The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 2 April 2026 at 09.30 – 12:45
Venue: Kao Park Boardroom

	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	17
09:35: Board Story: Maternity & Neonatal Voices Partnership (MNVP)					
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	24
10:10		*Opportunity for members of the public to ask questions about the board discussions or have a question answered*			
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 27.03.26 • Part I • Part II	Assure	Committee Chairs	 38 45
10:45	4.2	Maternity Reports: • Maternity Patient Safety Incidents (MPSIs)	Assure/ Approve	Interim Chief Nurse/ Director of Midwifery	48
10:55	4.3	Nursing, Midwifery and Care Staff Levels	Assure	Interim Chief Nurse	50
11:05	4.4	Learning from Deaths (Mortality) Report	Assure	Chief Medical Officer	66
		B R E A K 11:15 to 11:25			
05 People					
11:25	5.1	Report from People Committee 30.03.26	Assure	Committee Chair	75

11:35	5.2	Staff Survey Update	Assure	Chief People Officer	81
11:45	6.1	Report from Performance and Finance Committee 26.03.26	Assure	Chair of Committee	89
11:55	6.2	Finance Update including Operating Plan Update	Assure	Chief Finance & Infrastructure Officer	96
12:05	6.3	Corporate Trustee: Report from Charitable Funds Committee (CFC) 10.03.26	Assure	Chair of Committee	104
12:10	6.4	Integrated Performance Report (IPR) including: • Access Report	Discuss	Chief Operating Officer	107 139
12:20	7.1	Report from West Essex Health and Care Partnership Board 19.03.26	Assure	Chair of Committee	153
12:30	7.2	Report from Executive Board Meeting 17.03.26	Assure	Chair of Committee	160
		Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
08 Closing administration					
12:40	8.1	Any unresolved issues			Verbal
	8.2	Review of Board Charter			Verbal
	8.3	Summary of actions and decisions	-	Chair/All	Verbal
	8.4	New risks and issues identified	Discuss	All	Verbal
	8.5	Any other business	Review	All	Verbal
	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	Verbal
12:45		Close			

Date of next Public Board meeting: 4 June 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 2026/27			
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
		Executive Members of the Board (non-voting)	
Associate Non-executive Director *(on sabbatical)*	Ralph Coulbeck	Chief Strategy Officer	Michael Meredith
Associate 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 Kao Park Board Room
Thursday 5 February 2026 from 09:30 to 12:45

Present:

Darshana Bawa	**Acting Trust Chair (ATC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Liz Baker	Non-Executive Director (NED-LB)
David Baines	Non-Executive Director (NED-DB)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO)
Parag Jasani (non-voting)	Associate Non-Executive Director (ANED-PJ)
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)
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)
Jamie Coates	Head of People
Karen Kingsmill	Project Manager – Widening Access and Participation
Arleen Brown	Head of EDI
Alina Kushka	Pathology
Alex Turney-Challis	Supported Intern
Malcolm Shoebridge	Domestic
Marie Parsons	Consultant Clinical Scientist
Sam Gooden	Deputy Chief People Officer
Linda Machakaire (item 4.2)	Director of Midwifery
Monica Bose	Divisional Director – Planned Care
Zowie Copeman	Divisional Director – Family Diagnostics & Community
Gail de Souza	Divisional Director - Integrated Medical & Emergency Pathways
Finola Devaney	Director – Clinical Quality & Governance

Members of the Public:

Ann Nutt	Chair of Patient Panel
Trevor Arnold (for part)	Siemens
Mark Taylor	XY Laser Services

Apologies:

Michael Meredith (non-voting)	Chief Strategy Officer (CSO)

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, colleagues in attendance and members of the public introduced themselves.
1.1 Apologies	
1.2	Apologies were noted as above.

1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the previous meeting held on 11.12.25 with one amendment as follows: Minute 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~~ **principal** risks.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and no comments on the action log.
Staff Story: From Community to Career	
1.6	The Chief People Officer (CPO) then introduced the Staff Story: From Community to Career. The Board noted that before the formal development of the West Essex Health & Care Careers Pathway, the Trust had already been working creatively with partners to support people from the local community into employment. These early successes had demonstrated what could be achieved with personalised support, dedicated time and strong collaboration. Thanks to new funding from Essex County Council, the Trust now had a fully resourced project team.
1.7	To showcase the above colleagues from the People team introduced three individuals whose journeys had begun before the pathway had been launched. Those three individuals were: • A DWP/Job Centre referral who had joined the Trust as a domestic and gone on to win a staff award in 2025 - Malcolm. • A Ukrainian refugee who had been supported by the Trust with coaching in application and interview support and then a clinical attachment, who had then progressed into a role in Pathology – Alina. • A young person from the Trust's supported internship programme who had successfully moved into a substantive paid role within the hospital – Alex.
1.8	The individuals explained how securing substantive roles had positively impacted their lives. The Board noted the organisation would continue to build on this programme of work with the new West Essex Health & Care Careers Pathway and was committed to being an anchor institution using employment and other initiatives to reduce inequalities, support integration and improve lives.
1.9	Associate Non-Executive Director Anne Wafula-Strike (ANED-AWS) congratulated colleagues on their wonderful stories and reminded everyone that 'disability should never mean inability'.
1.10	The Chief Clinical Transformation Officer (CCTO) thanked the three individuals for sharing their journeys. He then commented that the Trust's work in this domain was quite Essex focussed and asked what it would take to now step into the Hertfordshire space. The CPO responded that this conversation was being had at regional level, which she appreciated was not specifically about Hertfordshire, but efforts were underway to ensure this pathway was mirrored in the East of England using PAHT as the role model.
1.11	ANED Ben Molyneux (ANED-BM) commented that the work must be resource intensive and he asked what funding was available. The Head of People (HoP) responded that his team had a post for Outreach & Retention which had been funded by Essex County Council (ECC). His ambition now was for this work to reach out beyond PAHT into other organisations within West Essex.
1.12	The CEO then thanked colleagues for their stories which were inspirational and heart-warming. He had met all three individuals on his organisational walkabouts and commended each one of them for the roles they undertook within the organisation – in his view they were all superstars.
1.13	The ATC thanked colleagues for sharing their wonderful stories/work.

02 Chair and Chief Executive's Reports	
2.1 Acting Chair's Report	
2.1	The ATC introduced her update. She drew members' attention to the regional steering group which had been set up by the NHSE East Regional Director to improve NED engagement. A meeting had been arranged for 08.04.26 and she hoped as many Trust NEDs as possible would attend. She also flagged that the MSE ICB Chair had asked for a PAHT tour so the plan was to combine this with the opening of the new Community Diagnostic Centre (CDC) in Epping.
2.2	The ATC continued that in line with a previous Board action, a new Board Development programme was being commissioned. Board members would therefore shortly be receiving a questionnaire which she would encourage colleagues to complete to support the planning of this programme.
2.3	In response then to a question from the CCTO related to a replacement for the Chair of the Charitable Funds Committee, the ATC responded that Helen Howe would chair her final meeting in March so there would be time to address this prior to next meeting after that which would be June. She took the opportunity at this point to thank Helen for her huge commitment to the Charity over recent years.
2.2 CEO's Report	
2.4	The CEO presented his update and the key headlines were as follows: **CQC Inspection:** The CQC inspection had more or less come to an end and the Board had previously discussed the early findings from the inspection of UEC, Surgery and Medicine back in November. The final part of the process had been the Well-Led inspection to test the organisation's governance arrangements and most of that work had concluded in the previous week. Some high level feedback from that element of the inspection had included three key positives and three areas for further focus as follows: Positives: • An enthusiastic and engaged Patient Panel representing the patient voice and allowing the organisation to connect effectively with the communities it served. • The visibility and skillset of the senior leadership team. • Commendation of anti-ligature shower and toilet facilities in the ED affording privacy and dignity to mental health patients. For future focus (and already being actioned): • Poor Maternity estate including IPC concerns around drain flies (Maternity theatres currently closed). • The way the recent change management process had been carried out and the associated impact on staff morale at all levels, risking further staff burnout and Trust objectives not being achieved. • Inclusiveness: Staff networks were in their infancy and senior leadership oversight of EDI objectives was an area for improvement.
2.5	In response to the above ANED-AWS commented that the Trust's Disability and Race Equality Networks had been running for some time. The CPO agreed but noted that both had been initiated around 2022 so were still at the beginning of their journeys.
2.6	At this point the CEO welcomed the three new divisional directors to the meeting. The organisation's new divisional structure had gone live as of 01.02.26 and he acknowledged the changes had been difficult for staff but the aim had been to increase the level of clinical leadership. This would also allow a focus on the reality of frontline care, reduce hierarchy and ensure alignment with divisional/operational and Executive matters.
2.7	The CEO continued that in terms of operational performance, PAHT was starting to attract national attention. Cancer and diagnostic performance had been de-escalated by NHSE because of recent improvements and the Trust was now in Tier 2 (rather than Tier 1) and

