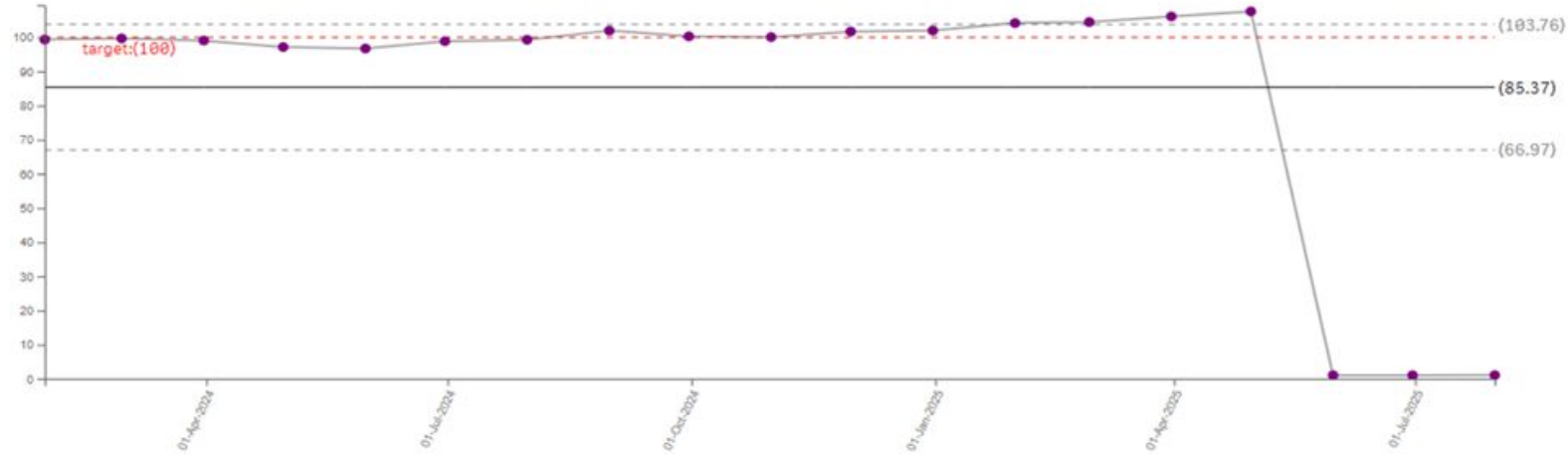
Previous month ...
June-2025

1

Month to date v...
July-2025

1

Target
July-2025
Target is at Trust-wide level



Latest
1
Variance Type
Common cause variation
Target
100
Target Achievement
The system may achieve or fail the target subject to random variation

PEOPLE PILLAR
SPCs

SPC for D.23 - Sickness Absence

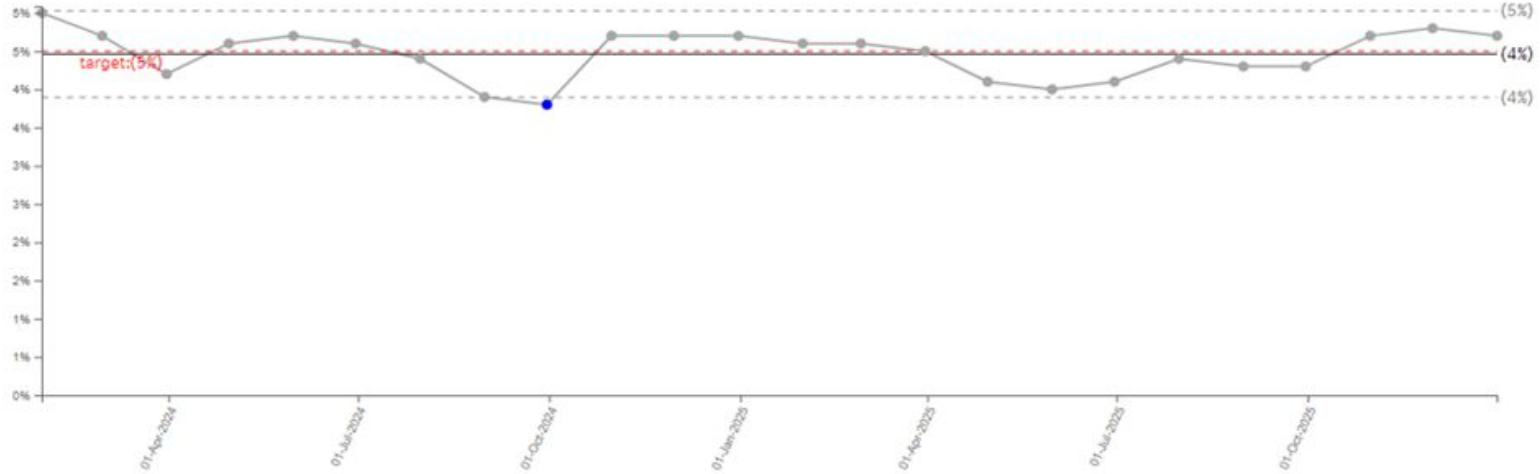
Previous month ...
November-2025

4.8%

Month to date v...
December-2025

4.7%

Target
December-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

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

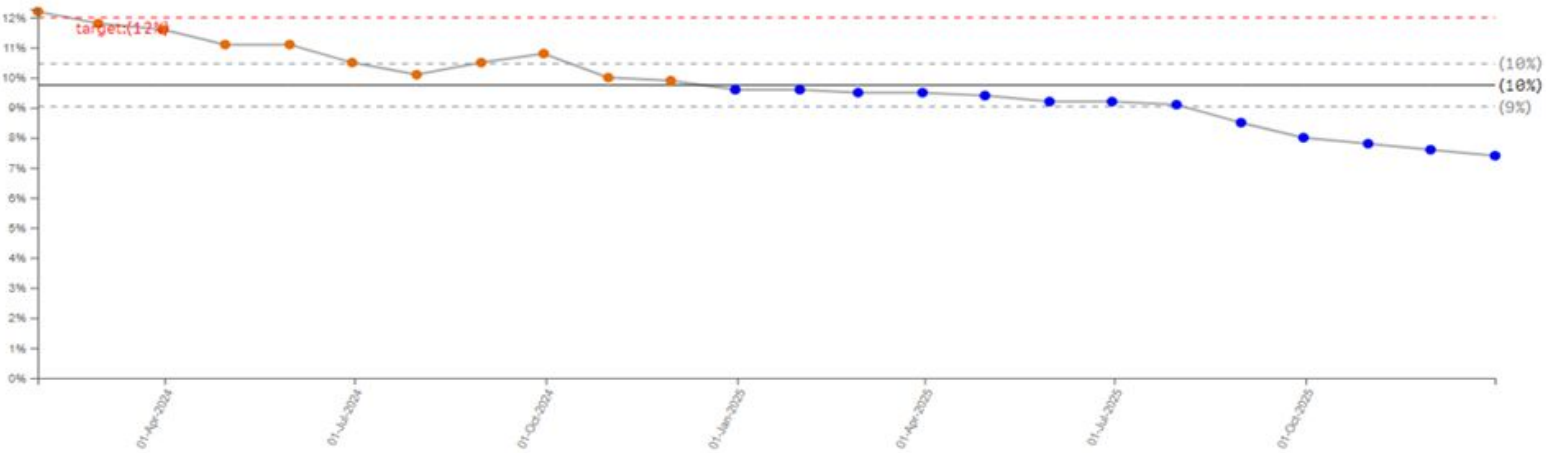
Previous month ...
November-2025

7.6%

Month to date v...
December-2025

7.4%

Target
December-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

Latest
7.4%
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.25 - Agency Staffing Spend

The Princess Alexandra Hospital NHS Trust

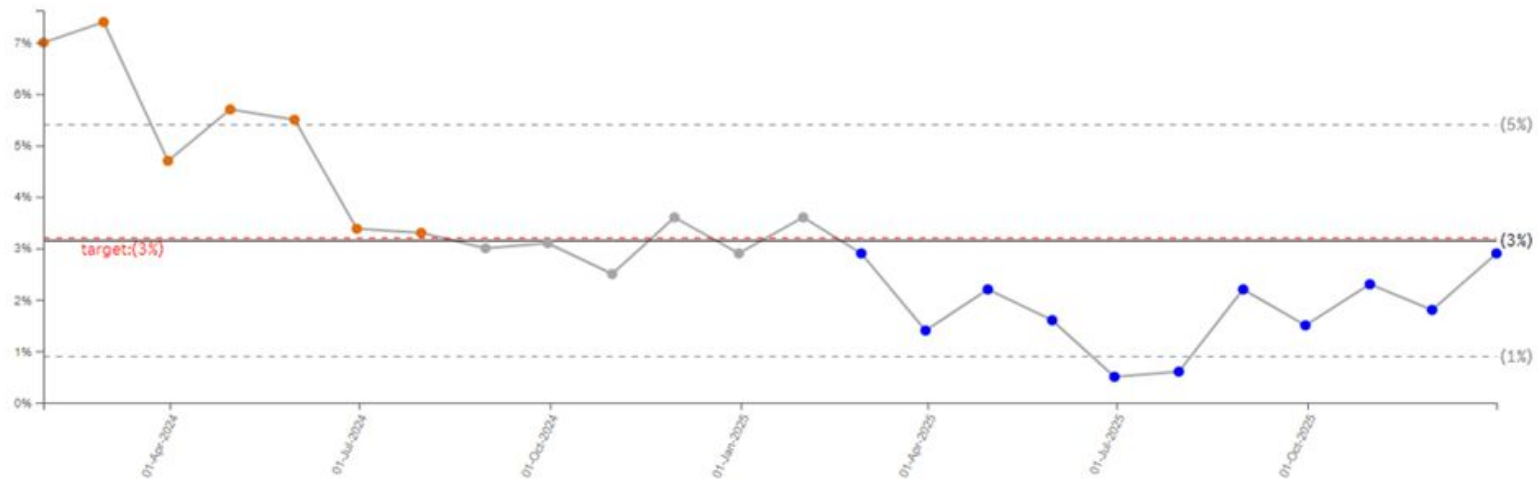
Previous month ...
November-2025

1.8%

Month to date v...
December-2025

2.9%

Target
December-2025
Target is at Trust-wide level



Latest
2.9%
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

The Princess Alexandra Hospital NHS Trust

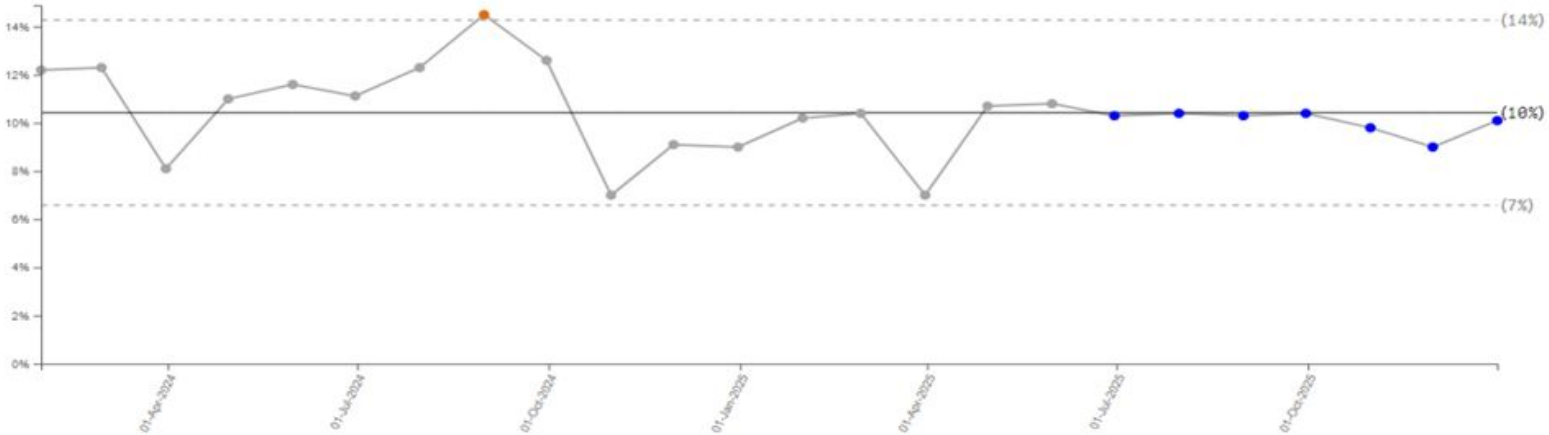
Previous month ...
November-2025

9.0%

Month to date v...
December-2025

10.1%

Target
December-2025
Target is at Trust-wide level



Latest
10.1%
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

SPC for D.28 - Appraisals - non medical

NHS The Princess Alexandra Hospital NHS Trust

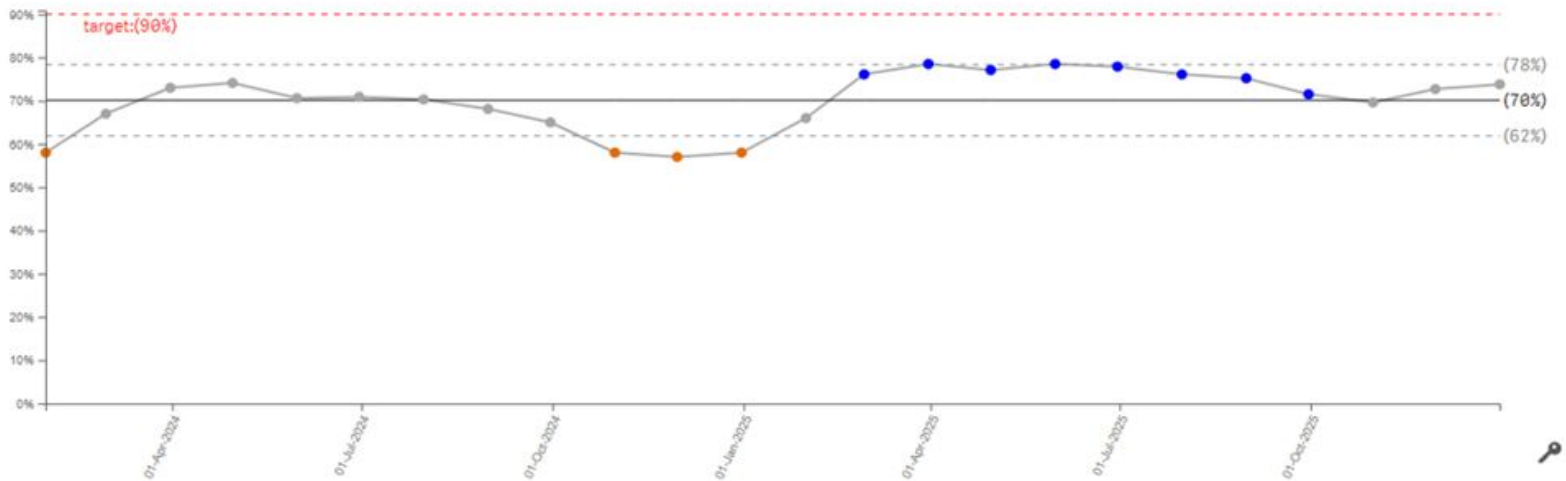
Previous month ...
November-2025

72.7%

Month to date v...
December-2025

73.8%

Target
December-2025
Target is at Trust-wide level



Latest
73.8%
Variance Type
Common cause variation
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

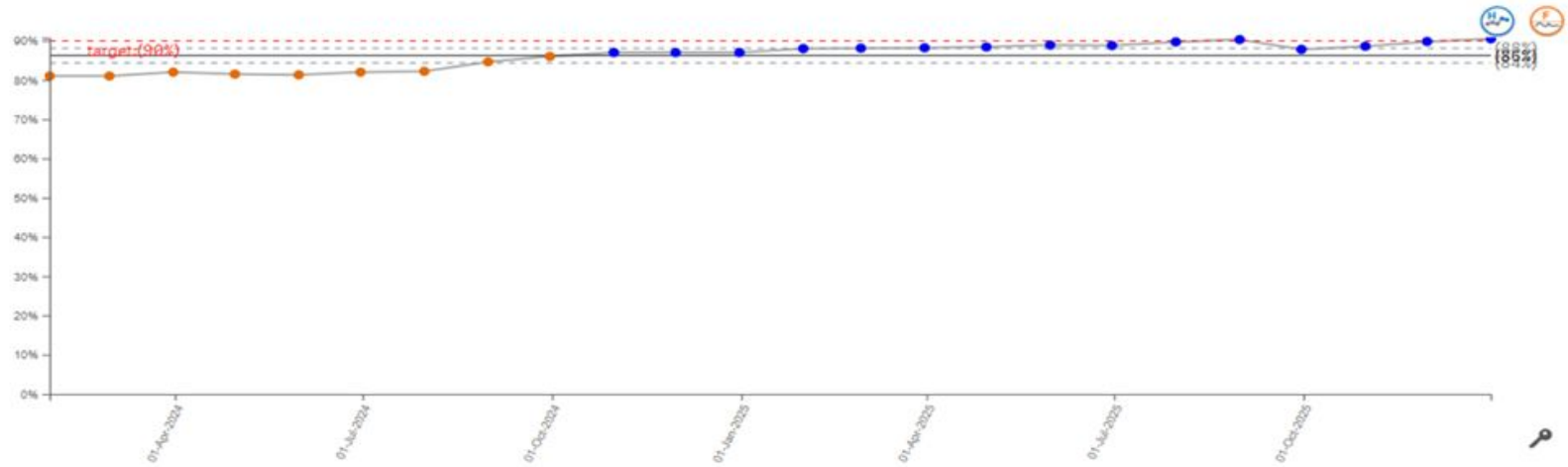
Previous month ...
November-2025

89.8%

Month to date v...
December-2025

90.5%

Target
December-2025
Target is at Trust-wide level



Latest
90.5%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
90%
Target Achievement
The system is expected to consistently fail the target

PERFORMANCE PILLAR
SPCs

SPC for E.40 - Proportion of Patients treated within 4 hours in ED

NHS The Princess Alexandra Hospital NHS Trust

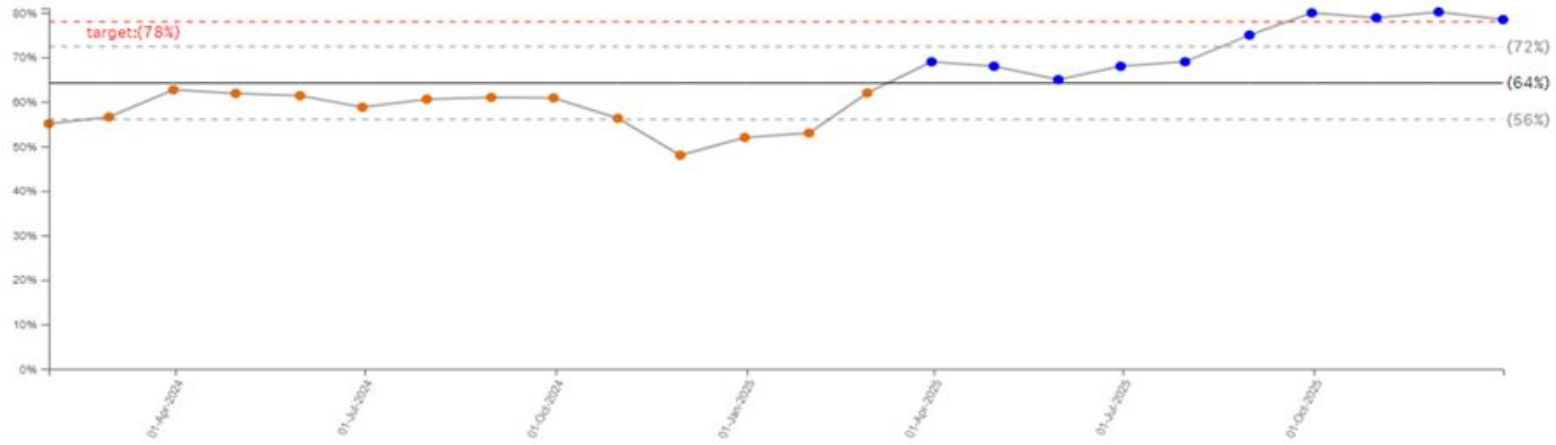
Previous month ...
November-2025

80.2%

Month to date v...
December-2025

78.5%

Target
December-2025
Target is at Trust-wide level



Latest
78.5%
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

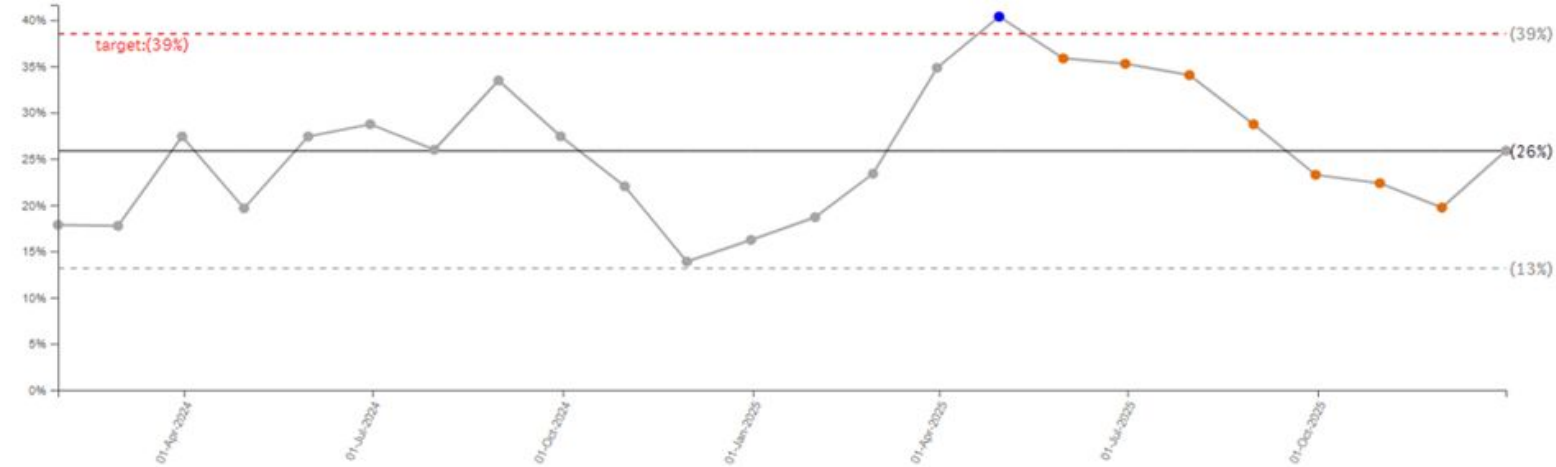
Previous month ...
December-2025

25.9%

Month to date v...
January-2026

16.5%

Target
December-2025
Target is at Trust-wide level



Latest
25.9%
Variance Type
Common cause variation
Target
39%
Target Achievement
The system may achieve or fail the target subject to random variation

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

NHS The Princess Alexandra Hospital NHS Trust

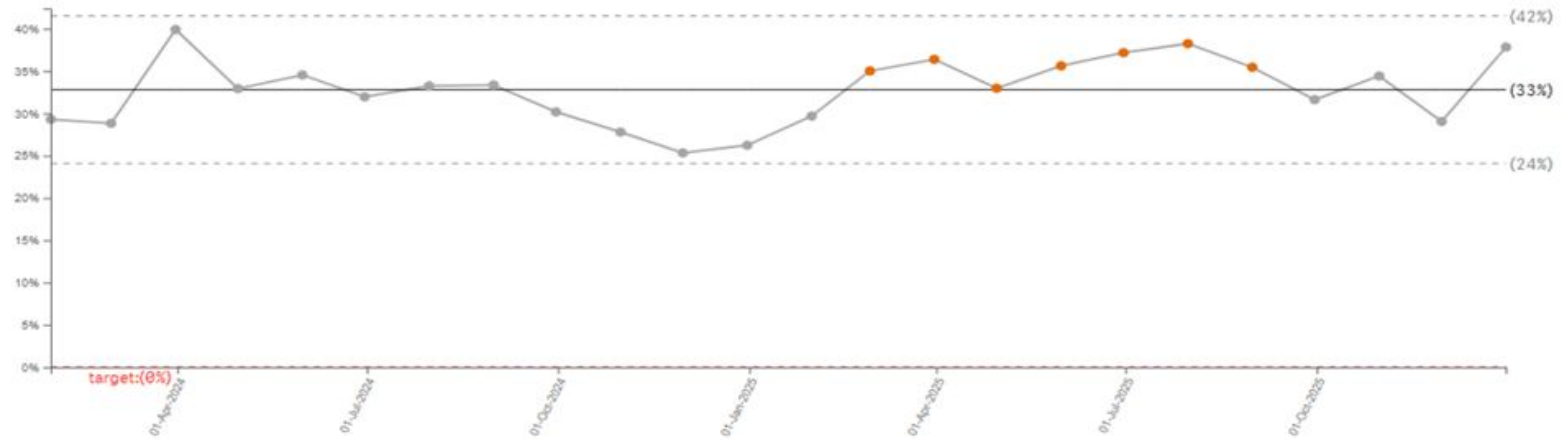
Previous month ...
December-2025

37.8%

Month to date v...
January-2026

23.3%

Target
December-2025
Target is at Trust-wide level



Latest
37.8%
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

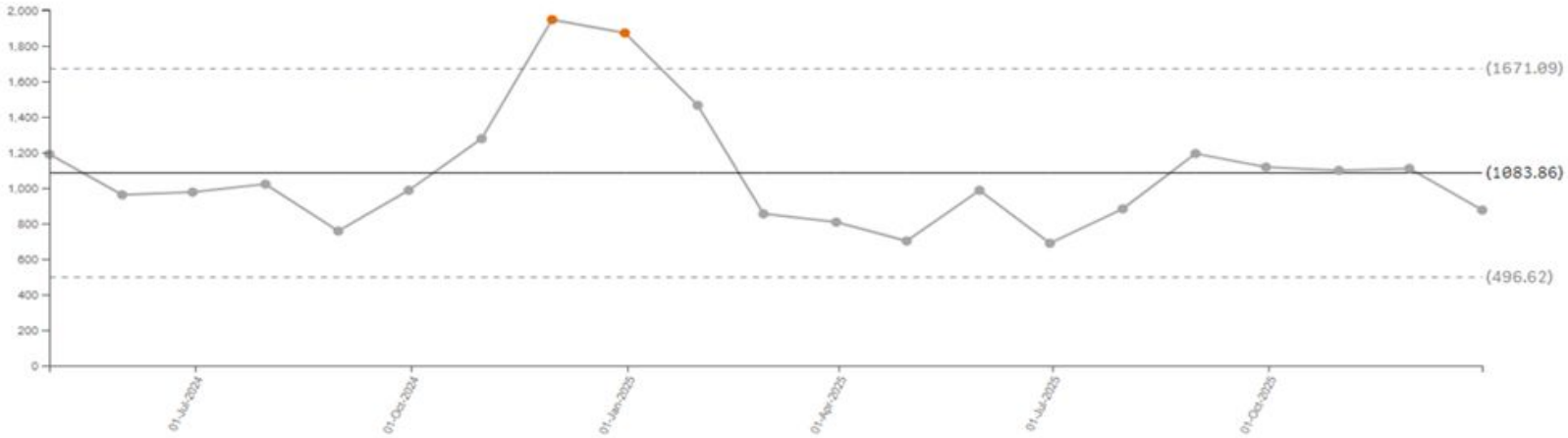
Previous month ...
November-2025

1,109

Month to date v...
December-2025

875

Target
December-2025
Target is at Trust-wide level



Latest
875
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

SPC for E.52 - ED Admitted Percentage

NHS The Princess Alexandra Hospital NHS Trust

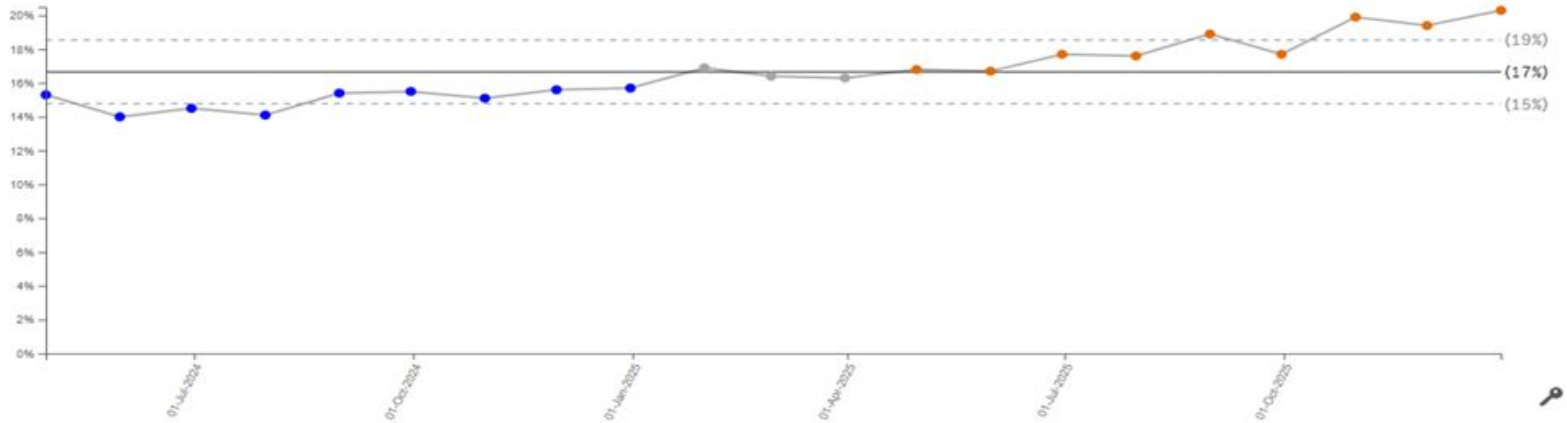
Previous month ...
November-2025

19.4%

Month to date v...
December-2025

20.3%

Target
December-2025
Target is at Trust-wide level



Latest
20.3%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

SPC for E.53 - ED Non - Admitted Percentage

NHS The Princess Alexandra Hospital NHS Trust

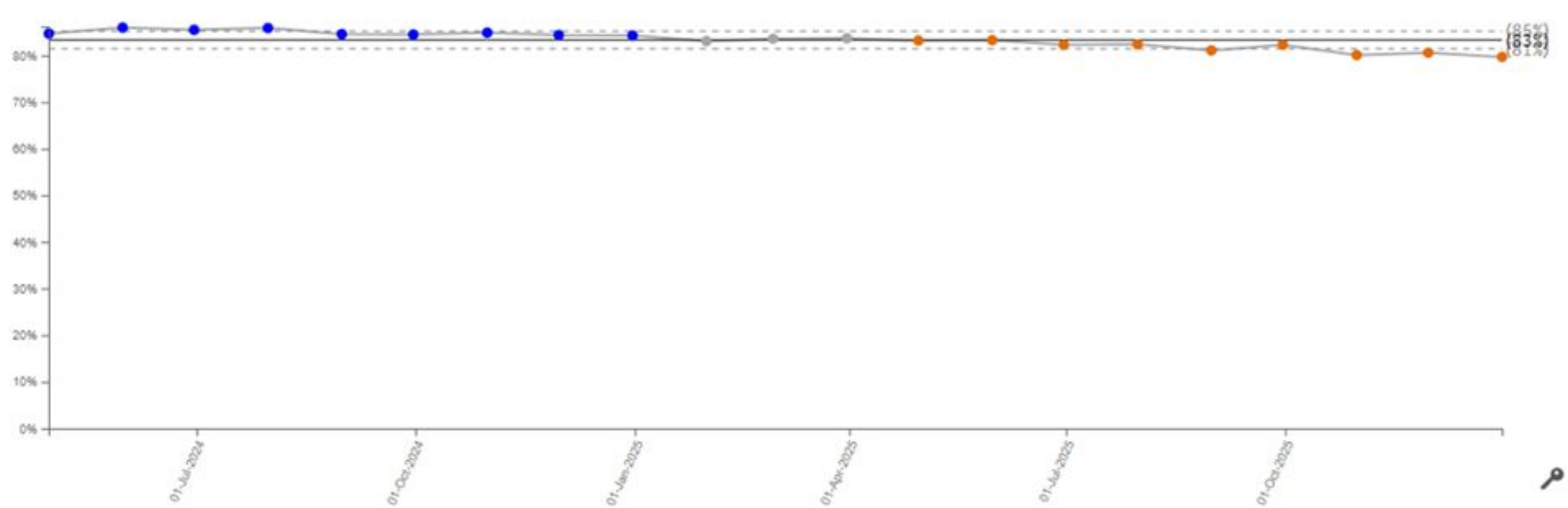
Previous month ...
November-2025

80.6%

Month to date v...
December-2025

79.7%

Target
December-2025
Target is at Trust-wide level



Latest
79.7%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
N/A
Target Achievement
N/A