	performance against the ED 4 hour standard had also been called out at a recent national meeting as one of the biggest improvements nationally, with a request to use Trust performance as an exemplar.
2.8	Staff Survey results remained under embargo until March 2026 but there would be a short summary of initial highlights in the private session.
2.9	Non-Executive Director Colin McCready (NED-CM) asked about plans for the forthcoming opening of the CDC in Epping. The Chief Finance & Infrastructure Officer (CFIO) responded that this was in the final stages of commissioning with a ribbon-cutting ceremony planned for May. The CEO added that the new Divisional Director for Planned Care had provided a very informative presentation on the CDC at a recent Executive Away Day which he felt would be useful for Board members.
ACTION **TB1.05.02.26/19**	**Executive Away Day presentation on the Community Diagnostic Centre to be shared with Board members.** **Lead: CEO/DCG**
2.10	In terms of the new RISE strategy referenced in the paper, ANED Bola Johnson (ANED-BJ) asked whether there was a way to translate the ambition of the framework into small measurable priorities. The CEO responded this work was underway. There would be strategy priorities in the next financial year linked to the NHS Ten Year Plan but there would also be HCP priorities going into 26/27 (including frailty, new pathways for adults with long-term conditions and pathways for children/young people).
2.11	In response to the above the ATC asked about plans to ensure staff were fully engaged with the above. The CEO responded that the Chief Strategy Officer (CSO) had developed a timeline for clinical, corporate and stakeholder engagement.
2.12	In response to a further question from the ATC, the CEO confirmed the date for launching the RISE Strategy remained April 2026.
2.13	In response to the above the CCTO added the measurement of the RISE outcomes could be managed by the PMO team as had been the case with the previous strategy (PAHT2030). The Interim Chief Nurse (ICN) added there had been significant clinical engagement to date which needed to be harnessed going forward.
2.14	The ATC thanked the CEO for his update.
Questions from the Public	
2.15	The Chair of the Patient Panel (CoPP) asked for an update on the new hospital plans and whether a communication strategy was in place in terms of keeping the local population updated. The CEO responded that the Trust was currently working through options which would require agreement from the NHP and NHSE. In the meantime some public events had been run locally to keep the public updated but at the current time no formal announcement could be made until there was agreement on a new hospital plan for Harlow from those who would provide the funding.
2.16	Trevor Arnold (member of the public) asked whether the Trust would consider private funding options for its new hospital. The CEO responded that at the current time no funding options could be ruled out.
03 Risk	
3.1 Corporate Risk Register (CRR)	
3.1	This item was presented by the Chief Medical Officer (CMO). The paper presented a summary of risks scoring 15 and above for all Trust services and was a snapshot taken from the Datix database on 07.01.26. The total number of risks scoring 15 and above approved for inclusion in the CRR was 24. There were no risks scoring 20, 2 new risks scoring 16 and no new risks scoring 15. In the terms of the 2 new risks scoring 16 those related to 1) Cardiology equipment and 2) Work Lists on the new electronic health record. Both had strong mitigations currently in place.
3.2	In response to the above ANED-BJ highlighted a large number of risks were breaching the Trust's own risk appetite and she asked whether there were plans to reduce the number of those over time. The CMO responded that all risks were reviewed on a regular basis and

	where risks might be 'stuck', colleagues were asked to present those to the Risk Management Group (RMG) for review.
3.3	NED-CM asked which Trust risk had reduced from 20. The CMO responded this was the risk related to the ED 4 hour standard.
3.4	NED Oge Austin-Chukwu (NED-OA) then highlighted a number of the risks were actually sitting above the Trust's risk appetite. The CMO responded the Trust's risk appetite had been discussed at a recent Board Development session.
3.5	The CEO then commented that some of the above had been discussed the previous day at Executive Cabinet with agreement for a new risk to be added to the CRR. The CMO continued that this risk related to data quality issues arising from the way in which the organisation was interacting with its electronic systems. It was not an Alex Health issue per se but about how data was recorded across a number of different domains which would now be grouped into one risk. The risk would be presented to RMG once worked up and could potentially be added to the BAF.
3.6	The Chief Operating Officer (COO) then commented the work list issue was well known and work on improvements in that area had led to other considerations. Now was the right time to bring everything into one risk which would be more about how the system was used and how colleagues were trained to use it.
3.7	The ATC thanked the CMO and colleagues for their update.
3.2 Board Assurance Framework 25/26	
3.8	This item was presented by the Director of Corporate Governance (DCG). She informed members the risks had been updated with Executive leads and reviewed at the relevant committees during January 2026. There were no changes to the risk scores that month with the exception of BAF risk 2.1 (staff resilience and morale) which had been revised to reflect the risk of staff burnout following a review of the initial results from the Staff Survey. It was proposed to increase the risk score from 12 to 16. The new wording for the risk was: *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*.
3.9	The CPO briefed the Board on the changes to the risk, explaining that the initial outputs from the staff survey were showing increased staff engagement so this element of the risk had improved and the focus needed to be on staff feeling burnt out and morale being low – this had also been picked up by the CQC. Members were content to approve the revision of the risk and the increase in risk score from 12 to 16.
3.10	The DCG continued that in relation to BAF risk 3.2 (system pressures) which was assigned to the Board for review, this had been updated by the CCTO but it was not proposed to change the risk score.
3.11	The DCG then informed members that QSC had discussed BAF risk 1.1 (clinical outcomes) and had noted it had been static for some time. There had been agreement therefore to take a more focussed approach on that risk looking at controls and mitigating actions and to report back to QSC in February 2026.
3.12	The ATC then drew members' attention to BAF Risk 5.1 (Finance – Revenue) with a risk profile through to 16 in December. She asked whether that meant the organisation was at risk of achieving its 25/26 plan. The CFIO responded there remained some moving parts some of which were outside the Trust's control.
3.13	In response to the above the CEO then commented his view was BAF Risk 5.1 also needed to be reframed. There was no risk to the 25/26 outturn but some risk linked to the planning process for 26/27.
3.14	NED David Baines (NED-DB) asked whether a new finance risk should be developed for 26/27. In his view these were two separate risks, not just a single annual risk and ANED-BJ supported this approach. The CEO agreed that the risk was about the medium to long term financial sustainability of the Trust. This was currently described as a 25/26 risk but it was more long term than that so the risk needed to be updated.
ACTION	**BAF Risk 5.1 (Finance – Revenue) to be updated.**

TB1.05.02.26/20	**Lead: Chief Finance & Infrastructure Officer/Director of Corporate Governance**
04 Patients	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	Quality & Safety Committee (QSC) 30.01.26 – Chair NED-OA NED-OA introduced her report and the key headlines were as follows: • 34 of 168 complaints in Surgery in-year, related to medical care so a deep dive had been scheduled. • QSC had endorsed the proposed approach to address work-list issues in Alex Health. • Alex Health and IPC data flow: Work was ongoing to ensure reliable electronic transfer of data, particularly in preparation for the laboratory's move off-site in the summer. This formed part of the Pathology IM&T work-stream and the CCTO had agreed to share the ongoing risk assessments with the DCG to ensure line of sight of this particular risk and its resolution. • There was limited assurance on compliance with NICE guidelines and 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. • Clinical Effectiveness: The outcome of a review of the effectiveness of this function would be presented to QSC in three months' time.
4.2	In relation to the 25% of Surgery complaints that did not relate to access, the ATC asked whether that cohort contained any patient harms. The ICN responded the number included a small percentage of patient harms however they were low harm. The biggest theme was communication which linked back to the Inpatient Survey results and there was already a workstream in place which was reporting into QSC.
4.3	Quality & Safety Committee Part II (QSCII) – 30.01.26 – Acting Chair NED-OA NED-OA introduced her report and the key headlines were as follows: • QSCII discussed the new MOSS (Maternity Outcomes Signal System). • The culture work, including listening exercises continued. • Telephone triage had started but no significant improvements were yet evident. Data capture for triage was also an issue.
4.4	At this point NED-CM flagged that vacancies were low but bank/agency spend remained above target due to supernumeraries. He asked whether that was temporary or long-term. NED-OA responded this was temporary and due to new colleagues not being able to practice without support when they started.
4.5	The CMO then provided assurance that whilst it was noted 'no further work' against Home Births and Maternity Patient Safety Incidents, there was work ongoing elsewhere to support improvements.
4.6	NED-OA then flagged the requirement for Board sign-off of the Maternity & Perinatal Incentive Scheme (MPIS) before the next Board meeting so delegated authority was sought for the QSCII Chair ANED Ben Molyneux (ANED-BM) and the ATC to undertake that. The Board was content to approve this request.
4.7	The CEO asked how assured QSC was in relation to the maternity culture work which had been ongoing for several months. ANED-BM noted that the divisional restructure might provide an opportunity to re-evaluate how the culture work was progressing. The CPO responded there was a plan for a future focus on maternity and culture, with work to be led by herself and the ICN to support the work of the Director of Midwifery (DoM) on this.
4.8	In response to the above the CCTO added, as Maternity Champion, that during his recent walkabouts there was evidence of a significant shift in culture in terms of all staff (medical, nursing and midwives). The Champions would continue to offer listening events for staff.
4.2 Maternity Reports	
4.9	Maternity Patient Safety Incident Report