SPC for E.48 ASIs

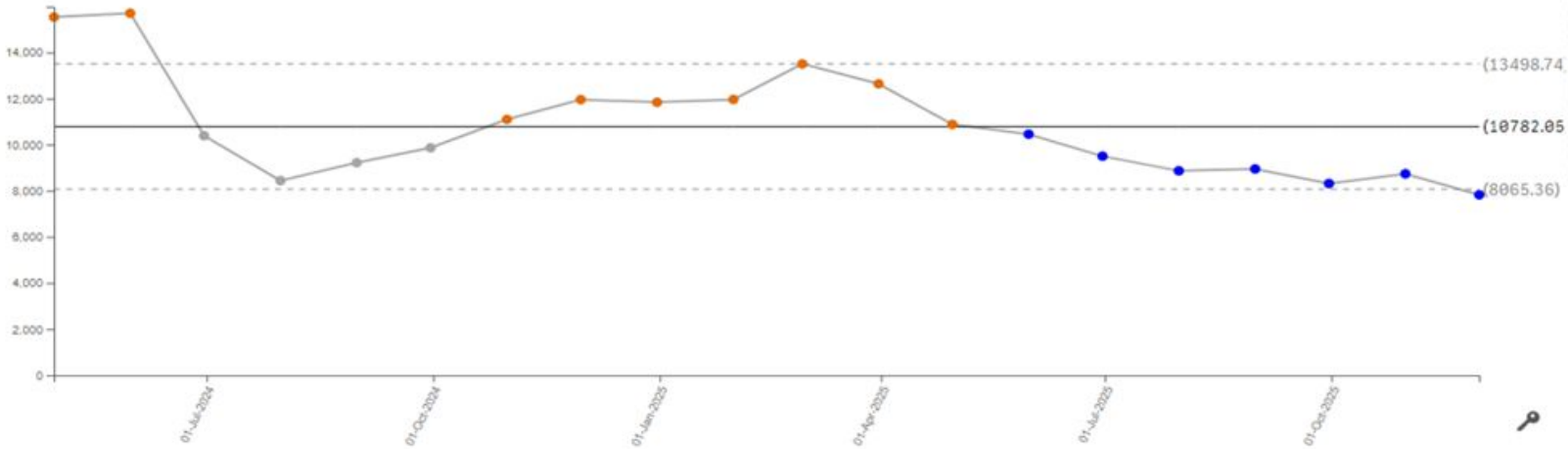
Previous month ...
October-2025

8,735

Month to date v...
November-2025

7,824

Target
November-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

Latest
7,824
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

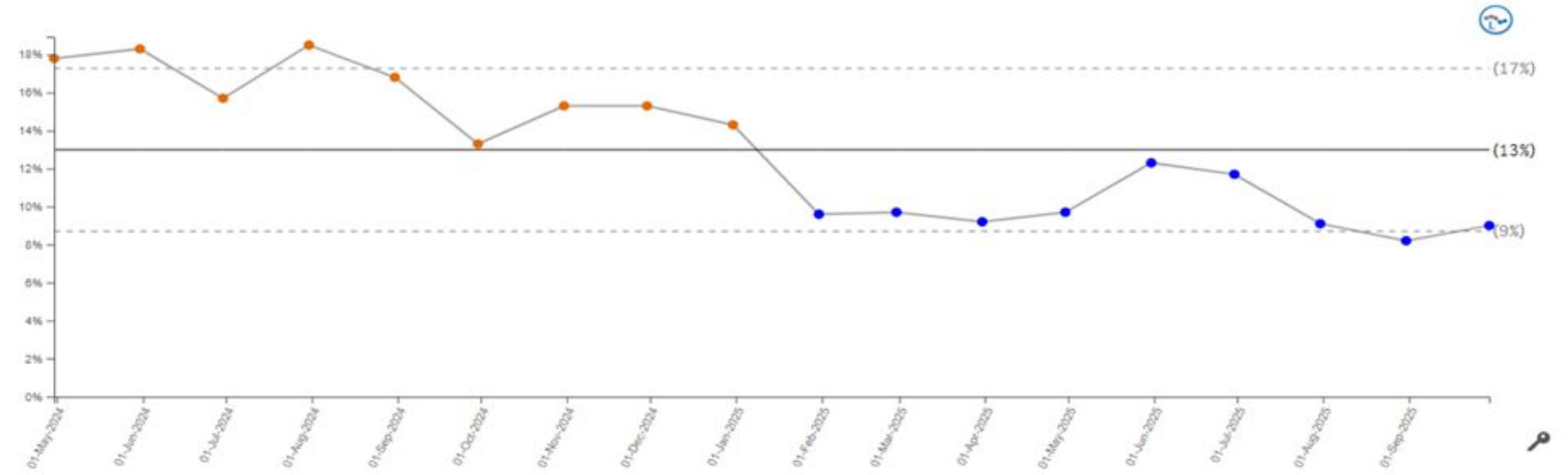
Previous month ...
August-2025

8.2%

Month to date v...
September-2025

9.0%

Target
September-2025
Target is at Trust-wide level



NHS
The Princess Alexandra Hospital
NHS Trust

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

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

NHS The Princess Alexandra Hospital NHS Trust

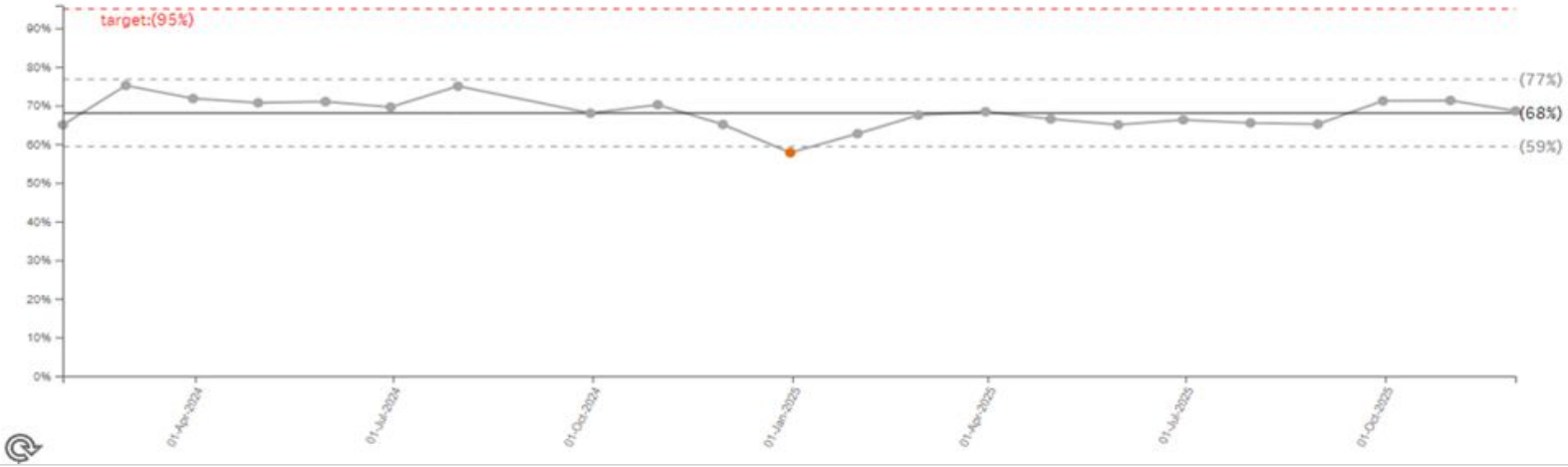
Previous month ...
October-2025

71.3%

Month to date v...
November-2025

68.6%

Target
November-2025
Target is at Trust-wide level



Latest
68.6%
Variance Type
Common cause variation
Target
95%
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

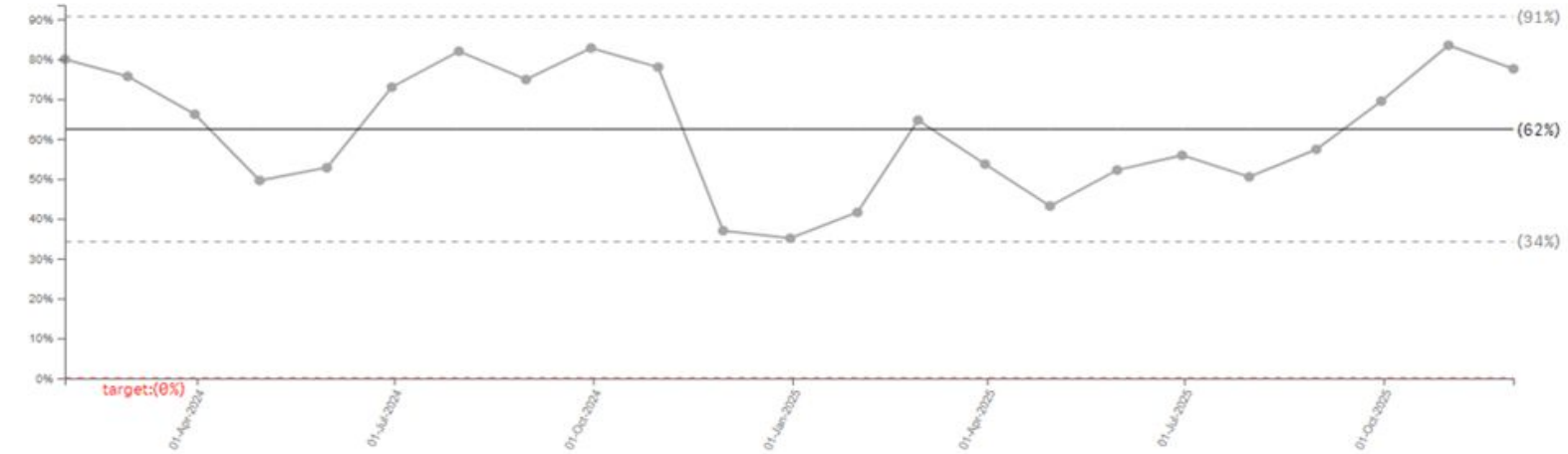
Previous month ...
October-2025

83.5%

Month to date v...
November-2025

77.6%

Target
November-2025
Target is at Trust-wide level



Latest
77.6%
Variance Type
Common cause variation
Target
0%
Target Achievement
The system is expected to consistently pass the target

SPC for C.22 - Cancer 28 Day Faster Diagnosis

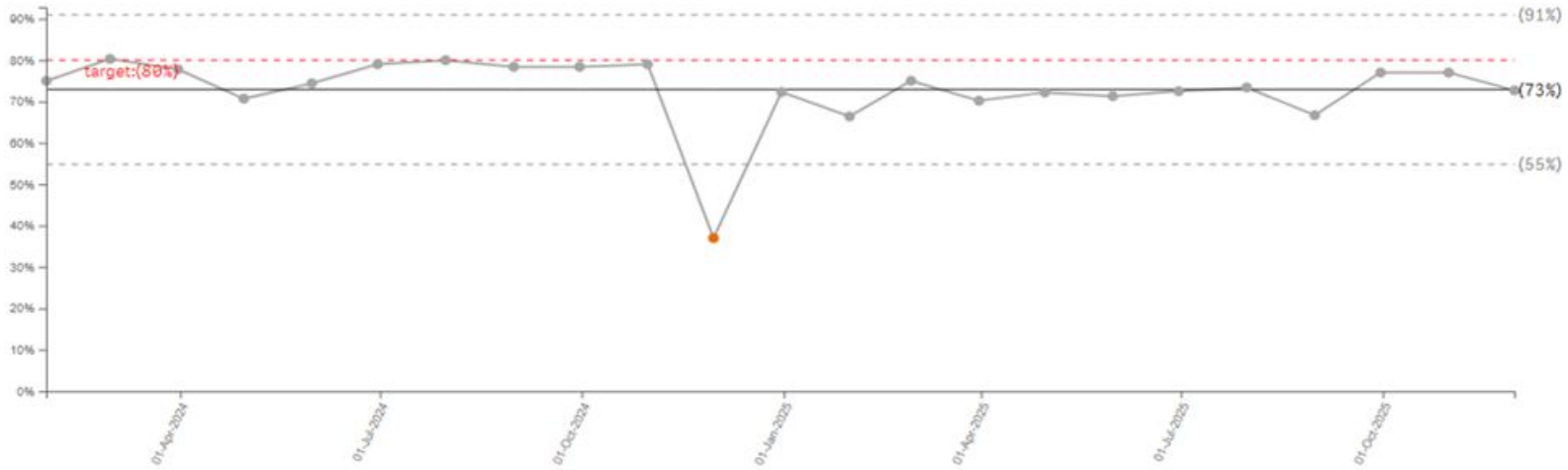
Previous month ...
October-2025

77.0%

Month to date v...
November-2025

72.7%

Target
November-2025
Target is at Trust-wide level



The Princes Alexandra Hospit
NHS Tr

Latest
72.7%
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

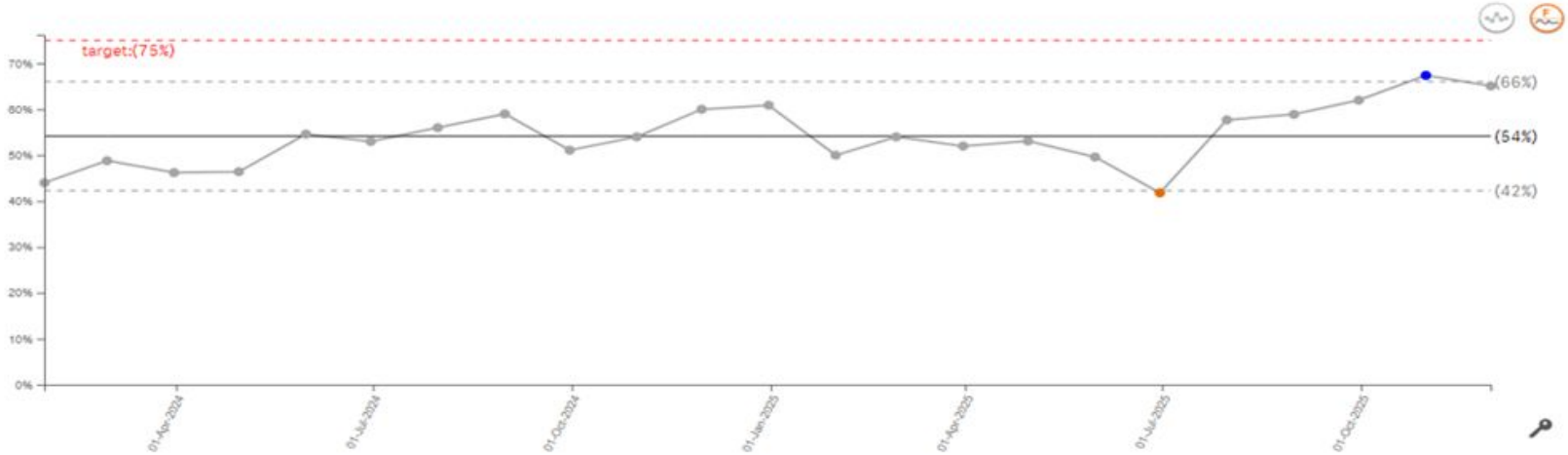
Previous month ...
October-2025

67.4%

Month to date v...
November-2025

65.1%

Target
November-2025
Target is at Trust-wide level



The Princes Alexandra Hospit
NHS Tr

Latest
65.1%
Variance Type
Common cause variation
Target
75%
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

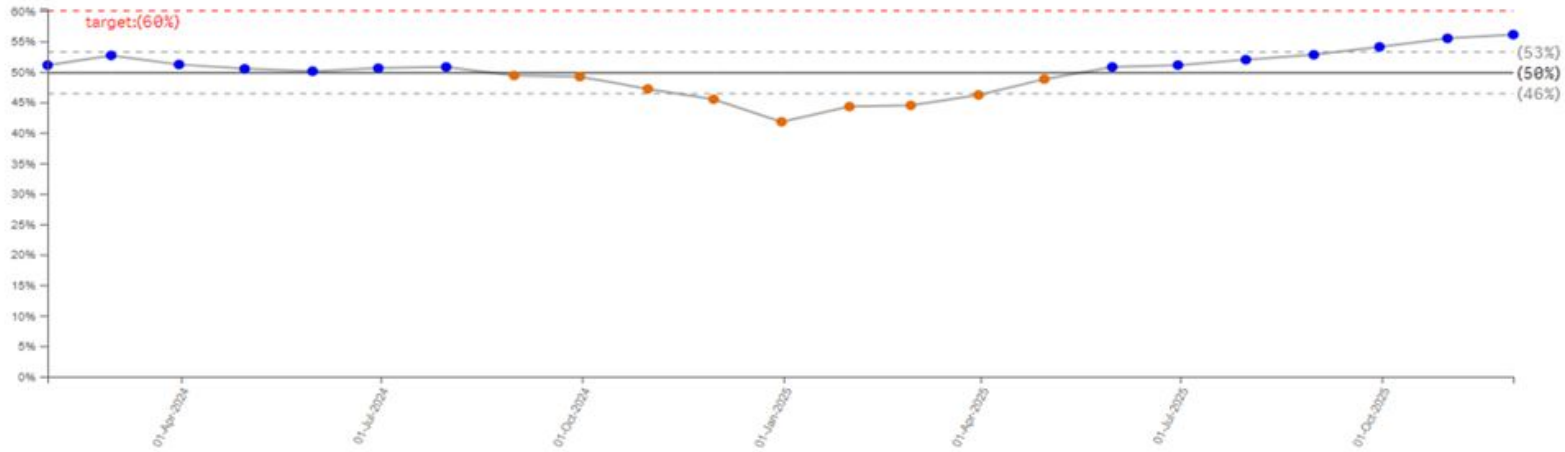
Previous month ...
October-2025

55.5%

Month to date v...
November-2025

56.1%

Target
November-2025
Target is at Trust-wide level



Latest
56.1%
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

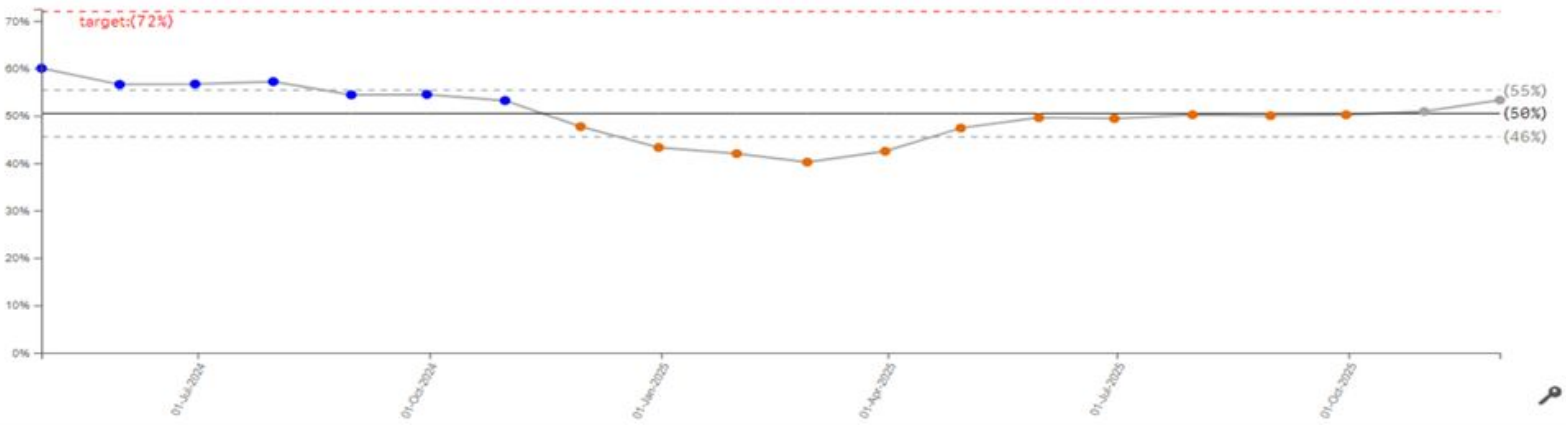
Previous month ...
October-2025

50.9%

Month to date v...
November-2025

53.3%

Target
November-2025
Target is at Trust-wide level



Latest
53.3%
Variance Type
Common cause variation
Target
72%
Target Achievement
The system is expected to consistently fail the target

SPC for D.41 - RTT over 65 week waiters

The Princess Alexandra Hospital NHS Trust

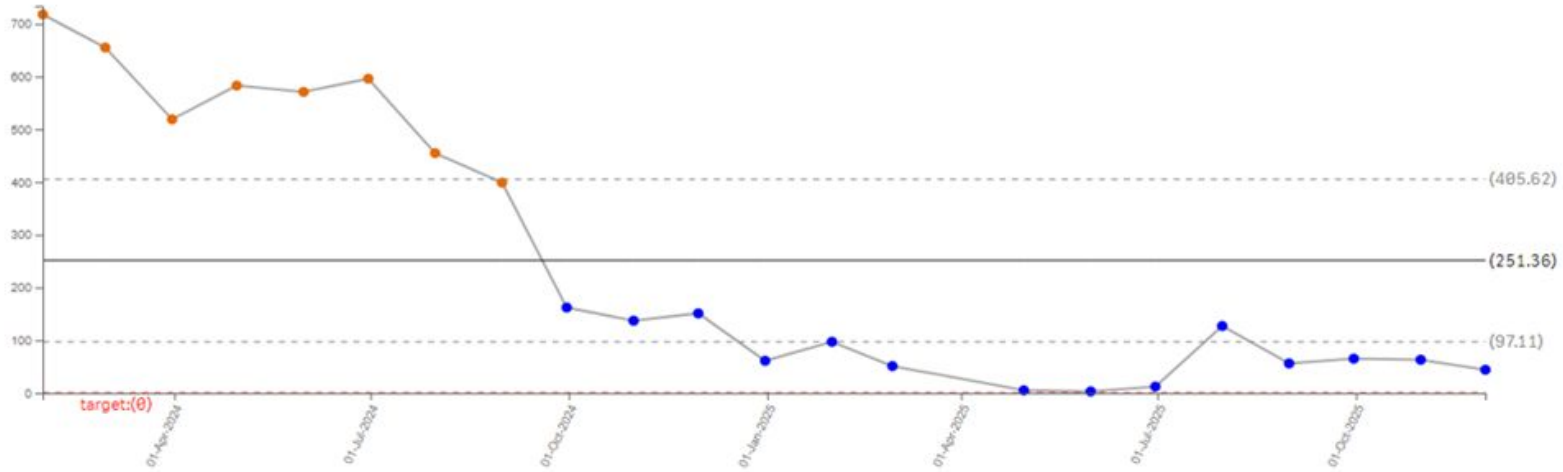
Previous month ...
October-2025

63

Month to date v...
November-2025

44

Target
November-2025
Target is at Trust-wide level



Latest
44
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

The Princess Alexandra Hospital NHS Trust

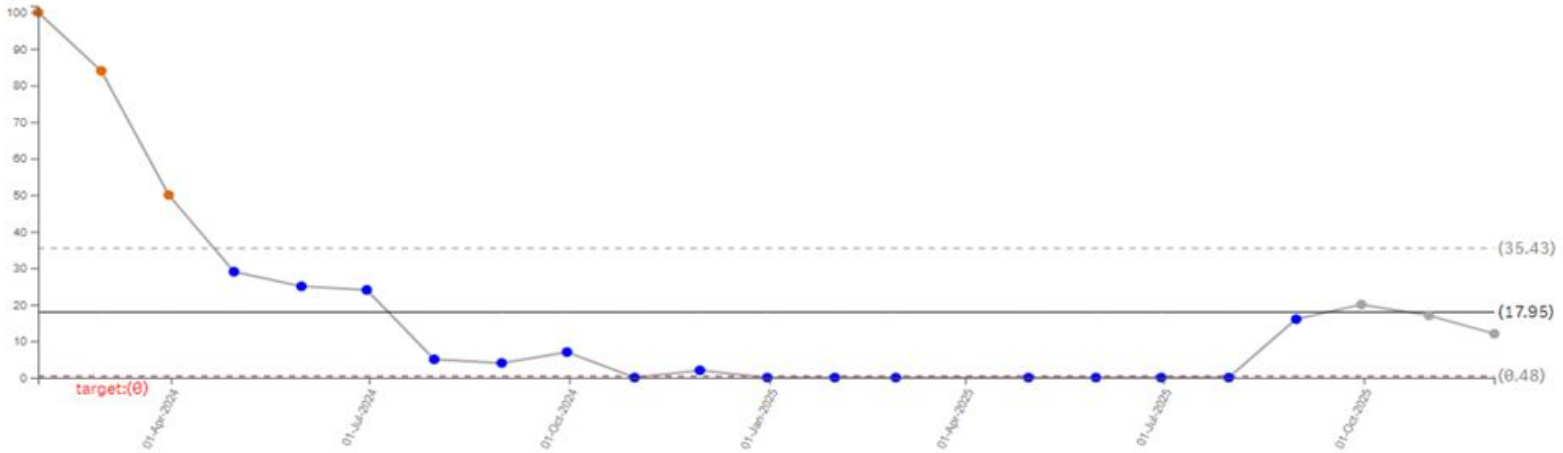
Previous month ...
October-2025

17

Month to date v...
November-2025

12

Target
November-2025
Target is at Trust-wide level



Latest
12
Variance Type
Common cause variation
Target
0
Target Achievement
The system is expected to consistently fail the target

POUNDS PILLAR
SPCs

SPC for F.1 - Surplus / (Deficit)