	This item was presented by the DoM. She informed members there had been no new Maternity PSIIs declared in Q3. One PSII had been closed in Q3 and there were three ongoing PSIIs, one of which was with the MNSI.
4.10	Maternity & Perinatal Incentive Scheme (MPIS) This item was also presented by the DoM and the following key headlines were noted: • One non-compliant safety action (SA): SA1 - PMRT. • Digital issues impacting SA2 which could change compliance assessment by NHS Resolution.
4.11	The ATC drew members' attention to p57 of the pack and asked about the incomplete data submission for MSDS. The DoM confirmed this had been an Alex Health upload issue but provided assurance MSDS was now content with the submission and that the Trust was addressing its data upload issues.
4.12	The ICN highlighted the huge amount of work undertaken by Maternity colleagues to meet the standards (bar one) and commended colleagues for their efforts.
4.13	NED-CM asked about the impact of non-compliance with SA1. The DoM responded the organisation had been in the same position the previous year and NHS Resolution (NHSR) had reviewed the Trust's mitigations and declared it fully compliant.
4.14	The ATC then drew members' attention to the reference on p58 of a QI project for respiratory distress with no evidence of the required progress reporting at six months. This element was noted as on track and RAG-rated green. The DoM agreed to look at that outside the meeting and provide an update.
ACTION **TB1.05.02.26/21**	**Maternity & Perinatal Incentive Scheme: Review the RAG rating for the item related to Respiratory Distress.** **Lead: Director of Midwifery**
4.15	At this point it was confirmed that the request for delegated authority for final Board sign-off of the scheme for 25/26 had been approved earlier in the meeting.
4.16	Home Birth Prevention of Future Deaths and PAHT Plans This item was presented by the DoM and the paper was taken as read. She informed members that the National PFD findings had highlighted important opportunities to strengthen safety in home birth services and to enhance the consistency of national guidance. At PAHT the review had identified areas for improvement around workforce variation, escalation processes, risk assessment and clinical exposure, providing a clear focus for development and future investment. Work was already underway to strengthen governance, SOPs and audit processes, with actions progressing well and creating a strong foundation for safer home birth care.
4.17	The COO asked how colleagues were feeling in light of the guidance and whether it had highlighted the potential risks with home births, at the same time acknowledging the Trust had to support patient choice. The DoM noted that, for those women who were suitable, a home birth was a good choice and the organisation should promote that. The issues were for those women falling outside of the guidance who still wanted a home birth. Trust guidelines around this particular issue were being ratified.
4.18	NED-CM asked whether the Board was being asked that day to support an investment. The CFIO responded it was not, that would come with the BirthRate+ plus review. Technically the required investment was already in the plan but not in some of the numbers.
4.19	In line with the recommendation the Board: • Noted the national PFD findings and implications for PAHT in terms of additional investment of 5.37 WTE required to support community service and home births. • Endorsed the PAHT Home Birth Action Plan and associated timelines. • Supported the development of the PAHT Home Birth Strategy. • Agreed with quarterly progress reports to QSC Part II.
4.3 Nursing Midwifery and Care Staff Levels	
4.20	This update was presented by the ICN and the key headlines were as follows: • Sustained overall registered staffing fill rate of >95% had been maintained.

	• No wards recorded an overall fill rate below 75% during the reporting month. • The continued increase in overall fill rates was multifactorial, including a rise in enhanced care requirements. • The full year nursing and midwifery establishment review was completed in September 2025 and progressing through the agreed governance processes, with submission to the People Committee in January 2026 and the Trust Board in February 2026.
4.21	In response to a question from NED-CM, the ICN responded that enhanced care requirements were mostly driven by falls/patient vulnerability.
4.4 Nursing Establishment Review	
4.22	The ICN introduced the full-year Nursing Establishment Review which had been carried out in line with National Quality Board and NICE guidance to assure safe staffing levels across inpatient and key clinical areas. The methodology used the Safer Nursing Care Tool, with data quality validation and benchmarked outputs compared against previous years' audits. This provided confidence that findings reflected sustained demand rather than temporary pressure.
4.23	Two priority areas required funding. First, the ICN explained that the ambulance cohort area, created following the decision in November to cease corridor care within ED, remained unfunded. Patients were now cared for in a safer and more appropriate environment and substantive funding was therefore required going forward. Second, the ICN presented the case for 16 substantive enhanced-care posts to reduce dependency on temporary staffing, improve continuity of care, strengthen oversight and escalation, and mitigate patient safety risks. She acknowledged recruitment challenges and confirmed that work continued with Harlow College and other partners to secure a sustainable future pipeline.
4.24	The ICN concluded that the review provided assurance that establishment decisions were based on triangulated evidence, acuity, sustainability and financial oversight.
4.25	In response to the above ANED-BM highlighted the clear trend in increasing acuity and the associated workforce requirements for that. He asked if the organisation was assured it had the right numbers of medics/AHPs. The CMO responded there was currently no tool to provide assurance around medical workforce. A review had been undertaken in the previous year on resident doctor numbers.
4.26	The ICN then informed members an AHP workforce tool was being developed nationally and PAHT would be an early adopter of that.
4.27	The CEO then commented the paper had been presented to other fora and had been challenged in terms of the numbers evidencing safety, but colleagues on the ground stating it felt understaffed. Colleagues were therefore taking steps to triangulate the evidence to provide full assurance. The ICN added the Fundamentals of Care Programme would be relaunched in February and would support a review of the quality of care.
4.28	NED-OA then commented she supported the request but highlighted the statement on p85 which was suggesting that bank spend would not reduce. The ICN responded it should reduce over time when people were in post. In response to a further question from NED-OA related to plans for the recruitment of healthcare support workers, the ICN responded there would need to be some creative recruitment of this cohort of colleagues in terms of apprenticeships or a non-medical career pathway.
4.29	The CEO then commented that he too supported the increase but flagged the significant tension in terms of the delivery of safe care versus the financial constraints. The organisation had a legal duty to ensure all clinical services were adequately staffed, but it was increasingly difficult to do that given the pressures to hit financial targets. The Trust had also carried an historical deficit but he provided assurance that quality and safety of care was the number one priority.
4.30	The ATC summarised that the Board was assured by the analysis and modelling, accepted the need for the proposed investment and approved the recommendations made in the paper. The CFIO added his view would be the above was approved as a direction of travel subject to colleagues working out the phasing of its implementation.

4.5 Learning from Deaths Update	
4.31	This item was presented by the CMO. He informed members that uncoded activity continued to negatively affect SMR and HSMR indicators. A fix was now in place, but it could take until May for an improvement to be seen and then again in July when year-end data was corrected.
4.32	In response to the above NED-DB commented that data appeared to be an issue generally for the organisation. He asked for further assurance on this issue.
4.33	As assurance the CCTO informed members he and his team were working very closely with the CMO on this. Work was underway to fix the number of 'encounters' in play at the front end of the ED pathway, training was being provided for colleagues on Alex Health generally, and the incomplete coding driven by gaps in the coding team, was also being addressed.
4.34	The CCTO continued that in terms of the gaps in the coding team, a partner was now working with the organisation to clear the backlog and deliver the freeze criteria. All of this, as stated above, would result in improvements from May onwards. In terms of assurance around patient care, he provided assurance that deceased patients were coded and weekend mortality was being audited to ensure the correct processes were being followed. In summary a robust plan was in place which would be tracked via the PMO and presented to Executive Board and QSC.
4.35	The CMO reminded Board members that a detailed discussion had also taken place at QSC and asked if there was a duplication in reporting. Following a discussion, it was agreed that it would be helpful for the Board to understand how assured QSC was by the information presented at the meeting.
4.36	The CEO then responded that 'Mortality' would always be on the Board agenda but his view would be that the preceding QSC discussions needed to be shared with the Board. .
Break 11:36 to 11:45	
05 People	
5.1 Report from People Committee (PC)	
5.1	This item was presented by the ATC and the key headlines were as follows: • Appraisal rates continued to improve, with targeted communications, automated reminders and increased training and drop-in support for managers and staff. • Sickness absence had increased, primarily driven by cold and flu during winter, but a robust flu prevention campaign had led to a 5% increase in vaccination uptake, meeting NHS England targets. • An internal audit had identified key risks in roster management, particularly around hours owed to staff and the Trust. The People team was working with the Corporate Nursing team to develop and implement a robust action plan. • Medical rostering was under review, with plans to procure a more suitable system that integrated with payroll and ESR, ensuring alignment across all staff groups. • Culture and behaviours remained a focus with planned input from OD colleagues. Overall, improvement actions were in progress with clear divisional accountability.
5.2	The ATC then flagged that whilst strengthened staff networks had been identified as an improvement, this had been flagged as an area of concern by the CQC, as referenced earlier. Going forward it would be key to ensure there was protected time for staff to both chair/attend these meetings. She also commended the work of the Voluntary Services team including their Community Ambassador initiative.
5.3	The CPO added that the Voluntary Services team was working in conjunction with the ICN on the 7 Day Service which would be implemented shortly. She also confirmed that work was underway to support the Chairs of the staff networks including agreements around protected time. In response to a question from NED-DB the CPO confirmed she would look into the possibility of combining staff networks/chairs within the ICB footprint and would report back to People Committee.