NHS The Princess Alexandra Hospital NHS Trust

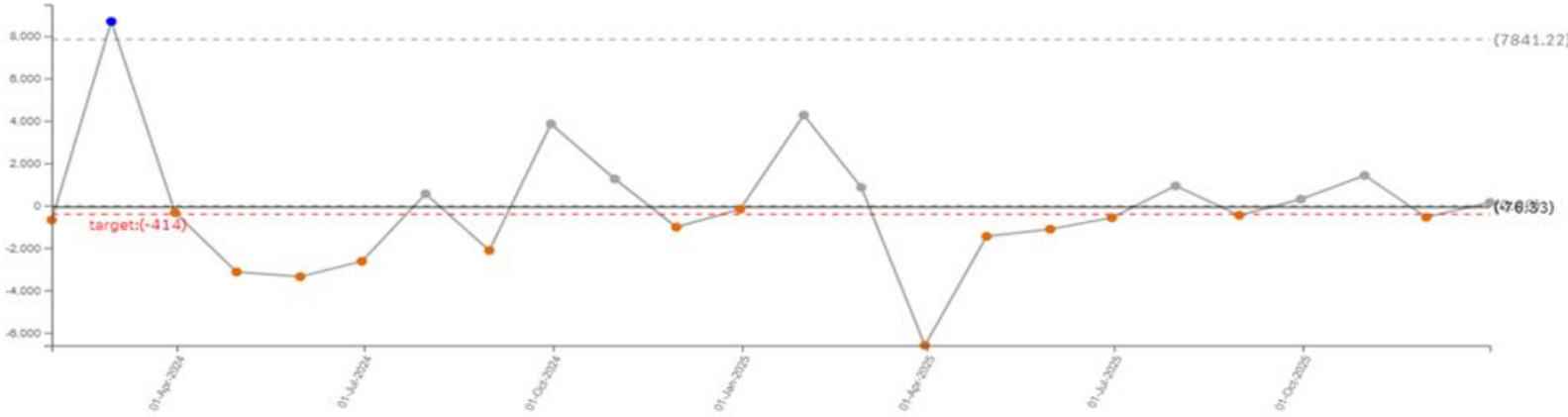
Previous month ...
November-2025

-547

Month to date v...
December-2025

150

Target
December-2025
Target is at Trust-wide level



Latest
150
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

NHS The Princess Alexandra Hospital NHS Trust

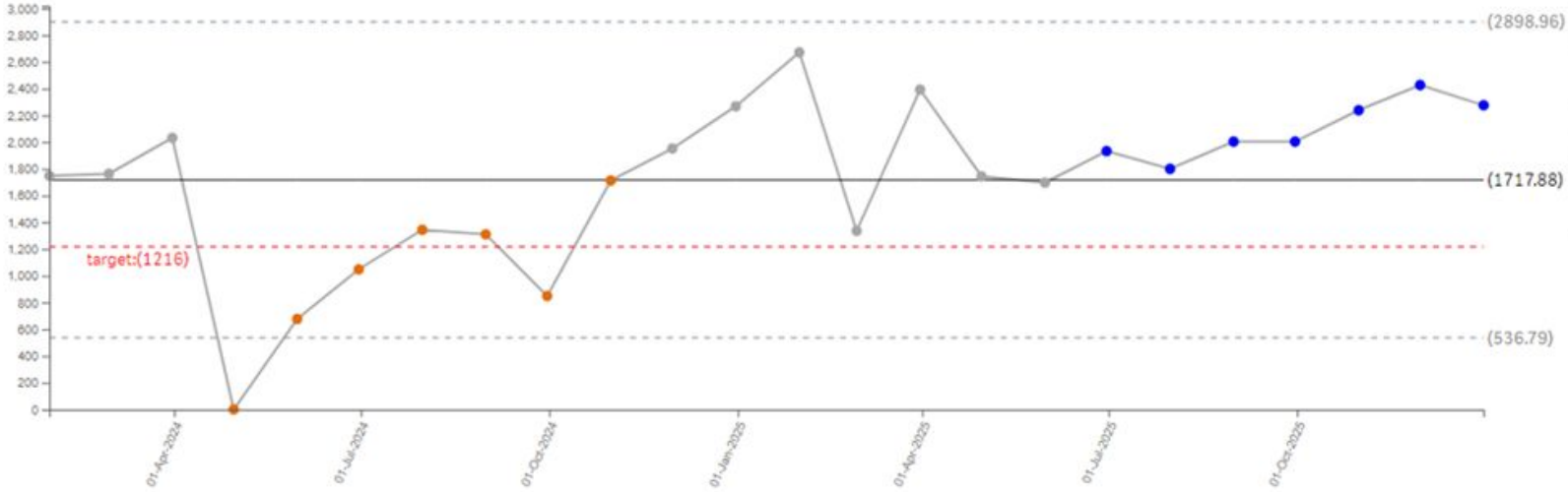
Previous month ...
November-2025

2,427

Month to date v...
December-2025

2,276

Target
December-2025
Target is at Trust-wide level



Latest
2,276
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

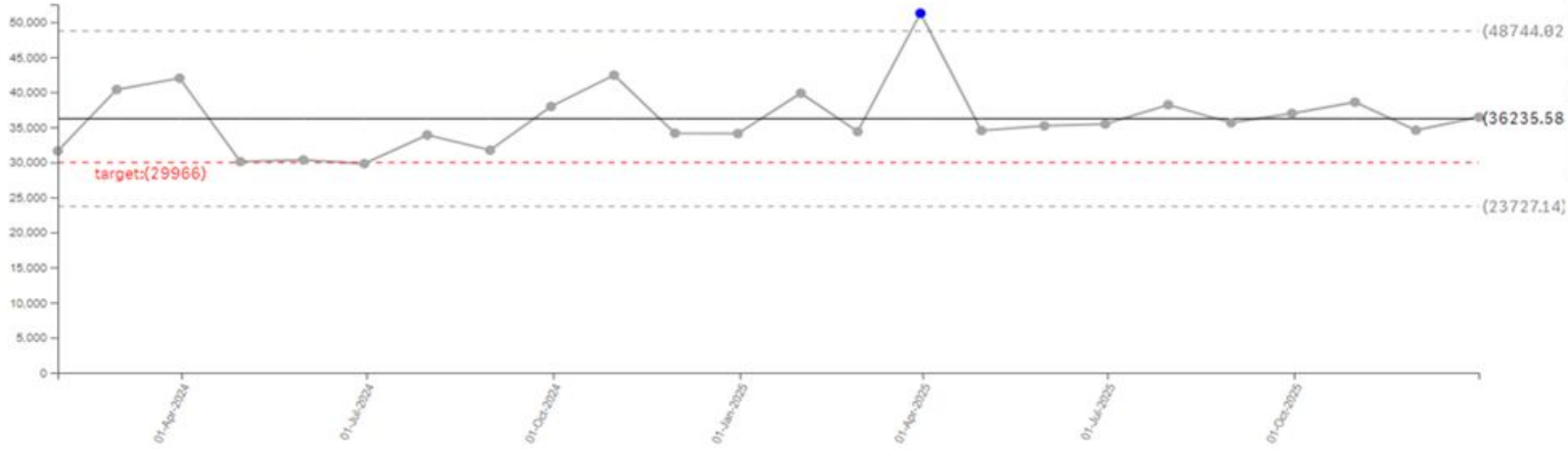
Previous month ...
November-2025

34,583

Month to date v...
December-2025

36,444

Target
December-2025
Target is at Trust-wide level



Latest
36,444
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

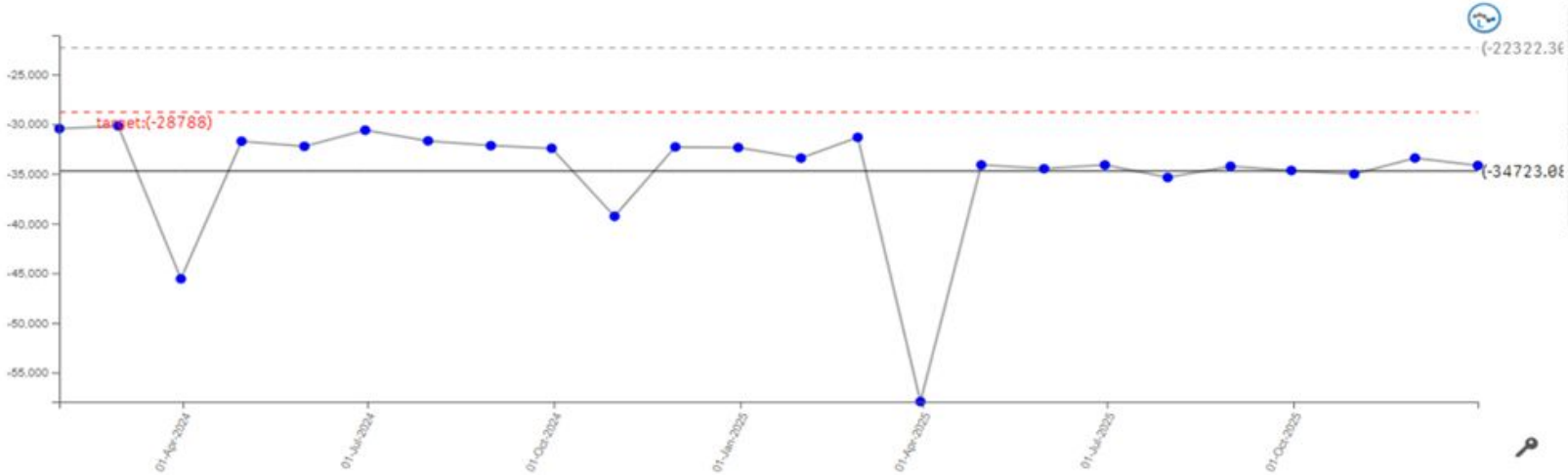
Previous month ...
November-2025

-33,418

Month to date v...
December-2025

-34,172

Target
December-2025
Target is at Trust-wide level



Latest
-34,172
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

NHS The Princess Alexandra Hospital NHS Trust

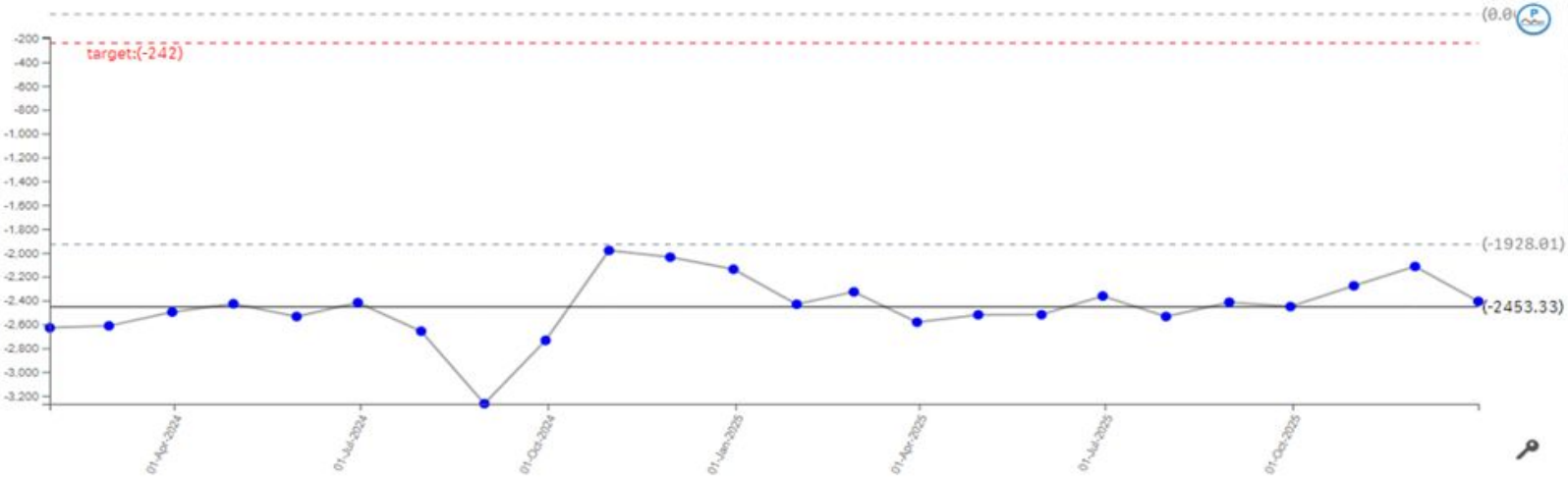
Previous month ...
November-2025

-2,115

Month to date v...
December-2025

-2,408

Target
December-2025
Target is at Trust-wide level



Latest
-2,408
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

NHS The Princess Alexandra Hospital NHS Trust

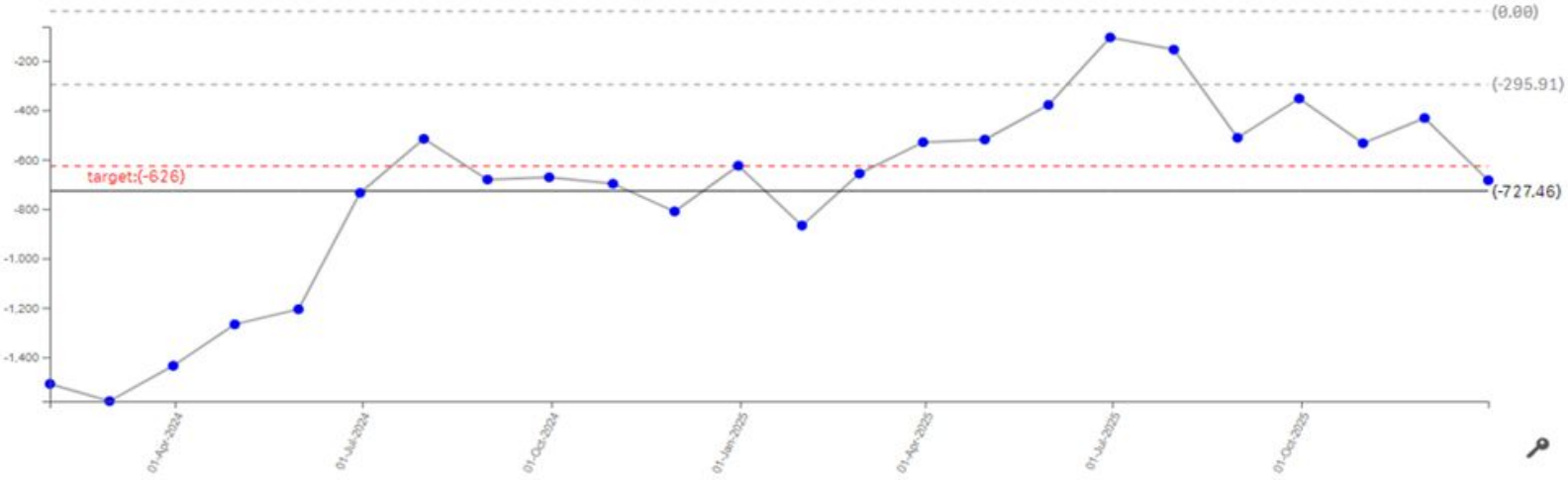
Previous month ...
November-2025

-432

Month to date v...
December-2025

-684

Target
December-2025
Target is at Trust-wide level



Latest
-684
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

The Princess Alexandra Hospital NHS Trust

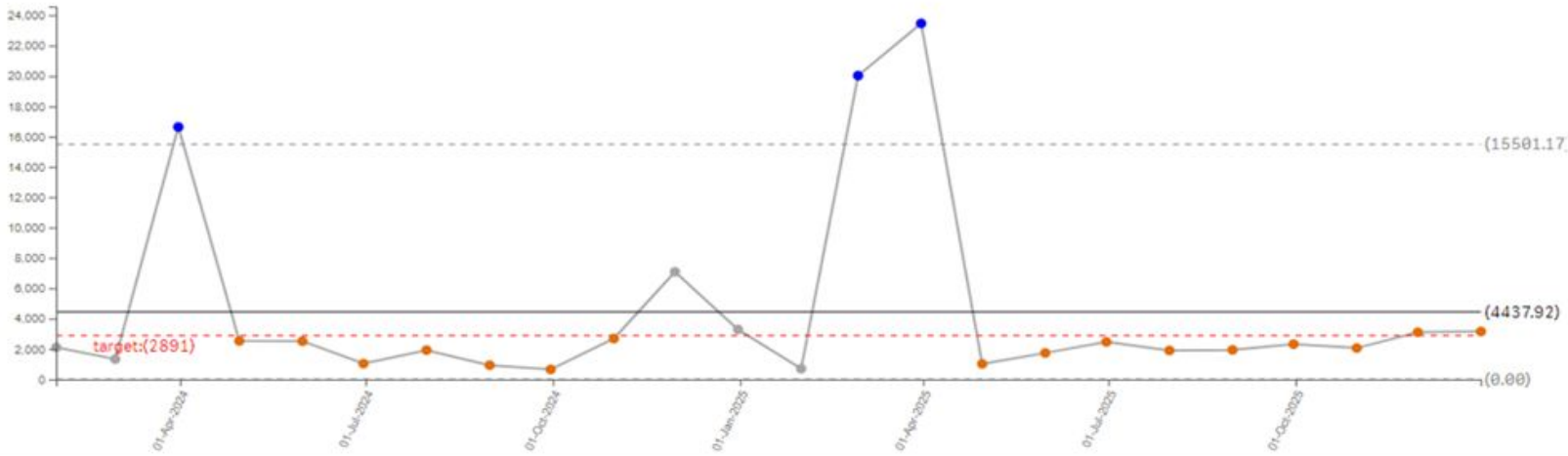
Previous month ...
November-2025

3,096

Month to date v...
December-2025

3,152

Target
December-2025
Target is at Trust-wide level



Latest
3,152
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

The Princess Alexandra Hospital NHS Trust

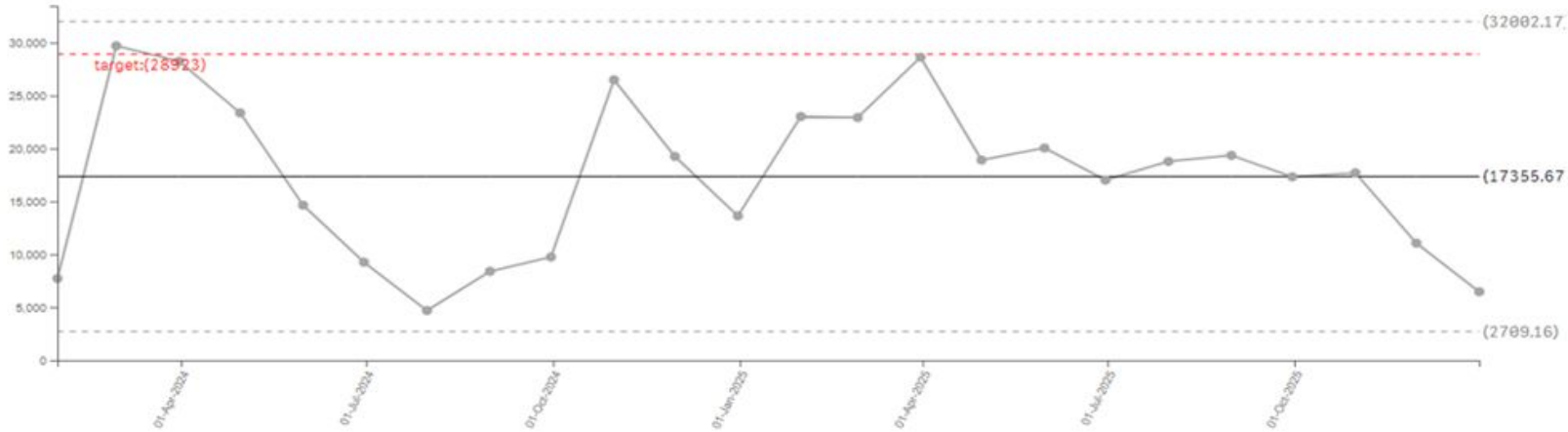
Previous month ...
November-2025

11,072

Month to date v...
December-2025

6,473

Target
December-2025
Target is at Trust-wide level



Latest
6,473
Variance Type
Common cause variation
Target
28923
Target Achievement
The system may achieve or fail the target subject to random variation

Trust Board (Public) – 5 February 2026

Agenda item:	6.3							
Presented by:	Anna Jebb, Chief Operating Officer							
Prepared by:	Rebecca Gildea, Associate Director of Performance							
Date prepared:	January 2026							
Subject / title:	Access Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**
Key issues:	This report provides a month 9 update against the 2025/26 Operating Plan, summarising performance against key statutory and contractual standards. It highlights areas requiring executive action or escalation and outlines performance across alert, advise, and assured measures. **Executive Risk Escalation / Discussion – see full– Page 1:** **Summary:** • Diagnostic Reporting (DM01) – Outstanding modality reporting • Endoscopy – Accurate reporting / data cleansing / utilisation • RTT 65+weeks – Risk of Q4 breaches – delivery forecast for 31/03/26 • 62day – deterioration against plan – mitigation required Performance Overview by Measure: Alert Measures • Diagnostic Endoscopy (DM01) Reporting – December performance accuracy and associated utilisation required • RTT Performance – 65-week and 52-week booked cohort at risk • Cancer 62day – Deterioration for November • ED 12hour – Deterioration against plan • Ambulance Handover <30min - Deterioration against plan Advise Measures • RTT – risk to all metrics against year-end performance • Cancer 28day FDS – deterioration for November, mitigation in place for December • Somerset Deployment – delay to 'go live' Assured Measures • Cancer 31-day – performance maintained • A&E 4-hour performance – performance maintained							
Recommendatio	The report is provided for information and assurance							
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	X		X					

Previously considered by:	Operational Board – PAF.29.01.26 and QSC.30.01.26
Risk / links with the BAF:	1.0 Covid-19 1.1 Variations in clinical quality of care
Legislation, regulatory, equality, diversity and	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

6.3

modern • integrated • outstanding

Performance Summary - Month 9 (December 25)

Items of risk / escalation presented to Executive Board 20th January 2026

1. **Diagnostic Reporting (DM01)**
   Some of the Endoscopy waiting list requests need checking to confirm they are still required. We are also awaiting a final reporting fix.
   - *PAF Committee is asked to note*: Risk to December and January DM01 reporting accuracy and endorse the revised completion deadline of 31/01/26.

2. **Endoscopy – Booking & Utilisation**
   We are not making full use of available endoscopy sessions. An updated utilisation report, which will help us understand the causes, is still pending.
   - *PAF Committee is asked to note*: The revised completion deadline of 31/01/26

3. **Referral to Treatment (RTT) Performance – 65+ Week Cohort & >52 Week OPAs**
   Our December performance did not meet plan (22 patients waiting more than 65weeks). Our aim remains to remove all 65week waits and reduce 52week waits to 1% by 31/03/26.
   - *PAF Committee is asked to note*: Risk to additional long waits in Q4 and endorse enhanced oversight through a new weekly COO-led meeting.

4. **62-Day Cancer Performance**
   Performance has dipped compared with last month and is likely to remain below our planned improvement target for December. Several tumour sites are under pressure (Head and Neck, Lower GI, Lung, Dermatology, Upper GI, Urology and Gynaecology).
   - *PAF Committee is asked to note*: Trust implementing targeted plans in each area with weekly review and clear pathway leadership.

Items for discussion / note presented to Executive Board 20th January 2026

1. **Demand and Capacity (D&C) Review**
   - Two review meetings took place on 15 and 19 January. The outputs from these sessions inform the forthcoming planning submission.

2. **12-hour A&E Performance & Ambulance Handover Delays**
   - Performance has deteriorated against plan in January (month-to-date 9%), reflecting ongoing winter pressures, with a risk of continued impact.

3. **Cancer Alliance Bids**
   - The bidding process is underway. Leads are reminded to engage promptly with Finance Business Partners to support robust and timely submissions.

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?
DM01 - Diagnostics within 6 weeks (>95%)	**Diagnostic DM01 Monthly Submission - November** • Revised script implemented - Performance improvement recorded against all Endoscopy modalities • Negative impact in some imagining modalities • Outstanding script for Urodynamics / Neuro-physiology	• Further validation / cleansing of request lists in Cerner • Solus (Endoscopy theatre reporting) utilisation data and analysis remains outstanding – feedback to Task and Finish Group due 21/01 • BI team to confirm accuracy of script output	Jan 26	Surgery
RTT 65+ weeks **And** **52week 1% March WL**	**Referral to Treatment Position** • 65weeks - Failed to deliver December month end target (22 vs 0 target) • 52weeks – Behind cohort reduction forecast and Jan 1st OPA's booked (14% booked by 31/01/26)	• RTT Forecasting – Weekly COO-chaired RTT PTL in place. • 52-Week Trajectories – Weekly service-level reduction targets issued. • Large-scale additional activity mobilising across all challenged specialties – Q4 • Response to Clare Panniker 09/01 – risk to Q4 65-week breaches, but assurance given regarding March 26 clearance	Ongoing	All divisions
Cancer 62 days	• **December unvalidated** 64.1% - target to deliver above Novembers position (65%-67%). • Additional capacity across all challenged tumour sites • Emerging risk – escalations for histo TAT and CT capacity/reporting • Recued operational management post Divisional restructure	• Implement the Urology BC – progress required • Large-scale additional activity mobilising across all challenged specialties – Q4 • Weekly histo PTL commenced – however attendance poor – to improve Jan • CT deep dive with support from CSS	Mar 26	All divisions
12 hour stays in ED	• Deterioration against plan affected by flow resulting in increased length of stay (15% Jan against MTD) • Re-designation EMSDEC	• Reduce crowding in ED – front door model • Reset AAU assessment function • Implement High Impact Actions for Wnter	Piot – end March 26	UEC
Ambulance Handover times < 30 mins	• December performance in line with plan, deterioration expected for January	• Ambulance conveyance trial with PAHT • Trust wide full capacity plan review	Ongoing	UEC

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?
RTT Incomplete %	• 18week performance – Behind performance forecast for November and predicting December to deliver 56.2% against target of 57%	• Additional agency validation resource to be implemented for Jan-Mar 26 • Large-scale additional activity mobilising across all challenged specialties	Jan 26	All Divisions
28-day FDS standard	**Drop in performance – reduction of 4% November, however December performance back on track (**unvalidated 76.8% against target of 77%).	• Cancer Q4 sprint - Radiology / MRI and Histopathology bids would support performance enhancement if successful • Urology – implement approved BC (additional diagnostic & consultant capacity) • Diagnostic reviews – backlog review for UGI	Jan 26	All Divisions
Somerset deployment	• Delay to deployment – Board agreement for revised 'go live' date – 02/03/26	• Training compliance to improve • 'Go, No Go' decision required • Final Testing and UAT outputs required	Jan 26	Somerset Project team / Cancer Lead / ADoP Perf

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	Maintaining performance against plan	Sustain current high performance against this standard	Ongoing	All
A&E 4 hr standard	Maintaining performance against plan	Assess Front Door model – and requirement for ongoing model Implement Winter funding resource	Ongoing	All

Appendix 1 - Raw Data

Cancer Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance															
		April		May		June		July		August		September		October		November	
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Cancer 28 Day Standard	80%	77%	72.2%	77%	71.3%	77%	72.5%	77%	73.4%	77%	66.7%	77%	77%	77%	77%	77%	72.7%
Cancer 31 Day Standard	96%	93%	95.2%	93%	89.5%	94%	93.9%	95%	91.9%	96%	96.9%	96%	93.9%	96.8%	93.8%	96.4%	97.2%
Cancer 62 Day Standard	75%	65%	53.1%	67%	49.6%	71%	41.8%	71%	57.7%	72%	58.9%	72%	61.7%	72.9%	67.4%	72.7%	65.1%

RTT Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance															
		April		May		June		July		August		September		October		November	
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
RTT Incomplete Standard	65% - National 60% - Planning target	47.70%	48.80%	49.50%	50.80%	50.70%	51.10%	51.90%	52.00%	52.30%	52.80%	53.70%	54.10%	55.10%	55.50%	56.50%	56.10%
RTT 65 + week waiters	0	0	5	0	3	0	12	0	27	0	46	0	39	0	39	0	24
RTT >52week Standard	498	2748	2403	2494	2175	2278	2265	2066	2402	2300	2449	2200	2157	1800	1947	1350	1931
	1%	5.00%	4.70%	4.60%	4.40%	4.30%	4.70%	3.90%	5.10%	3.60%	5.50%	3.20%	5%	2.80%	4.6%	2.50%	4.7%
RTT 1st OPA Standard	72% - National 67% - Planning target	47.40%	47.40%	49.20%	49.60%	50.90%	49.40%	52.70%	50.20%	54.50%	50.00%	56.30%	50.20%	58.10%	50.90%	59.80%	53.30%
Aged 18 and under RTT metrics – Incomplete 52 + weeks	0	220	232	175	267	137	264	103	219	73	201	50	194	29	180	13	192
		8%	9.70%	7%	12.30%	6%	11.70%	5%	9.10%	4%	8.20%	3%	9%	2%	9.2%	1%	9.9%
Reduction in ASIs	0		12074		10071		9197		8683		8591		8157		8669		8858

Diagnostic Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance																	
		April		May		June		July		August		September		October		October		November	
		Target	Actual	Target	Actual	Target	Actual	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%	90.70%	95%	89.87%	95%	89.87%	95%	87.41%
Computed Tomography (CT)	95%	92%	92.81%	95%	93.54%	95%	99.39%	95%	99.85%	95%	98.63%	95%	96.59%	95%	94.56%	95%	94.56%	95%	80.25%
Non-obstetric Ultrasound (NOUS)	95%	74%	69.46%	73%	70.99%	74%	74.98%	74%	77.40%	75%	75.38%	75%	82.42%	75%	80.77%	75%	80.77%	75%	82.32%
Colonoscopy	95%	92%	30.96%	92%	29.28%	93%	23.98%	94%	25.55%	95%	15.90%	95%	20.33%	95%	23.36%	95%	23.36%	95%	33.44%
Flexi Sigmoidoscopy	95%	90%	24.04%	90%	25.83%	90%	26.56%	90%	21.48%	93%	15.29%	93%	23.66%	93%	19.28%	93%	19.28%	93%	28.91%
Gastroscopy	95%	93%	29.14%	93%	22.40%	93%	20.26%	94%	20.60%	94%	16.45%	94%	25.81%	94%	27.80%	94%	27.80%	94%	31.64%
Echocardiography	95%	80%	87.69%	85%	97.25%	87%	96.52%	87%	95.84%	87%	98.15%	87%	98.62%	87%	96.36%	87%	96.36%	87%	87.48%
Audiology Assessments	95%	15%	19.86%	15%	15.52%	15%	18.57%	15%	17.27%	15%	13.47%	15%	15.51%	15%	13.87%	15%	13.87%	15%	12.22%
Cystoscopy	95%	TBC	50.00%	TBC	46.15%	TBC	40.00%	TBC	50.00%	TBC	42.11%	TBC	42.86%	TBC	41.18%	TBC	41.18%	TBC	66.67%

Urgent Care standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance															
		April		May		June		July		August		September		October		November	
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
A&E 4h Standard	78%	67%	68.40%	69%	64.80%	70%	68.00%	71%	69.10%	71%	75.00%	73%	80%	73%	79%	72%	81%
A&E 12h Standard	6.50%	7.99%	6%	7.80%	8.00%	7.60%	6%	8.40%	8%	12%	12%	10%	11%	10%	11%	9%	12%
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	37 mins	41.44 mins	39 mins	58.24 mins

Appendix 2 – Non-Elective and Elective Benchmarking

A. 4 Hour

System	Trust level performance	Performance in December last year	December to date	Comparison to last year	Plan	Comparison to plan	Required to achieve plan for remainder of month	Average over last 7 days	Tue 30 Dec	Mon 29 Dec	Sun 28 Dec	Sat 27 Dec	Fri 26 Dec	Thu 25 Dec	Wed 24 Dec
BLMK	Bedfordshire Hospitals NHS Foundation Trust	71.6%	77.0%	5.4%	76.5%	0.6%	59.9%	80.1%	68.5%	78.8%	85.8%	82.2%	82.3%	82.8%	81.2%
BLMK	Milton Keynes University Hospital NHS Foundation Trust	68.4%	75.9%	7.5%	73.5%	2.4%	2.8%	79.9%	72.5%	78.4%	81.8%	80.4%	80.1%	83.9%	84.6%
C&P	Cambridge University Hospitals NHS Foundation Trust	67.0%	68.8%	1.7%	75.4%	-6.6%	Not Achievable	71.8%	63.8%	72.6%	75.7%	75.7%	68.7%	70.4%	75.3%
C&P	North West Anglia NHS Foundation Trust	57.1%	68.6%	11.5%	69.6%	-1.0%	99.1%	68.0%	62.8%	67.5%	56.9%	61.8%	80.3%	81.3%	72.4%
HWE	East and North Hertfordshire NHS Trust	66.6%	72.4%	5.8%	71.3%	1.1%	36.9%	72.5%	67.8%	79.3%	69.2%	62.7%	79.2%	81.9%	73.2%
HWE	The Princess Alexandra Hospital NHS Trust	51.7%	77.3%	25.6%	71.0%	6.3%	Achieved	79.1%	74.6%	81.3%	83.1%	76.8%	78.9%	75.2%	82.4%
HWE	West Hertfordshire Teaching Hospitals NHS Trust	76.4%	84.0%	7.6%	80.1%	3.9%	Achieved	80.6%	81.6%	75.4%	77.3%	72.7%	88.0%	87.5%	87.7%
MSE	Mid and South Essex NHS Foundation Trust	64.0%	70.2%	6.2%	73.0%	-2.8%	Not Achievable	72.2%	62.6%	73.1%	71.4%	71.7%	83.0%	77.8%	69.4%
N&W	James Paget University Hospitals NHS Foundation Trust	62.3%	73.3%	11.1%	71.0%	2.4%	0.4%	71.3%	57.4%	67.3%	76.9%	78.0%	75.0%	69.6%	76.0%
N&W	Norfolk and Norwich University Hospitals NHS Foundation Trust	80.3%	81.0%	0.7%	80.1%	0.9%	52.5%	80.0%	73.3%	82.5%	74.1%	83.1%	83.3%	83.1%	82.3%
N&W	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	57.3%	66.4%	9.2%	68.2%	-1.8%	Not Achievable	67.4%	49.1%	69.3%	73.4%	77.9%	67.4%	73.0%	65.2%
SNEE	East Suffolk and North Essex NHS Foundation Trust	71.1%	75.1%	4.0%	77.5%	-2.4%	Not Achievable	76.8%	83.0%	78.3%	75.1%	76.2%	74.1%	72.0%	77.5%
SNEE	West Suffolk NHS Foundation Trust	62.0%	70.9%	8.9%	69.2%	1.7%	17.7%	74.9%	63.3%	77.0%	65.4%	70.8%	88.3%	82.0%	85.5%
	Region	67.3%	74.1%	6.8%	75.1%	-1.0%	Not Achievable	75.4%	68.8%	75.8%	74.2%	74.5%	80.0%	79.2%	77.2%