ACTION TB1.05.02.26/22	**Look into the possibility of combining staff network chairs within the ICS and report back to People Committee. Lead: Chief People Officer**
5.4	At this point the CMO highlighted the recent success of the Resident Doctors' 10 Point Plan with a significant increase in completion (65% to 88%) with thanks to the Medical Education team and Estates team for their work around this.
5.5	The CEO then flagged that whilst the report from the People Committee referenced positive staff engagement/wellbeing, his view was that consideration should be given to some new staff wellbeing metrics following the recent restructure.
ACTION TB1.05.02.26/23	**Consideration to be given to some revised staff wellbeing metrics and reported to People Committee. Lead: Chief People Officer**
5.6	In response to the above the CCTO commented there should be a move towards live metrics so that the position could be tested on a daily basis – the CEO agreed.
5.7	NED-CM then asked, with the recent changes to employment law, if NHSP was working on how this might impact the temporary workforce. The CPO confirmed that a working group was in place, meeting monthly with region, but in her view, the impact would be minimal. NED-CM responded it was interesting to see what was being said in relation to bank and cancelled shifts. The CPO agreed to bring an update on this via the People Committee.
ACTION TB1.05.02.26/24	**Provide an update on the impact of recent changes in Employment Law on the temporary workforce to People Committee. Lead: Chief People Officer**
5.8	ANED-BM then asked the following questions: • Were all medics signed up to HealthRoster? • What could be done to speed up the joining process for volunteers? • In terms of setting up networks, had the organisation reached out to ask which groups wanted to be heard?
5.9	In response to the first question the CPO responded that 30% of medics were currently signed up.
5.10	The CPO continued that in relation to the question around the recruitment process for volunteers an element that is outside the organisation's control is DBS checks. These are essential but can delay the process. .
5.11	In terms of the question around staff networks, she confirmed that colleagues' views had been sought.
5.12	As a final point the ATC informed members that from April the People Committee would start to meet monthly instead of bi-monthly.
5.2 Staff Survey Update	
5.13	(Discussed above).
06 Performance/Pounds/Places	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This update was presented by NED-DB and key headlines were as follows: • The Trust was on track to deliver the financial position at year-end. • Significant improvement noted in ED 4 hour performance. • PAF had been assured by the analysis and modelling in terms of the Nursing Establishment Review and had accepted the need for the proposed investment and agreed to endorse the recommendations made in the paper. • PAF had endorsed the MSK contract award • PAF had taken assurance on the six monthly EPRR Update noting the Trust's substantial compliance and clear identification of improvement areas, particularly business continuity planning. • PAF had noted the Trust's fire risk rating score, which had been reduced from 20 to 15.

6.2	The CEO requested NED-DB's perspective on whether PAF appropriately balanced financial performance with delivery of operational standards. NED-DB replied that he did not yet have complete assurance but provided reassurance that patient safety remained central to the discussions.
6.2 Finance Update	
6.3	This item was presented by the CFIO. He informed members the organisation was on track to hit the year-end forecast outturn but there remained some risk in terms of the delivery of the system control total. The organisation's cash position was improving with the recent receipt of some capital funds but this position would need to be reviewed in the latter half of 26/27.
6.4	During the meeting, ANED-BM raised concerns regarding certain unidentified Productivity and Quality Programme (PQP) elements, noting that these issues had arisen quite late in the financial year. The Chief Finance and Information Officer (CFIO) responded by explaining that non-recurrent measures would be necessary to achieve the financial position for the current year. However, the CFIO cautioned that these measures would not be sourced through the PQP programme as a whole. In summary, it was confirmed that the unidentified PQP elements would remain unaddressed and would not be identified in the current reporting period.
6.3 Integrated Performance Report including Access Report	
6.5	This item was presented by the COO. She reminded members that the revised Integrated Performance Report (IPR) would be presented to Board in draft In March 2026, using February data. Overall performance was noted as positive. There was a positive variation for the Friends & Family Test at 85.1% in December, with statutory and mandatory training performance remaining above 90% and positive trends in bank and agency usage. Significant assurance was provided on the four-hour Emergency Department standard, with performance improving from 78.5% in December 2025 to 80.3% in January 2026. While not all standards were being met, particularly in relation to waiting lists, members noted that RTT and ASI performance continued to improve. It was also noted that the Trust had been de-escalated by NHSE from Tier 1 to Tier 2 for cancer diagnostic performance, meaning cancer diagnostics, elective care and urgent and emergency care were now all in Tier 2, providing assurance that performance was moving in the right direction.
6.6	Areas of concern were highlighted including ambulance handover performance. This had peaked in November 2025, improved to 39 minutes in December 2025, and deteriorated again in January 2026. Diagnostic performance was noted to have declined in November 2025, in line with earlier discussions on ambulance handovers and diagnostic queues. Members were advised that a move to a new theatre DM01 diagnostic report had resulted in variation across services, with improvements in Endoscopy performance but a reduction in CT performance, and that work was underway to ensure reporting accuracy.
6.7	The Board then noted twelve-hour ED waits remained relatively stable and cancer performance was also stable, though a step-change in improvement was required. The focus for the remainder of the year would be on reducing waiting lists, supported by additional funding, with NHS England prioritising an overall reduction in waiting lists and long waiters by year end.
6.8	ANED-BJ asked what actions were in place in terms of reducing waiting lists. The COO responded there were plans to add additional activity over the next three months (clinics and lists) and work was underway with local GPs to introduce a triage model for new referrals and enable to the organisation to increase its current insourcing – check wording. A demand and capacity exercise had also been undertaken with all specialties.
6.9	In response to the above the CEO informed members that in addition to the new format IPR, the COO was also looking at the national oversight framework (NOF) metrics and how the Trust could improve its ranking to NOF3.
6.10	The ATC commended colleagues on the improvements in performance.

6.4 Emergency Planning & Preparedness Update	
6.11	The COO presented the six monthly Emergency Preparedness, Resilience and Response (EPRR) report, which was required to be submitted to the Board to provide assurance on the Trust's level of preparedness for emergency planning. The COO continued that the Trust had achieved substantial compliance, with 7 of 62 elements not scoring full compliance. The areas where full compliance was not achieved largely related to business continuity planning, an area recognised as challenging across many trusts due to the complexity of maintaining plans and this had been identified as a key focus for the coming year. A further area identified for development was the full testing of the Trust's lockdown plan.
6.12	The COO highlighted the significant testing activity undertaken over the previous year. This included CBRNE testing, confirmation that the decontamination tent was operational, and that 120 Emergency Department staff had been trained in donning protective suits. It was noted that 95% of Gold and Silver on-call staff had received appropriate training. Plans for further testing and training were set out for the coming year. The Trust also continued to work collaboratively with partners, including the Essex Resilience Forum, Hertfordshire Resilience Forum, and Health Resilience Forums.
6.13	NED Liz Baker (NED-LB) then informed members that the Trust's EPRR lead had attended PAF the previous week where it had been helpful to hear about his focus on making preparedness tangible through on-the-ground testing. The COO added he was a real asset to the organisation, noting that while plans could often be theoretical, his hands-on approach and continuous engagement with staff significantly strengthened emergency planning and preparedness
6.14	In response to a question from ANED-BJ as to whether all departments had a Business Continuity Plan (BCP) , the COO confirmed that while all departments should have these, this was not currently the case. The Trust had BCPs in place for key areas such as power and EPRR, but not all services had up-to-date plans. A programme was in place to ensure BCPs were written and updated during the coming year, and this gap had contributed to the Trust not achieving full compliance in the annual assessment.
07 STRATEGY/GOVERNANCE	
7.1 Report from West Essex Health & Care Partnership Board 15.01.26	
7.1	The CEO updated that the meeting had touched on the ambition for the HCP Board to operate within a new multi-neighbourhood provider model, with an application submitted for the system to be one of the first pilot sites. This would involve the delegation of certain commissioning responsibilities to the host organisation, enabling greater local control over how services were shaped. This would be a significant opportunity to ensure services were better joined up.
7.2	The meeting had also discussed ongoing conversations with EPUT regarding more formalised organisational buy-in to the HCP Board. The HCP Board currently operated as a PAHT committee of the Board, and there was a need for shared ownership across both organisations, including mental health services. These discussions were described as being at an early stage.
7.3	The CEO then flagged it would be unusual for PAHT to continue chairing the HCP Board, as this role would ordinarily be undertaken by a Non-Executive Director. Arrangements were in place to transition the chair role to a new NED. The HCP Board had discussed estate planning in relation to St Margaret's and the CEO emphasised the importance of considering all neighbourhood assets across West Essex. This would include public spaces, primary care estates and community hospitals. It was noted that planning for the New Hospital Programme or St Margaret's could not be undertaken effectively without a full neighbourhood-wide understanding of assets, population health management data, service flows to PAHT and clarity on where services should be located.
7.4	The ATC thanked the CEO for his update.
7.2 Report from Executive Board Meeting	
7.5	The CEO presented his update and members had no comments.

Questions from the Public	
7.6	The CoPP highlighted that the Trust had withdrawn from the surgical hub at St. Albans (as noted in the report form the Executive Board meeting). She asked for an update given this had been identified as the way forward in terms of reducing the organisation's orthopaedic waits (hips/knees).
7.7	The COO explained why the Trust had withdrawn from the surgical hub. Firstly, the hub would predominantly offer ENT procedures. Whilst it would also include T&O procedures it would not provide the volume currently required by the Trust in order to reduce waits and the volume of ENT procedures could be undertaken at PAHT. The Trust would also be increasing T&O activity over the next few months
7.8	The CoPP then asked whether the issues with corridor care had now been moved to the wards. The ICN acknowledged that an additional patient was taken to most wards but those would be the least acute patients, so there was a safety net to manage expectations.
08 CLOSING ADMINISTRATION	
8.1 Any Unresolved Issues?	
8.1	There were no unresolved issues.
8.2 Review of Board Charter	
8.2	Members agreed that behaviours had been in line with the Charter.
8.3 Summary of Actions and Decisions	
8.3	These are noted in the shaded boxes above.
8.4 New Issues/Risks	
8.4	The CEO flagged the risk around data quality which should be added to the Corporate Risk Register (CRR). The CMO responded this would be assessed first at the Risk Management Group.
8.5 Any Other Business (AOB)	
8.5	The ATC then presented ANED-AWS with a gift and cake given it was her last meeting as a Board member. She thanked her for over five years of service to the Trust and the different perspective she had brought to the Board/organisation with her focus on equity and equality. Her future role as a Community Ambassador would be key.
8.6	ANED-AWS thanked the ATC for her kind words. During her tenure as a Board member she had grown and learned as a person and hoped she had contributed to a cause which made the lives of many better.
8.6 Reflections on Meeting	
8.7	Members reflected there had been some good discussion on a variety of subjects reflecting the significant changes to come. ANED-BM commented he had found the Staff Story heart-warming in terms of how it had truly changed lives. The Divisional Director for Integrated Medical & Emergency Pathways reflected that the Staff Story highlighted that the organisation's people were its biggest asset and should be nurtured.
8.8	The meeting closed at 12:48.

Signed as a correct record of the meeting:	
Date:	02.04.26
Signature:	
Name:	Darshana Bawa
Title:	Acting Trust Chair

ACTION LOG: Trust Board (Public) 02.04.26

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.05.02.26/19	Community Diagnostic Centre Presentation	Executive Away Day presentation on the Community Diagnostic Centre to be shared with Board members.	CEO DCG	TB1.02.04.26	Actioned.	Closed
TB1.05.02.26/20	BAF Risk 5.1 (Finance – revenue)	BAF Risk 5.1 (Finance – Revenue) to be updated.	CFIO DCG	TB1.02.04.26	Actioned.	Closed
TB1.05.02.26/21	Maternity & Perinatal Incentive Scheme	Maternity & Perinatal Incentive Scheme: Review the RAG rating for the item related to Respiratory Distress.	DoM	TB1.02.04.26	The Trust Board, CEO and ICB Accountable Officer have since signed off Year 7 MIS via a sub-committee held in February. The Trust has declared compliance with 9 out of 10 safety actions (including 'Respiratory Distress'), the exception being Safety Action 1 (Perinatal Mortality Review Tool) due to non-compliance with one of the standards at the beginning of 2025.	Proposed for closure
TB1.05.02.26/22	Staff Networks	Look into the possibility of combining staff network chairs within the ICS and report back to People Committee.	CPO	TB1.02.04.26	To be addressed at PC.30.03.26.	Proposed for closure
TB1.05.02.26/23	Wellbeing Metrics	Consideration to be given to some revised staff wellbeing metrics and reported to People Committee.	CPO	TB1.02.04.26	To be addressed at PC.30.03.26.	Proposed for closure

ACTION LOG: Trust Board (Public) 02.04.26

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.05.02.26/24	Temporary Workforce	Provide an update on the impact of recent changes in Employment Law on the temporary workforce to People Committee.	CPO	TB1.02.04.26	To be addressed at PC.30.03.26.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

Public Meeting of the Board of Directors – 2 April 2026

Agenda item:	2.1							
Presented by:	Darshana Bawa, Acting Trust Chair							
Prepared by:	Darshana Bawa, Acting Trust Chair							
Date prepared:	27.3.26							
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.

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

This report outlines my activities since my last report to the Board in February 2026.

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:

Recruitment is under way to appoint a substantive Chair for the Trust with interviews scheduled for next month.

I am pleased to report that Ralph Coulbeck will be returning from his sabbatical on 6th April. His experience and insight has been greatly missed.

Liz Baker will be stepping down from her non-executive role at the end of June. We will be very sorry to lose her, not just because of the skillset and experience she brings to the Trust but also as a trusted, kind and supportive colleague.

3.0 Recent activity:

The first of two Board Development sessions took place at the beginning of this month, and I have received very positive feedback. Culture is a theme that runs through several of the reports today.

Board culture is key – our behaviours, communication and decision-making have a direct impact on everything from patient safety to staff morale and performance. It becomes even more important as we continue our transformation journey.

As required by the NHSE's 10-point plan to improve the working lives of resident doctors, we met the Resident Doctor Peer Lead (Garima) and attended the RDC meeting. This provided a good insight into some of the challenges faced by the RD and there was good discussion on how these might be addressed. The next step in terms of leadership from my perspective is the requirement to appoint a non-executive director to attend the RDC meetings.

The Regional East of England ICB and Provider Trusts CEO & Chairs meeting was held at the end of last month. Apart from meeting new colleagues from both ICBs, it was useful to understand the challenges other Trusts are facing and their plans to overcome them.

The Aspiring Chairs Programme for 25/26 concluded in early March, and I am pleased to report that I successfully 'graduated'.

Appraisal season is upon us, these have been scheduled throughout April and May with the process for 360 degree feedback under way for both Executive and Non-Executive Directors.

The Princess Alexandra Hospital NHS Trust

4.0 Board visibility:

We have seen a very high demand for our services in recent weeks and on behalf of the Board I would like to note our thanks and appreciation for everything our amazing teams do, to provide the best possible health care for our patients.

As part of our commitment to board-level visibility and staff engagement, we are ramping up the Chairs walk rounds having completed 3 since the last report. Details of these are in the appendix attached to this report.

I would like to note our thanks to the staff who take time out of their busy day to host our visits. It is a two-way experience, providing us with an invaluable opportunity to engage and receive direct feedback, and it's also appreciated by the staff and patients we speak to.

The Board is asked to note the report.

Author: **Darshana Bawa**
Acting Trust Chair

Date: 27.3.26

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

The Princess Alexandra Hospital NHS Trust

Chair's Walk Rounds - Action Matrix

Team: PAHT Chair and Non-executive Directors – update to 27 March 26

Non-Executive Directors initials:		Key for others
DB: Darshana Bawa (Acting Chair) LB: Elizabeth Baker (SID) CM: Colin McCready OA: Oge Austin-Chukwu DB: David Baines	RB: Ralph Coulbeck (Associate) BJ: Bolanle Johnson (Associate) BM: Dr Ben Molyneux (Associate) PJ: Dr Parag Jasani (Associate)	PP: Patient Panel FTSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Action
12.2.26	DBawa	Locke ward	Themes identified: • Continued system pressure on patient flow, with use of non-standard care areas to maintain safety. • Patient dignity and privacy maintained • Positive staff culture, with staff reporting commitment and feeling supported. • Workforce pressures evident, with staffing challenges noted on the day.	Jo ward	To continue follow ups on a monthly basis, including a visit to the cohort area
5.3.26	D Bawa PJasani	ED, EM-SDEC, Cohort area	Themes identified: • No corridor care observed in ED, offering reassurance on standards. • Strong staff morale and clear escalation routes, with staff feeling supported. • Variable waiting times, particularly within EM-SDEC during busier periods. • Cohort area functioning well, maintaining privacy, dignity and readiness for demand.	ED Matron ED DDN	Data on EM-SDEC waiting times to be reviewed to understand the full picture.

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

The Princess Alexandra Hospital NHS Trust

17.3.26	DBawa B Johnson	RTT/ Bookings	Themes identified: • Significant workforce pressures, with teams balancing high demand against limited capacity and tools. • Impact of the restructure was discussed • Strong local line-management support, with staff feeling safe to raise concerns. • System and data access limitations present an ongoing risk to oversight and waiting list assurance. • Positive learning from digital rollouts, with improved training approaches strengthening future readiness.	Managers: Cance, RTT & OAD	Explore how targets are set and whether they are appropriately balanced with workforce capacity and current skills levels. Identify where pathway knowledge is at risk and put interim knowledge-transfer in place. To follow up on system and data access limitations

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 April 2026

Agenda item:	2.2								
Presented by:	Thom Lafferty - CEO								
Prepared by:	Thom Lafferty - CEO								
Date prepared:	25 March 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 and 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)

1.0 Personal Reflections

At a time when many of our performance indicators suggest that the Trust is improving, several factors give me pause for thought.

One is our financial position, tightly controlled this year as ever, which faces significant pressure in the new financial starting in April. Another is that our staff and inpatients both told us in surveys taken during 2025 that their experience is not satisfactory, and that many of the criticisms we hear through surveys, complaints and less formal channels, chime with feedback we are receiving from the Care Quality Commission (see below).

My response to all of these challenges is that we need to listen, think and adapt. Just over a year into my time at The Princess Alexandra Hospital Trust, I have learned that as good as it is having expert, caring and kind colleagues, they also need to be empowered and encouraged to innovate, and it is my firm intention to find ways to make this a reality.

2.0 Our Patients

We've received initial draft feedback from the Care Quality Commission (CQC) related to their inspection, which concluded earlier this year. So far, we have received draft reports on Urgent and Emergency Care and Surgery – Medicine will follow shortly, as will the Well-led draft report. We continue to respond to the CQC's helpful and constructive feedback, as indeed we did when they were still with us.

Our new *InTouch* magazine

I am pleased that the second edition of our new magazine, ***InTouch, has been published. The magazine's audience is*** our community –our people, patients, carers and families. It provides a space for us to celebrate the incredible work happening every day across the Trust.

The second edition **can be read online via this link**, and at the time of writing we are awaiting delivery of hard copies that will be available in public areas across all our sites.

You can read more on our website >

Patients and the public hear vision for local healthcare at community event

I was delighted to welcome local residents, patients, and visitors to a public meeting where we shared updates on the future of local healthcare and key service developments.

Held at Epping Hall on **26 February**, topics included the New Hospital Programme, the redevelopment of St Margaret's Hospital, and the Community Diagnostic Centre (CDC).

The event was part of our ongoing commitment to engage with local communities and involve patients and the public in shaping how services develop in the future, both in hospital and closer to home.