B. 12 Hour

System	Trust level performance	Performance in December last year	December to date	Comparison to last year	Plan	Comparison to plan	Required to achieve plan for remainder of month	Average over last 7 days	Sun 28 Dec	Sat 27 Dec	Fri 26 Dec	Thu 25 Dec	Wed 24 Dec	Tue 23 Dec	Mon 22 Dec
BLMK	Bedfordshire Hospitals NHS Foundation Trust	7.8%	3.8%	-4.0%	3.9%	-0.1%	4.4%	1.4%	2.1%	1.1%	1.0%	0.7%	0.9%	1.3%	2.4%
BLMK	Milton Keynes University Hospital NHS Foundation Trust	7.8%	5.8%	-2.0%	6.0%	-0.2%	7.4%	2.8%	0.0%	0.8%	2.1%	1.1%	0.4%	6.2%	4.7%
C&P	Cambridge University Hospitals NHS Foundation Trust	13.0%	9.4%	-3.6%	6.4%	3.0%	Not Achievable	3.8%	4.2%	5.0%	2.3%	2.6%	4.0%	6.1%	2.1%
C&P	North West Anglia NHS Foundation Trust	11.5%	11.0%	-0.4%	11.5%	-0.5%	15.8%	10.7%	13.5%	8.1%	6.5%	8.0%	16.9%	12.2%	9.0%
HWE	East and North Hertfordshire Teaching NHS Trust	17.0%	10.9%	-6.1%	11.3%	-0.4%	15.1%	9.5%	11.2%	9.4%	5.6%	2.7%	11.3%	13.3%	10.1%
HWE	The Princess Alexandra Hospital NHS Trust	18.5%	9.3%	-9.3%	7.1%	2.2%	Not Achievable	6.9%	7.7%	3.9%	1.8%	4.1%	11.5%	15.2%	5.1%
HWE	West Hertfordshire Teaching Hospitals NHS Trust	7.3%	6.3%	-1.0%	6.9%	-0.7%	13.0%	4.9%	6.5%	4.9%	1.7%	3.6%	1.3%	8.7%	6.3%
MSE	Mid and South Essex NHS Foundation Trust	10.8%	12.2%	1.5%	9.8%	2.5%	Not Achievable	8.5%	11.0%	6.5%	2.1%	3.6%	10.9%	11.8%	11.0%
N&W	James Paget University Hospitals NHS Foundation Trust	10.3%	8.1%	-2.3%	7.6%	0.5%	2.9%	4.7%	6.8%	3.7%	2.7%	5.9%	5.6%	4.3%	4.6%
N&W	Norfolk and Norwich University Hospitals NHS Foundation Trust	6.4%	5.5%	-0.9%	3.5%	2.0%	Not Achievable	3.3%	5.4%	3.2%	1.4%	0.3%	3.8%	3.4%	4.3%
N&W	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	15.7%	14.2%	-1.4%	8.9%	5.4%	Not Achievable	12.7%	8.1%	9.1%	14.8%	0.0%	16.4%	18.1%	12.2%
SNEE	East Suffolk and North Essex NHS Foundation Trust	16.9%	11.1%	-5.9%	10.2%	0.9%	1.9%	6.8%	8.9%	7.0%	4.1%	4.7%	10.9%	7.2%	7.8%
SNEE	West Suffolk NHS Foundation Trust	14.2%	7.5%	-6.7%	3.8%	3.7%	Not Achievable	4.3%	7.9%	3.7%	1.3%	0.5%	3.4%	6.9%	5.5%
	Region	11.7%	9.1%	-2.7%	7.8%	1.3%	Not Achievable	6.3%	8.2%	5.2%	3.2%	3.3%	7.8%	8.6%	6.9%

C. Cancer – 62day

	Aug-25	Sep-25	Oct-25			
	% in target (Total)	% in target (Total)	Cases	Breaches	% in target (Total)	Change from last month
EAST AND NORTH HERTFORDSHIRE NHS TRUST	86.2%	83.3%	237.5	34	85.7%	2.4%
WEST SUFFOLK NHS FOUNDATION TRUST	78.2%	84.9%	180	33	81.7%	-3.3%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	79.1%	75.3%	189.5	46	75.7%	0.4%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	73.6%	67.5%	263.5	65.5	75.1%	7.7%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	74.9%	71.2%	268.5	79.5	70.4%	-0.8%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	72.0%	70.4%	289	91.5	68.3%	-2.0%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	58.9%	61.9%	158	51.5	67.4%	5.5%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	61.2%	72.0%	160	54.5	65.9%	-6.1%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	62.9%	56.6%	359	130	63.8%	7.2%
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	40.0%	40.5%	20.5	8	61.0%	20.5%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	43.8%	52.1%	104.5	41.5	60.3%	8.2%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	65.1%	70.7%	323	133.5	58.7%	-12.0%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	66.1%	63.0%	151	70.5	53.3%	-9.7%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	47.0%	47.3%	583	308.5	47.1%	-0.2%
Total	65.8%	65.4%	3287	1147.5	65.1%	-0.3%

RAG rating used

Dark Green ≥85%
Light Green 75-85%
Amber: 70-75%
Red <70%

D. 28 Day FDS

	Aug-25	Sep-25	Oct-25			
	% in target (Total)	% in target (Total)	Cases	Breaches	% in target (Total)	Change since last month
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	87.1%	82.1%	1,879	281	85.0%	3.0%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	79.8%	75.8%	2,519	403	84.0%	8.2%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	73.6%	69.5%	3,154	571	81.9%	12.4%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	73.4%	73.7%	3,751	681	81.8%	8.2%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	78.9%	76.3%	1,747	391	77.6%	1.3%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	77.3%	71.2%	1,733	393	77.3%	6.1%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	66.7%	77.0%	1,919	442	77.0%	-0.1%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	78.3%	73.9%	3,089	727	76.5%	2.5%
WEST SUFFOLK NHS FOUNDATION TRUST	79.9%	74.1%	1,528	388	74.6%	0.5%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	74.8%	76.5%	1,328	350	73.6%	-2.9%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	60.1%	69.6%	1,454	469	67.7%	-1.9%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	72.3%	70.5%	3,561	1,202	66.2%	-4.3%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	59.6%	60.5%	6,898	2,670	61.3%	0.8%
Total	71.9%	70.9%	34,560	8,968	74.1%	3.1%

RAG rating used
Green: ≥80%
Amber: 75-80%
Red: <77%

E. Elective – Waiting for First Attendance

		Baseline (w-e 01 Dec 24)	w-e 09 Nov 25	w-e 16 Nov 25	w-e 23 Nov 25	w-e 30 Nov 25	w-e 07 Dec 25	w-e 14 Dec 25	
Org cod	Org Name	% 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%	59.4%	60.1%	60.3%	60.8%	60.8%	61.0%	-6.0%
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD	54.2%	62.6%	63.0%	63.1%	63.4%	63.2%	63.7%	-3.3%
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD	58.6%	62.2%	62.6%	62.9%	63.1%	63.1%	63.1%	-3.9%
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	58.6%	63.4%	64.1%	64.6%	65.1%	65.4%	65.9%	-1.1%
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	56.4%	51.7%	52.0%	51.9%	51.2%	50.5%	50.2%	-16.8%
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	59.9%	55.6%	55.8%	56.1%	59.6%	60.1%	60.5%	-6.5%
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	65.5%	70.8%	69.9%	70.0%	70.1%	70.3%	70.4%	-0.2%
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	56.2%	64.0%	64.1%	64.0%	64.0%	64.2%	64.3%	-2.7%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	63.6%	62.5%	63.1%	63.4%	63.5%	63.7%	63.8%	-4.8%
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	65.7%	68.4%	69.1%	69.3%	70.2%	70.7%	71.7%	0.9%
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	63.2%	68.0%	68.0%	68.0%	68.0%	68.0%	68.0%	-0.2%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	64.4%	56.8%	57.1%	57.2%	57.8%	58.3%	58.7%	-10.7%
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	56.4%	51.7%	52.0%	51.9%	51.2%	50.5%	50.2%	-16.8%
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	47.7%	58.8%	60.2%	60.8%	61.9%	60.6%	62.2%	-4.8%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	58.0%	54.0%	54.2%	55.0%	61.1%	61.8%	62.5%	-4.5%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	53.5%	60.9%	61.2%	61.5%	61.8%	61.8%	61.7%	-5.3%
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	77.4%	92.8%	92.0%	92.6%	92.3%	92.3%	92.6%	10.2%
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	47.7%	51.4%	51.8%	52.2%	52.4%	52.8%	53.0%	-14.0%
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	61.0%	58.4%	58.4%	57.8%	58.1%	58.1%	57.9%	-9.1%
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	68.4%	69.2%	70.1%	70.8%	70.8%	71.0%	71.0%	-2.4%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	73.9%	74.1%	74.5%	74.9%	75.2%	75.9%	76.1%	-2.8%

F. Elective – Total Waiting trend

Org code	Org Name	w-e 09 Nov 25	w-e 16 Nov 25	w-e 23 Nov 25	w-e 30 Nov 25	w-e 07 Dec 25	w-e 14 Dec 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	862,438	861,973	860,675	853,562	850,115	847,827	-2,288	-3,537	1,249
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD	120,997	121,335	120,413	121,063	119,720	119,987	267	-337	604
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD	152,279	152,019	151,690	151,471	150,612	149,508	-1,104	-628	-476
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	144,011	144,374	144,129	143,394	143,349	143,319	-30	-264	234
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	181,354	180,941	181,194	180,532	179,846	178,854	-992	-522	-470
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	142,612	141,959	142,064	136,100	136,109	135,270	-839	-1,672	833
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	121,185	121,345	121,185	121,002	120,479	120,889	410	-114	524
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	87,336	86,527	85,874	86,054	85,716	85,307	-409	-305	-104
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	67,089	66,931	66,429	66,081	65,446	65,011	-435	-480	45
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	52,885	53,290	53,435	53,196	53,538	53,742	204	113	91
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	88,189	88,189	88,189	88,189	88,189	88,189	0	0	0
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	34,064	33,666	33,891	33,869	33,820	33,315	-505	-88	-417
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	181,354	180,941	181,194	180,532	179,846	178,854	-992	-522	-470
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	33,661	34,808	34,539	35,009	34,004	34,680	676	-32	708
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	81,467	81,346	81,431	75,815	75,933	75,691	-242	-1,414	1,172
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	79,364	79,328	79,473	79,709	79,489	78,913	-576	-104	-472
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	5,826	5,760	5,788	5,681	5,677	5,584	-93	-44	-49
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	43,053	42,915	42,352	41,843	41,799	41,514	-285	-350	65
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	27,081	26,947	26,742	26,416	26,356	26,264	-92	-171	79
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	48,073	48,169	48,342	48,355	48,012	48,063	51	-27	78
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	32,996	33,156	32,996	32,813	32,290	32,700	410	-114	524

G. Elective – 52week Reduction Forecast

Treatment Function Code	Week ending:	07/12/2025	14/12/2025	21/12/2025	28/12/2025	04/01/2026	11/01/2026	18/01/2026	25/01/2026	01/02/2026	08/02/2026	15/02/2026	22/02/2026	01/03/2026	08/03/2026	15/03/2026	22/03/2026	29/03/2026
Trust Totals	Cohort plan/trajectory					6794	6244	5694	5144	4594	4044	3494	2944	2394	1844	1294	744	498
	Cohort actual	8374	7862	7508	7220	6939												
	Cohort variance					-145												
	52+ breach plan/trajectory	1081	1044	1007	970	933	896	859	822	785	748	711	674	637	600	563	526	498
	52+ actual	2022	2002	1819	1801	1891												
	Actual variance	-941	-958	-812	-831	-958												
T&O	Cohort plan/trajectory					1406	1296	1186	1076	966	856	746	636	526	416	306	196	100
	Cohort actual	1743	1639	1538	1474	1432												
	Cohort variance					-26												
	52+ breach plan/trajectory	204	198	192	186	180	174	168	162	156	150	144	138	132	126	120	114	100
	52+ actual	530	537	480	455	451												
	Actual variance	-326	-339	-288	-269	-271												
ENT	Cohort plan/trajectory					1082	1002	922	842	762	682	602	522	442	362	282	202	100
	Cohort actual	835	908	1113	1094	1098												
	Cohort variance					-16												
	52+ breach plan/trajectory	195	189	183	177	171	165	159	153	147	141	135	129	123	117	111	105	100
	52+ actual	267	295	296	306	322												
	Actual variance	-72	-106	-113	-129	-151												
Gynaecology	Cohort plan/trajectory					419	394	369	344	319	294	269	244	219	194	169	144	99
	Cohort actual	442	411	413	421	431												
	Cohort variance					-12												
	52+ breach plan/trajectory	206	199	192	185	178	171	164	157	150	143	136	129	122	115	108	101	99
	52+ actual	166	162	140	155	156												
	Actual variance	40	37	52	30	22												
Cardiology	Cohort plan/trajectory					752	692	632	572	512	452	392	332	272	212	152	92	50
	Cohort actual	1152	985	886	826	770												
	Cohort variance					-18												
	52+ breach plan/trajectory	119	115	111	107	103	99	95	91	87	83	79	75	71	67	63	59	50
	52+ actual	140	103	74	74	84												
	Actual variance	-21	12	37	33	19												
General Surgery	Cohort plan/trajectory					364	344	324	304	284	264	244	224	204	184	164	144	99
	Cohort actual	469	447	393	382	370												
	Cohort variance					-6												
	52+ breach plan/trajectory	202	195	188	181	174	167	160	153	146	139	132	125	118	111	104	99	99
	52+ actual	144	140	115	118	114												
	Actual variance	58	55	73	63	60												
Urology	Cohort plan/trajectory					285	260	235	210	185	160	135	110	85	60	35	10	0
	Cohort actual	421	380	326	309	289												
	Cohort variance					-4												
	52+ breach plan/trajectory	35	33	31	29	27	25	23	21	19	17	15	13	11	9	7	5	0
	52+ actual	122	114	102	95	105												
	Actual variance	-87	-81	-71	-66	-78												
Gastroenterology	Cohort plan/trajectory					261	244	227	210	193	176	159	142	125	108	91	74	50
	Cohort actual	383	357	322	279	274												
	Cohort variance					-13												
	52+ breach plan/trajectory	104	101	98	95	92	89	86	83	80	77	74	71	68	65	62	59	50
	52+ actual	57	57	53	46	45												
	Actual variance	47	44	45	49	47												

Continued

Treatment Function Code	Week ending:	07/12/2025	14/12/2025	21/12/2025	28/12/2025	04/01/2026	11/01/2026	18/01/2026	25/01/2026	01/02/2026	08/02/2026	15/02/2026	22/02/2026	01/03/2026	08/03/2026	15/03/2026	22/03/2026	29/03/2026
Dermatology	Cohort plan/trajectory					39	36	33	30	27	24	21	18	15	12	9	6	0
	Cohort actual	73	56	45	42	39												
	Cohort variance					0												
	52+ breach plan/trajectory	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1	0
	52+ actual	9	9	9	10	9												
	Actual variance	7	6	5	3	3												
Oral Surgery	Cohort plan/trajectory					466	426	386	346	306	266	226	186	146	106	66	26	0
	Cohort actual	572	556	527	501	476												
	Cohort variance					-10												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	176	189	189	172	166												
	Actual variance	-176	-189	-189	-172	-166												
Rheumatology	Cohort plan/trajectory					374	344	314	284	254	224	194	164	134	104	74	44	0
	Cohort actual	457	432	407	395	375												
	Cohort variance					-1												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	89	98	88	90	166												
	Actual variance	-89	-98	-88	-90	-166												
Neurology	Cohort plan/trajectory					297	272	247	222	197	172	147	122	97	72	47	22	0
	Cohort actual	366	342	314	314	299												
	Cohort variance					-2												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	14	9	2	4	4												
	Actual variance	-14	-9	-2	-4	-4												
Endocrinology	Cohort plan/trajectory					280	255	230	205	180	155	130	105	80	55	30	5	0
	Cohort actual	358	342	317	313	283												
	Cohort variance					-3												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	106	95	93	98	85												
	Actual variance	-106	-95	-93	-98	-85												
Ophthalmology	Cohort plan/trajectory					208	191	174	157	140	123	106	89	72	55	38	21	0
	Cohort actual	314	297	261	239	210												
	Cohort variance					-2												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	59	65	60	53	44												
	Actual variance	-59	-65	-60	-53	-44												
Vascular Surgery	Cohort plan/trajectory					168	154	140	126	112	98	84	70	56	42	28	14	0
	Cohort actual	244	222	197	196	171												
	Cohort variance					-3												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	71	67	57	59	57												
	Actual variance	-71	-67	-57	-59	-57												
Respiratory Medicine	Cohort plan/trajectory					137	125	113	101	89	77	65	53	41	29	17	5	0
	Cohort actual	187	172	155	150	171												
	Cohort variance					-34												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	18	12	12	15	16												
	Actual variance	-18	-12	-12	-15	-16												