3.0 Our People

NHS Staff Survey results

Thank you to all our people who shared their feedback as part of the NHS Staff Survey 2025. The results were published on 12 March.

We saw the highest response rate in recent years and one of the highest rates nationally, giving us the opportunity to hear from more voices than ever before. Staff voices help to shape the development of PAHT for the future.

I recognise that alongside ratings that improved or were stable, the results raise a number of areas for improvement. We are committed to working together to implement changes to support our people's experience of working at PAHT.

4.0 Our Performance

Our operational performance

Our improvement has been recognised in the latest NHS Oversight Framework, NHS England's league table for acute trusts, which sees us move into segment three and rise to 96th place - the third biggest improvement in the country.

This reflects the significant progress we are making in both our performance and financial management, although we recognise there is still more to do. Our priority is sustained improvement, and we remain committed to delivering better experiences and outcomes for the people we serve.

One key element driving our improved position in the table is people waiting less than four hours to be seen in our Emergency Department. This was recently recognised in an NHS England Board paper, which noted "The Princess Alexandra Hospital Trust have delivered substantial improvements in urgent and emergency care services for patients, and achieved a 23 per cent improvement in 4-hour performance in December 2025, compared to the same month the previous year."

Productivity

The latest national data shows that we saw a significant 16.8% productivity growth in November – the highest growth rate for an acute hospital trust in England for the second month running.

We are focused on significantly reducing waiting times and improving patient experience, which drives improved productivity.

We are continuing to implement initiatives to sustain this improvement with new approaches to patient flow in urgency and emergency care and working with our system partners from GPs to community providers to ensure patients receive the right care, in the right place, at the right time. Some of these improvements are due in part to data capture and recording; we are working hard to ensure our data is accurately reported.

5.0 Places and Partnerships

New hospital update

The current hospital estate is ageing and increasingly difficult to maintain. While our clinical and operational teams continue to work tirelessly to improve services and performance, outdated buildings make this more challenging than it should be.

Recent reporting from the National Audit Office suggested that the planned new hospital may not open before 2040. That is too long for our community to wait and while we remain committed to our long-term ambition, we have begun exploring an additional option. We are now exploring whether and how we could redevelop our existing site. Previously, this was not considered possible because of the amount of space required for services. Thanks to our work to bring care closer to patients, that has changed.

For example, blood testing services are soon moving to The Harvey Centre, and the new Community Diagnostic Centre (CDC) opened its doors at St Margaret's Hospital on 16 March. By delivering more services in community locations, we have reduced the overall space needed for our acute hospital. This means redevelopment of our current site may now be achievable - something that was not an option before.

Our Community Diagnostic Centre (CDC) update

We were pleased to welcome our first patient to the Community Diagnostic Centre (CDC) at St Margaret's Hospital, Epping, on **16 March**.

We will begin to see some clinical activity through the centre including cardiology, respiratory and imaging diagnostics (CT, MRI and ultrasound) ahead of the official opening on **8 May**.

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

You can read more on our website >

New fibroscanner unveiled: Celebrating innovation in liver health

We hosted the official ribbon cutting ceremony for our state-of-the-art fibroscanner on **12 March**.

This milestone event marked a significant advancement in our commitment to improving liver health and early detection of liver disease within our community.

The fibroscanner is currently located in the Endoscopy Department at The Princess Alexandra Hospital – it is planned to be moved to the Community Diagnostic Centre (CDC) at St Margaret's Hospital later this year.

You can read more on our website >

6.0 Our Pounds

With financial year-end approaching, we have twin ambitions of delivering our year-end position in line with our plans, and agreeing next year's plan with NHS England and our local system.

At the time of writing, we have reason to be optimistic about delivering our year-end position. Conversations related to next year's plan are at a crucial stage and I look forward to updating the Board at a later date.

Thom Lafferty
Chief Executive
April 2026

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 April 2026

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 – updated 16.03.26							
Subject / title:	Corporate Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents a summary of risks scoring 15 and above for all our services. It is a snapshot taken from our Datix database on 04.03.26. **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 23. **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 no new risks scoring 16 **Section 5** - There is one new risk 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 04.03.26.

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.

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

2.0 Risk data

There are 23 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)	2 (3)	0 (0)	0 (0)	**2 (3)**
Corp - Estates & Facilities	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
CHAWs Child Health	1 (0)	2 (2)	0 (0)	0 (0)	**3 (2)**
CHAWs Women's Health	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Surgery	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 (7)	0 (1)	0 (0)	**7 (7)**
Totals	**8 (7)**	**15 (21)**	**0 (1)**	**0 (0)**	**23 (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	19 (18)	76 (79)	11 (12)	8 (8)	0 (2)	**114 (117)**
Quality – Patient Experience	≥ 12		10 (11)	0 (0)	1 (1)	0 (0)	**11 (12)**
Quality – Clinical Effectiveness	≥ 12		26 (24)	0 (0)	6 (9)	0 (0)	**32 (33)**
People	≥ 15			1 (3)	1 (1)	(0)	**2 (4)**
Statutory Compliance & Regulation	≥ 12		11 (10)	2 (3)	0 (0)	0 (0)	**13 (13)**
Finance	≥ 12		5 (5)	0 (0)	0 (0)	0 (0)	**5 (5)**
Reputation	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**
Infrastructure	≥ 15			(0)	1 (0)	0 (0)	**1(0)**
Information and Data	≥ 10	0 (0)	8 (8)	0 (0)	0 (0)	1 (0)	**9 (8)**
Systems and Partnerships	≥ 15			0 (0)	1 (1)	0 (0)	**1 (1)**

3.0 Summary of risks scoring 20 on corporate level register

There are no risks scoring 20 on the corporate level register

4.0 New risks to corporate level register scoring 16

None

5.0 New risks to corporate level register scoring 15

Risk id 657 current score 3 x 5 = 15. Safety risk. Relates to middle grade staffing gap in paediatrics and impact on provision of clinical care. Mitigation includes use of bank / agency staff, consultant cover. Process to recruit in place.

7.0 Recommendation

Risk management group members are asked to

- Review and discuss the contents of the corporate risk register

Author: Lisa Flack – Compliance and clinical effectiveness manager

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 April 2026

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 (April 2026)

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 March 2026. There are no changes to the risk scores this month except for BAF risk 5.1 – the score has been reduced from 16 to 12 to reflect progress against plan at M11. BAF Risk 5.2 is a new risk reflecting the revenue risk for 26/27 - 28/29 and a score of 16 has been assigned. This risk was developed following the discussion at Board in February and has been discussed at PAF in March and recommended to Board for approval. 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 the resources section of Diligent.
Recommendation:	The Board is asked to: - Approve the reduced score for BAF risk 5.1 - Approve the new risk – BAF Risk 5.2 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 March 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 5.1, 5.2 and 3.2 and BAF summary