Continued

Treatment Function Code	Week ending:	07/12/2025	14/12/2025	21/12/2025	28/12/2025	04/01/2026	11/01/2026	18/01/2026	25/01/2026	01/02/2026	08/02/2026	15/02/2026	22/02/2026	01/03/2026	08/03/2026	15/03/2026	22/03/2026	29/03/2026
Colorectal Surgery	Cohort plan/trajectory					89	82	75	68	61	54	47	40	33	26	19	12	0
	Cohort actual	149	130	121	119	89												
	Cohort variance					0												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	31	28	24	25	25												
	Actual variance	-31	-28	-24	-25	-25												
Chemical Pathology	Cohort plan/trajectory					89	82	75	68	61	54	47	40	33	26	19	12	0
	Cohort actual	115	98	96	91	89												
	Cohort variance					0												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	10	10	14	14	24												
	Actual variance	-10	-10	-14	-14	-24												
Paediatric ENT	Cohort plan/trajectory					48	44	40	36	32	28	24	20	16	12	8	4	0
	Cohort actual	57	53	50	48	48												
	Cohort variance					0												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	10	10	8	9	15												
	Actual variance	-10	-10	-8	-9	-15												
Diabetes	Cohort plan/trajectory					13	12	11	10	9	8	7	6	5	4	3	2	0
	Cohort actual	14	14	14	14	13												
	Cohort variance					0												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	1	1	1	1	1												
	Actual variance	-1	-1	-1	-1	-1												
Paediatrics	Cohort plan/trajectory					12	11	10	9	8	7	6	5	4	3	2	1	0
	Cohort actual	23	21	13	13	12												
	Cohort variance					0												
	52+ breach plan/trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	52+ actual	2	1	2	2	2												
	Actual variance	-2	-1	-2	-2	-2												

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 February 2026

6.4

Agenda item:	6.4							
Presented by:	Kelvin Langford and Franca Gaiteri							
Prepared by:	Anna Jebb – Chief Operating Officer							
Date prepared:	8th January 2026							
Subject / title:	Emergency Preparedness Resilience Response (EPRR) and Business Continuity Report							
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	• 2025 EPRR Assurance Process for which the trust has achieved substantially compliant. • Business Continuity Programme and Business Continuity Management System • Major Incident preparedness & Training and Exercise							
Recommendation:	• Consider the core standards submission • Be assured that the Business continuity management programme is now a work in progress • Onward presentation to Public Board Feb 2026							

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

Previously considered by:	Operational Board (13th Jan 26), PAF.29.01.26
Risk / links with the BAF:	Direct links to BAF risks: 1.1 – Variations in outcomes, due to constraints with system wide flow 1.3 – Poor outcomes due to inability to delivery the national access standards 1.5 – Risk of Trust wide loss of IT infrastructure & systems from Cyber attack
Legislation, regulatory, equality, diversity and dignity implications:	Civil Contingency Act 2004 Health and Social Care Act 2022 NHS England EPRR Core standards NHS England EPRR Framework 2021
Appendices:	Core Standards Report 2025

1.0 Purpose/issue

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

The paper will cover:

- The trust's Emergency preparedness, measured through the 2025 Core standards report
- The business continuity management system (BCMS) cycle and programme
- Testing and exercising - Major incident preparation of staff, equipment and preparedness

2.0 Background

The CCA 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level.

PAHT is a category 1 responder and as such has a legal duty to ensure its preparedness and ability to respond during a civil emergency or event, whilst continuing with its responsibilities as an acute hospital.

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

3.0 Emergency preparedness and Core Standards report

As an organisation the Trust scored and retained its status as substantially compliant against the 2025 NHS England Core Standards Assurance.

The core standards report highlighted several areas of improvement with business continuity being the main area of concern, a work plan is now in place to ensure that this is implemented.

The need for additional staff within the EPRR team was also highlighted during the core standards assurance process.

Appendix 1 shows the breakdown of the substantially compliant areas across the 10 domains which include governance, business continuity (BC) and Cooperation. Overall, 55 out of the 62 areas were fully compliant and 7 partially compliant, giving an overall rating of substantially complainant at 89%

The scoring for the core standards is based on the following criteria.

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

A number of plans and policies relating to PAHT emergency preparedness that have been reviewed to date to ensure that these are still in line with national and local guidelines, this has resulted in the Major and Critical Incident Plan, Adverse Weather plan and a new CBRN SOP been created / updated.

4.0 Business Continuity

Business continuity management process continues to be developed, this includes the updating of the trust wide business continuity policy, which is currently being reviewed by the Health and Safety committee, as well as a new combined business impact analysis and business continuity plan template, which will enable divisions to write and update plans with prompts

and identify risks. This will also remove inconsistencies across divisions by introducing a standardised format.

Business continuity training has continued and is still in place for those departmental business continuity champions, this is being run by the ICB. This training will ensure that staff in charge of their departments business continuity plans are fully conversant with the completion, review and testing procedures required

Additionally, a member of the EPRR team has completed a certified business continuity management professional development course (CBCMP) to be able to fully support divisions with business continuity planning.

5.0 Testing and Exercise

Since the last board report work has been carried out on the testing and exercise programme, with a number of tabletop exercises having been undertaken including the delivery of face-to-face Tactical training provided by Hertfordshire Fire and Rescue service at KAO Park.

We continue to exercise our decontamination tent erection procedure for CBRNe incidents and are in the planning phase to carry out a live multi-agency training exercise to be held at PAHT in cooperation with Essex Police Resilience, Essex County Fire and Rescue Service as well as East of England Ambulance. Monthly tabletop exercises have also been planned for the year ahead.

Throughout the year, the EPRR team has attended a number of external multi-agency exercises, including exercise Solaris and Pegasus (pandemic planning) and a Cyber exercise held by the Hertfordshire Local resilience forum attended by our Head of EPRR and two members of PAHT ICT.

Looking forward our plans for the upcoming year include our continued commitment to training and exercising with monthly walk around for business continuity and tabletop exercises testing our policies and plans.

Training and exercising will be continued throughout 2026 to ensure that all on-call commanders have the tools they need to be able to respond to incidents with a programme of works to include that Business Continuity plans are also tested

6.0 Major Incident preparation of staff equipment and preparedness

The trust's major incident policy has now been updated and published trust wide.

Major Incident store overhaul has been conducted to ensure that all equipment is readily available and organised for quick access including a CBRN SOP, with plans going forward to include training facilities for Hazmat and CBRN.

There were no major incidents to report, however there have been a number of business continuity incidents throughout the year, which were resolved internally.

Throughout 2025, PAHT collaborated with the Hertfordshire Local Health Resilience Partnership (LHRP) to ensure system wide health resilience and planning, providing strategic direction for Health EPRR in Hertfordshire. PAHT have also collaborated with the Essex Resilience Forum to ensure that we build stronger relationships with links to all multi-agencies represented within the Essex Resilience Forum. The ICB have represented PAHT at the Essex LHRP.

7.0 Training

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

CBRNe training continued throughout the year with 120 members of staff trained in Adult Emergency department with the donning and doffing a Hazmat PRPS suit and the processes in the management of a CBRNe incident. Training has been extended to include Children's Emergency Department as well as additional support staff within the trust.

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

There has been an increase in the number of PAHT staff who have undertaken ICB loggist training, as of 2025 we now have 13 trained staff who should an incident occur can undertake loggist duties. Furthermore, two members of staff have undertaken a train the trainer loggist course enabling delivery of Loggist training directly within the trust.

8.0 2026 Look forward

The first of our internal monthly EPRR Organisational Resilience Group meetings have been held on the 8th of January 2026, which will report into a newly formed EPRR Strategic Resilience Group. Meetings for the Strategic group will be quarterly and provide assurance and report directly into the Health and Safety Committee and onto the Performance and Finance Committee. These will also be reported back into the Operational Board and Executive board for information and for assurance.

A work plan has been developed which includes, monthly tabletop exercises to test and exercise plans and policies including the Major and Critical Incident Plan, CBRN plan and Alex Health Downtime.

Through our enhanced multi-agency collaboration with the Essex Resilience Forum, the Trust now has access to additional training resources. This partnership enables shared learning opportunities and allows the Trust to assess free training for Operational, Tactical, and Strategic Commanders.

8.0 Recommendation

The Board to consider and takes assurance on the 2025 Core standards *substantially compliant* return prior to formal presentation and approval at the public board (Feb 2026) and is assured that the ongoing programme of EPRR work will be undertaken to mitigate any risks to the organisation.

Author: Kelvin Langford and Franca Gaiteri
Date: 8th January 2026

The Princess Alexandra Hospital NHS Trust

APPENDIX 1 – core standards report PAHTT 2025 - Substantially Compliant

Core Standards Report PAHTT 2025

See separate appendix A documentation.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	11	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	55	7	0

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APPENDIX 2 – EPRR Workplan 2026

January to July 2026

Tabletop Exercises

Testing and exercising of plans / policies

Name	Date
Surge Plan	15th January 2026
Adverse Weather	5th February 2026
Major and critical incident plan	20th February 2026
Pandemic	5th March
Bomb threat	19th March
Lockdown	2nd April
Cyber & 724 Downtime	16th April
Fire evacuation / evacuation	7th May
Loss of Utilities	21st May
Surge Plan	4th June
Adverse Weather	2nd July
Major and critical incident plan	16th July

Live – Multi-agency Exercise

Name	Date
CBRN / Hazmat	Apr-26

CBRN / Hazmat – Major incident training

	Training Dates
Monday	02/02/2026
Monday	09/02/2026
Monday	09/03/2026
Thursday	12/03/2026
Monday	13/04/2026
Tuesday	14/04/2026
Monday	11/05/2026
Thursday	14/05/2026
Tuesday	09/06/2026
Tuesday	16/06/2026
Monday	20/07/2026

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BOARD OF DIRECTORS:	**Trust Board (Public) – 5th February 2026**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board**	
REPORT FROM:	**Chair: Tom Lafferty**	
DATE OF COMMITTEE MEETING:	**15th January 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Citizens' Advice Manifesto	Y	Y	Y	Partners agreed to support the Citizens' Advice Manifesto in their organisations and to work collaboratively on referral opportunities & co-location.
2.2 Indices of Deprivation Report	Y	Y	Y	The Board was asked how we can use this report to target services to areas of most need. Agreed to use the report alongside the National Neighbourhood Health Implementation Programme (NNHIP) work with residents with frailty and long term conditions. In addition it can be used to risk stratify against long waiting lists of elective patients. Health literacy is a public health priority that we can all support through the partnership.
2.3 National Neighbourhood Health Implementation Programme	Y	Y	N	Noted the change of the Senior Responsible Officer to Nicole Rich, Director of Adult Community Services, EPUT. Approved the population cohorts for the programme, continue with frailty, expand to people with long term conditions and rising risk (to reduce the risk of people developing long term conditions in future). Noted alignment between PAHT Strategy and NNHIP to work on out-patient remodelling. Noted the maturity of the NNHIP baseline assessment and areas of further work. Noted the risks to the programme from the ICB restructure & winter pressures. Children & Young People requested to be included in the programme in future, by building on the Harlow Family Hub.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5th February 2026**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board**			
REPORT FROM:	**Chair: Tom Lafferty**			
DATE OF COMMITTEE MEETING:	**15th January 2026**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 St Clare Hospice Funding	Y	Y	Y	The Board agreed to work with St Clare Hospice to collate end of life services and risk assess the impact of limited future funding & identify opportunities for integration. Escalation to the Essex ICB for funding discussions.
2.5 St Margaret's Estate Planning	Y	Y	N	Update on estates plans for St Margaret's Hospital site, the integration with wider west Essex estates and wider public estates.
2.6 WE HCP Planning Priorities	Y	Y	N	The Board agreed to the proposal to reframe the 2nd year of the west Essex HCP integrated delivery plan to the Neighbourhood Health Transformation plan, in alignment with the NHS 10 Year plan and NNHIP. Three focuses: 1. Prevention 2. Neighbourhood Health 3. Enablers Essex County Council to assist with further details on Children & Young People mental health and other prevention schemes.
2.8 Locality Highlight Report	Y	N	N	
4.1 WE HCP Commissioning Assurance Report	Y	N	Y	Support two business cases to Essex ICB for commissioning, Frontline & Integrated Dermatology.

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BOARD OF DIRECTORS:	**Trust Board – 5th February 2026**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**Executive Board (EB)**			
REPORT FROM:	**Committee Chair – Thom Lafferty**			
DATE OF COMMITTEE MEETING:	**20th January 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Strategy Update – Mental Health Strategy Refresh	Y	Y	N	EB noted there has been good engagement with EPUT colleagues and there is a clear action plan with timeline in place. Colleagues from Primary Care & HPFT will be invited to future review meetings. Next steps are to review the Paediatric mental health strategy and update Executive Board on progress.
New Hospital Programme Update	Y	Y	Y	Executive Board discussed the new hospital strategy which will be discussed further at Trust Board. PAHT has been put forward as host provider the new Multi Neighbourhood hub in Hertfordshire. PAHT is working with colleagues in Hertfordshire to take this forward
Cancer Improvement Plan Update	Y	Y	N	EB noted the report. Urology performance remains an area of focus and is impacting on the 28-day ad 62 performance Trust overall cancer performance. Executive Board discussed the short-term improvement actions that dovetail with the urology business case resource coming online
Finance Update	Y	N	N	EB noted that in M9, the Trust delivered a £1.4m deficit (on plan), with PQP delivery remaining on track to the end of the year.

Planning Update	Y	Y	N	EB noted the challenging planning timescales. Following meetings with the Divisions, a proposal on planned values will be submitted to Executive Cabinet at the end of January, PAF and Trust Board in February for approval.
Withdrawal from Surgical & Critical Care Elective Hub	Y	N	N	EB approved PAHT's withdrawal from the Surgical & Critical Care Elective Hub in St Albans. This had been discussed and supported by Operational Board.
Staff Survey	Y	Y	N	CPO reported a good level of engagement with the staff survey. Survey scores are consistent with previous years with work still to do to make improvements.
Nursing Establishment Review (bi annually)	Y	Y	N	EB noted and approved the Nursing Establishment review and request to increase establishment in the following areas: Enhanced Care demand (Level 1C/1D) and the ambulance cohort area in ED.
CQC update & Well Led Inspection	Y	Y	N	CQC well led inspection taking place on the 27th/28th & 29th January. Good engagement with pre interview preparations. Fifty six interviews are taking place.
Clinical Divisional Re-structure update	Y	N	N	EB noted that go live of the new structure will be on the 1st February. Handover meetings are taking place. Weekly structure transitions group meetings are in progress.

Risk Management Group Report	Y	Y	N	CMO reported that all risks scored above 20 have been cleared from the corporate risk register EB noted risk ID 820 current score 4 x 4 = 16 relates to risk associated with ability to meet increasing demand for category 4 caesarean lists impacting on scheduling and waiting for time critical surgery. This risk is currently completing due process for executive sign-off and will be re-submitted subject to receipt of this. EB approved for inclusion onto the corporate risk register: • **Risk id 657 current score 3 x 5 = 15** relates to risk associated with medical staffing gaps and impact on treatment and care of children requiring paediatric medical care. • **Risk id 810 current score 3 x 4 = 12** risk associated with the inability of Cerner to prioritise priority precautions for patients requiring more than one type of isolation. • **Risk id 862 current score 4 x 3 = 12** relates to poor workforce behaviours that could result in staff accidently or maliciously misusing patient data as there is no privacy officer in post to check access rights. • **Risk id 864 current score 4 x 4 = 16** risk associated with the Cerner and system process issues affecting a number of critical activities that could impact on pharmacy related performance across the Trust. EB approved for inclusion on the trust wide risk register:

				• **Risk id 810 current score 3 x 4 = 12** infection prevention and control risk associated with the inability of Cerner to prioritise priority precautions for patients requiring more than one type of isolation. • **Risk id 814 current score 3 x 4 = 12** infection prevention and control risk associated with incomplete mapping in system resulting in some 'abnormal' results not being recognised and flagged. • **Risk id 862 current score 4 x 3 = 12** relates to poor workforce behaviours that could result in staff accidently or maliciously misusing patient data as there is no privacy officer in post to check access rights. • **Risk id 864 current score 4 x 4 = 16** risk associated with Cerner functionality issues affecting a number of critical activities that could impact on pharmacy related performance across the Trust. • **Risk id 865 current score 3 x 4 = 12** risk associated with there not being any Trust inventory or oversight of medical gas cylinder usage across the organisation (these are rented).
Corporate Risk Register	Y	N	N	EB noted the Corporate risk register report.
Performance Reports	Y Y	N Y	N N	The Operational Board report was noted by EB Access Report – EB noted the report.

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