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2025-26**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
5.1		**Finance - revenue 25/26:** 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 ERF funding has been agreed to be a block for 2025/26 linked to delivery of RTT performance by March 2026.	**Causes:** The main causes of risk are : (i) The current financial regime operates under predominantly 'block contract' arrangements in the main (c. 70% of activity). There is limited capacity for Commissioner contracts to be varied and we do not feel the current allocation recognises the full cost of delivering services e.g. growth in urgent care, coupled with an increasingly challenged primary care offer. Much of our improved financial delivery requires us to maximise the variable elective aspect of our financial plans and significantly improve productivity. (ii) Productivity remains a challenge for the Trust. (iii) Financial plans include a requirement to deliver CIPs which remain branded as Patient Quality and Productivity schemes (PQP). PQP programme is identified but delivery will be challenging; there the plans have been modelled against GIRFT opportunity and there remains a plan for delivering the full amount but it will be challenging to deliver savings at this level. (iv) The delivery of our financial position requires the support of the ICB / Place to redesign pathways, maximise flow etc. This requires a full disclosure of our collective financial position which to date, there has been no appetite to explore. We are endeavouring to move this forward and believe we have identified our structural deficit but need recognition at system level to tackle these issues. v) We have no assumptions for any lost activity and income relating to EHR or any impacts arising from Industrial Action which we will keep under review. vi) The proposed plan includes £15m of system efficiency which relies on support from the ICB/ICS to identify and deliver.	**4 X 5 = 20**	**Exec leads:** CFIO **Committee** : Performance and Finance Committee	Key Controls include : (i) Oversight of Directorates and their PQP programmes; the financial position is much better understood by all. We have undertaken a thorough budgeting approach this year and resolved a number of historic budgeting issues to ensure we can better manage the bottom line. (ii) Divisional / Corporate performance review meetings are in place and the emphasis on Performance Review as part of PQP Sessions is being further strengthened. (iii) Vacancy control groups are in place but will attract more scrutiny and oversight; linked to double and triple lock measures that are being mandated nationally. (iv) Oversight of the Trust's financial performance by the Executive Cabinet, Executive Board, PAF, People and Audit Committee. (v) Monthly monitoring of financial performance by HWE and NHSE through the submission of financial returns; [potential to move to a more challenging environment e.g. SOF4. (vi) Strengthening of financial control and governance including an improved governance process for business case investment approval process. The Business Case Group is being refreshed. (vii) The Financial Recovery Programme Board has been instigated at a system level and have been driving system recovery since 2024/25 and continued into 2025/26; plans are being developed that cross-cut at Place and System Level. (viii) Enhanced cash monitoring will be undertaken in year with more granularity on Capital Vs Revenue Cash. (x) New financial ledger (Oracle SBS) implemented which allows for better self service and oversight of individual positions.	(i) Performance review meetings - monitoring against plan and forecast, including reinvigorated Performance Review Meetings (PRM's). (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) PQP tracking including 'deep dives' by lead NED. (vi) Reductions in run rate evidenced alongside transformation initiatives.	Positive Assurances : (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial assurance rating on internal audit reports. iv) Monthly reports to PAF and IPR reporting v) A bottom up exercise is being undertaken to better understand the cost pressures driving the underlying position within the Trust. vi) The Trust is now more cognisant of the risks around financial delivery and actions are being taken to reduce run rates across all areas. vii) The position is being discussed with commissioners and regulators alike. viii) The system has now moved to a monthly cycle of meetings with NHSE chairing to oversee financial delivery within the Trust. ix) We are close to agreeing the year end system position following additional income being made available for sprint activity.	**4x3=12**	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning not fully triangulated with finances. (iii) PQP delivery plans established but being refined. (iv) Embedding management of temporary staffing costs and impact on the ground in light of clinical need. (v) We require the system to respond to our challenge to the underlying structural deficit across all healthcare provision within the system; we have not been able to progress this work to date. The move to Greater Essex has created further complication.	**Gaps in Assurance :** (i) Proposed financial regime for oversight to be confirmed (both system level and regional) (ii) Fully triangulated business and operational planning including demand and capacity plans. (iii) Business case benefits development and realisation process. (iv) Focus and prioritisation of finance across the wider gamut of challenges across the Trust. (v) Pace of change of delivery given other cultural challenges. (vi) Impact of EHR on ability to record data may lead to issues on recurrency of reporting.	18/03/2026	**Residual risk score reduced to 12**	**4 x 2 = 8 (Q4 25/26)**
			Effects: (i) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability. iii) May require additional external support in addition to prescribed system financed initiatives (above).							**ACTIONS:** (i) Transformational and modernisation work plans. (i) Demand and capacity planning and modelling underway				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2025-26**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
5.2		**Finance - revenue 26/27 - 28/29:** There is a risk that the Trust will not deliver its 2026/27 financial plan. There is a risk that non-delivery of the 2026/27 financial plan will move to an adverse cash position. The risk if non delivery of the plan is due to the scale and identification of the 26/27 PQP programme (£26.5m), productivity constraints against an ambitious elective programme, restricted income growth during EHR-related block contracting, and dependency on ICB/Place pathway redesign and Lead/Host Provider arrangements. There is a risk that if the Trust does not deliver the 2026/27 financial plan it potentially impacts on the organisations' medium to long-term financial sustainability. The plan submission for future years is breakeven. The longer term risk is that the recurrent deficit grows, reducing future investment opportunities, limiting strategic flexibility, and increasing the likelihood of regulatory intervention.	(i) The 2026/27 financial plan includes a requirement to deliver £26.5m of efficiencies plus a further £3.5m stretch via the Patient Quality and Productivity (PQP) programme. While opportunities have been identified, the programme does not yet comprise a fully developed and costed delivery plan across all schemes. Delivery is further constrained by the requirement to continue improving operational performance and maintaining quality. (ii) Productivity remains a challenge for the Trust. An ambitious Elective Programme has been agreed for 2026/27 to deliver national access standards; however, this requires significant improvement in productivity. (iii) Due to the impact of EHR we will enter into block arrangements for a period of time. While these will safeguards against data issues, the potential for growth in income is restricted. (iv) The delivery of our financial position requires the support of the ICB / Place to redesign pathways, maximise flow and enable contracts to be managed through lead/host provider delegations.	**4 X 5 = 20**	**Exec leads:** CFIO **Committee :** Performance and Finance Committee	Key controls include: (i) Trust-wide PQP governance arrangements with executive oversight and scheme-level tracking. (ii) Divisional / Corporate performance review meetings are in place along with an updated accountability framework. (iii) Oversight of the Trust's financial performance by Executive Cabinet, Executive Board, PAF, People and Audit Committees, Trust Board. This includes monthly forecasting, variance analysis and key KPI's. (iv) Vacancy control panel and non pay review panels are in place aligned to the NHSE Triple Lock process. (v) ERF block arrangement in place with shadow monitoring to track activity, income and data quality. (vi) Monthly monitoring of financial performance	Sources of Assurance: (i) Performance review meetings - monitoring against plan and forecast, including reinvigorated Performance Review Meetings (PRM's). (ii) PQP programme highlight reports and delivery trackers. Includes 'deep dives' and peer benchmarking. (iii) Internal audit reports / Head of Internal Audit Opinion (iv) External audit opinion (v) Cash management monitoring and adequate cash balances		**4 x4 = 16**	Gaps in control: (i) PQP schemes not yet fully identified, costed, owned and mobilised with consistent delivery trajectories. (ii) Restricted ability to generate additional income during block arrangement period. (iv) Reliance on external system partners for pathway redesign, corporate transformation and Lead / Host Provider delivery. (v) Limited financial headroom should material slippage occur early in the financial year.	Gaps in Assurance: (i) Limited assurance that productivity improvements can be delivered at the pace required alongside sustained operational pressures.	18/03/2026	**New risk**	**4 x 2 = 8 (Q4 26/27)**
			Effects: (I) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability. iii) May require additional external support in addition to prescribed system financed initiatives (above).							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling underway				

Risk Key														
Extreme Risk		15-25												
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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 arrarngemtns 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 iii) 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	01/03/2026	**Risk score to remain at 16.**	**4x3=12** **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,												

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	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	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	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	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	12	**16**	**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	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	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 2025/26 : 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 ERF funding has been agreed to be a block for 2025/26 linked to delivery of RTT performance by March 2026.	12	16	16	16	16	12		**Risk score reduced**	8	CFIO
5.2	Finance - revenue 26/27 - 28/29: There is a risk that the Trust will not deliver its 2026/27 financial plan. There is a risk that non-delivery of the 2026/27 financial plan will move to an adverse cash position. The risk if non delivery of the plan is due to the scale and identification of the 26/27 PQP programme (£26.5m), productivity constraints against an ambitious elective programme, restricted income growth during EHR-related block contracting, and dependency on ICB/Place pathway redesign and Lead/Host Provider arrangements. There is a risk that if the Trust does not deliver the 2026/27 financial plan it potentially impacts on the organisations' medium to long-term financial sustainability. The plan submission for future years is breakeven.						NEW RISK 16		**NEW RISK**	8	CFIO

Board Assurance Framework Summary 2025.26

	The longer-term risk is that the recurrent deficit grows, reducing future investment opportunities, limiting strategic flexibility, and increasing the likelihood of regulatory intervention.										

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 M11 Integrated Performance Report	Y	Y	N	Metrics with **concerning** variations at M11 are: Complaints, ED Admitted Percentage, ED Non-Admitted Percentage, Capital Spend, Diagnostic Times (patients seen within 6 weeks) and Mortality (SHMI). Metrics showing an **improving** variation are: Voluntary Staff Turnover, CTG Training Compliance (midwives), Bank Spend, Mental Health Patient Incidents, C-diff Hospital Onset Cases, Friend & Family Test, Statutory/Mandatory Training, Appointment Slot Issues and PQP. QSC requested further assurance on the actions underway to improve the 62 day Cancer performance. Handover 45 was also discussed and the committee requested further assurance at a future meeting on the impact on patients.
2.2 Access Report	Y	Y	N	QSC noted sustained pressures across RTT, cancer, urgent care and diagnostics pathways, alongside key risks linked to reporting readiness and validation activity, all of which may influence delivery trajectories through Q4.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 Infection Prevention & Control Updates	Y	Y	N	<u>Bi-Monthly IPC Update</u> QSC noted key headlines including: • C. difficile: Higher-than-usual cases (7 HOHA, 5 COHA) but rates remain below EoE average • Respiratory viruses: Influenza A surge managed without winter surge plan activation. Two outbreaks in January (gastroenteritis on Lister; flu on Tye Green) contained effectively. • Meningococcal outbreak: Linked to University of Kent; Trust IMT convened • Ward decant/refurbishment programme, including Winter ward legionella remedial works, to recommence in April (to include Locke, Winter and Ray wards). • Legionella isolated in new CDC (four outlets) – point of use filters installed, regular flushing and remedial works on-going.
3.2 CQC Update	Y	Y	N	Key headlines:

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Live inspection period has now concluded. • No immediate regulatory action is required. • Action plan oversight via QCIG. • Awaiting final report for core services and well-led where new rating will be recorded.
3.3 Learning from Deaths Update	Y	Y	N	Key headlines: • Uncoded activity is negatively affecting SMR and HSMR indicators. • Quality of coding remains a focus of improvement. • No care or service delivery problems identified on reviews of patients who have died.
3.4 Patient Safety & Quality Update	Y	Y	N	Key headlines: • 1078 incidents reported during February 2026, 528 (52%) have been closed. 99% are no/minor harms and 1% moderate graded harms. • 1,456 total open incidents, with 685 (47%) open >30 working days; 387 of these are patient safety incidents. • 19 open severe harm cases and 6 open deaths remain under investigation. • 9 PSII's remain under investigation. • Seven claims closed including one high value claim of £1,500,000.

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
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DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Eight new inquests received and three inquests closed. • Clinical Audit Policy published in line with Internal audit recommendations. • Quality account audits 11 remain outstanding. • Quality account recommendations 74 remain not assessed. • NICE implementation 140 overdue review. • Challenges with NCEPOD due to case note submission
3.5 Update on 'Waiting Well' Initiative	Y	Y	N	The Waiting Well programme will introduce approaches to improve transparency on waiting times and enable patients to access timely information about their pathway.
3.6 Patient Experience 4 Monthly Update	Y	Y	N	Key headlines for Q3/Q4: • The number of formal complaints being received remains at a high level (55% higher than in 2024/25). • The highest number of formal complaints received are for Women's Services (30%) and Orthopaedics (11%). • Communication issues feature in 16% of formal complaints and 24% of PALS concerns. • 52% of our formal complaints are resolved within the 60 working day target date.

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Recovery plans are in place within the divisions to address their formal complaint and PALS backlogs, and achievement of resolution targets. • 80% of inpatients rate their experience as good or very good. QSC requested a deep dive into complaints in the FDC Division which will be discussed at the Patient Experience Group and QSCII.
3.7 Update from Patient Panel	Y	Y	N	Key headlines: • Successful recent public engagement meeting. • New contact telephone number for the Patient Panel. • Patient Panel recipient of an Amazing people Award.
3.8 Review of BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	BAF Risk 1.1 (Clinical Outcomes) is being updated to ensure that risks and controls are current. A working group is developing an updated risk assessment. QSC received a summary of the most recent workgroup meeting including a timeline for next steps. In line with the recommendation it was agreed that the risk score would remain at 16.

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 Reports from Feeder Groups	Y	Y	N	There were no escalations from the following groups: • Patient Safety Group • Clinical Effectiveness Group • Vulnerable People Group • Patient Experience Group
4.2 HWE Place – Quality & Safety Update				Key headlines from the meeting of WEHCP Quality & Transformation Group on 12.02.26: • Progress noted on the first year of the 3 year integrated delivery plan along with details of the second year priorities and re-framing of the plan to the WE Neighbourhood Transformation Plan. Draft outcome metrics were also detailed. • Review/recommendation of four business cases for approval through the HCP & ICB governance processes.

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2 April 2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**27.03.26**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Receipt of a report on Frailty Services in West Essex from Healthwatch. • Details of the 5 open risks presented - none are over 12. Two new risks are being drafted, out of hours emergency eye services and risks associated with the transition from HWE to Essex ICB.
4.3 Horizon Scanning Update				QSC noted the following information: • Death following a Hospital Acquired Infection – good practice guidance on infection control practices • Outbreak of meningococcal disease linked to University of Kent and the area of Canterbury – awareness of situation.

BOARD OF DIRECTORS:	**Trust Board 02.04.2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ben Molyneux, Committee Chair/ Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**27 March 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: • Smoking at delivery reported at 5.4% and described as a positive improvement against national expectations • Early booking improved to ~85% (above national average but below the national target referenced as ~90%). • Stillbirth rate reported as above target (3.14 per 1,000), with two cases in February under investigation • Preterm birth above target (reported 7.7% vs target <6%), with a plan to job-plan a consultant lead for prevention/optimisation work • Triage performance (15-minute standard) remains a persistent challenge; recruitment and capacity constraints noted, with expected improvement from July. The Committee asked for further assurance on actions being taken to meet the trajectory. • Health inequalities identified as a consistent theme (particularly in stillbirth and early booking), with planned updates through the inequalities paper. • Obstetric Anal Sphincter Injury (OASI) remains above benchmark; there are plans to job-plan a pelvic floor gynaecology lead to oversee prevention and postnatal management, embedded in the consultant job planning cycle leadership.
2.2 Maternity Monthly Report	Y	Y	N	Highlights included: • Targeted listening events with ethnic minority service users with improved engagement and positive feedback • Leadership engagement through a Band 7/8 away day to embed the Trust-wide RISE strategy into maternity improvement planning. • Staff recognition/retirement celebration and strong presence at a Quality Improvement showcase, including improvements in birth reflections pathway and neonatal admission pathway. • Commitment to develop and bring back a maternity strategy using RISE, including stakeholder engagement.

BOARD OF DIRECTORS:	**Trust Board 02.04.2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ben Molyneux, Committee Chair/ Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**27 March 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	Y	N	The home birth paper was presented as an assurance update rather than a full strategy, pending national and regional work commencing later in the year. Current focus remains on ensuring safe provision, updating guidance to address identified gaps, and continuing work on staffing and service models. A full strategic position will be brought back once wider alignment is clearer.
2.4 Health Inequalities	Y	Y	N	The health inequalities update reinforced that this work is embedded across all maternity activity, with a focus on women at highest risk of poor outcomes. Continuity of carer and pregnancy and parenting circle models were highlighted as key strengths, with PAH recognised nationally for leadership in group care. However, the Committee raised concern regarding poor MSDS data quality, which limits assurance and population health insight. An update on digital and BI support requirements was requested for May.
2.5 Culture Update	Y	Y	N	The culture update provided assurance on a broad programme of work, including civility and active bystander training and the mandating of Birthrights training for maternity staff. Early delivery has begun, supported by external culture facilitation. Further work is planned to strengthen real-time feedback mechanisms and triangulate staff and patient experience. Links were made to emerging themes from complaints and patient experience work, which will be explored further.
2.6 Maternity Patient Safety Incidents (MPSIs) Update	Y	Y	N	There are currently three ongoing maternity patient safety incident investigations, with all showing good progress and clear action plans being developed. There was one new maternity PSII declared in February 2026. Internal PSII – 1. One closed in March 2026 MNSI - 2
2.8 Maternity Safety Champions Update	Y	N	N	The Maternity Safety Champions report was received and noted, with appreciation expressed for the impact of walkabouts and engagement across maternity and neonatal services. Key themes, particularly triage and culture, were reflected elsewhere in the agenda.

BOARD OF DIRECTORS:	**Trust Board 02.04.2026**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ben Molyneux, Committee Chair/ Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**27 March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Any Other Business	Y	N	N	Under any other business, the Committee endorsed a time-critical bid to NHS Resolution for transformation funding to address repeated challenges with the Perinatal Mortality Review Tool. This would support a more holistic redesign of the process rather than continued ad-hoc responses. The substantive appointment of the Deputy Director of Midwifery was also welcomed.

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Trust Board (Public) – 2 April 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:	19/03/2026							
Subject / title:	Overview of Patient Safety Incidents within maternity services (March 2026 summary)							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues:	There was one new maternity PSII declared in February 2026. There have been no closures in February 2026. Maternity services currently have 3 PSII investigations ongoing: Internal PSII – 1: one closed to PSIAP March 2026 MNSI - 2							
Recommendation:	To provide assurance to QSCII 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		X

Previously considered by:	FDC Governance FDC Divisional Board PSG (Feb 2026) and QSCII.27.03.26
Risk / links with the BAF:	BAF 1.1 Clinical Outcomes
Legislation, regulatory, equality, diversity and dignity:	Ockenden Report (2022) Three Year Delivery Plan for Maternity and Neonatal Services (2023) Maternity (and perinatal) Incentive Scheme Year 7 (2025) Perinatal quality oversight model (2025)
Appendices:	1. Open Patient Safety Incident Investigations under investigation

The Princess Alexandra Hospital NHS Trust

1.0 Purpose

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

2.0 Background

The Ockenden Report (2022) recommended that all maternity Serious Incidents (SIs) reports and a summary of the key issues are shared with Trust boards. This is similarly reflected in MIS Year 7 safety actions 9 and 10. With the implementation of PSIRF the service will continue this practice by reporting Patient Safety Incident Investigations.

3.0 Analysis

Maternity currently have four open PSIIs. Learning actions have been completed and are in progress for the three older investigations.

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 accept the report with the information provided and the ongoing work with the investigation process.

Author: Emma Rose, Head of Women's Health Governance & Assurance
Date: 19/03/2026

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 April 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:	March 2026
Subject / title:	Safe Staffing Monthly report – February 2026

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 mid-year nursing establishment review is in progress. • The Maternity birth rate-plus recommendations and Neonatal BAPM recommendations are being presented at People Committee in May 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:	PC.30.03.26
Risk / links with the BAF:	n/a
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Ward and divisional fill rates by month against adjusted standard planned template. **Appendix 2**: Ward and divisional CHPPD data **Appendix 3:** Nursing red flags **Appendix 4:** Nursing quality indicators

The Princess Alexandra Hospital NHS Trust

Executive Summary

Safe staffing was maintained in February 2026 with reasonable assurance. Registered nurse fill rates improved to an average of 101.9%, with overall staffing fill reaching 106.2%, and no wards recording an average fill rate below the 75% threshold. Care Hours Per Patient Day (CHPPD) increased to 8.2, reflecting improved registered staffing input, though levels remain below the national median benchmark.

Quality indicators showed continued improvement, with total inpatient falls reducing to 65 and reportable hospital-acquired pressure ulcers decreasing to 31. Complaints and PALS activity remained broadly consistent with January and continued to be concentrated in high-acuity areas, while compliment capture improved slightly but remains inconsistent.

A sustained volume of Nursing Red Flags continued to be reported; however, the majority remain unactioned within SafeCare, limiting assurance on whether risks were mitigated at the point of escalation. Enhanced Care (ETOC) remains the most significant workforce risk due to the absence of a substantive establishment and ongoing reliance on temporary staffing.

Overall judgement: Overall, staffing in February was safe and demonstrated improving resilience. However, assurance continues to be constrained by enhanced care pressures and inconsistent Red Flag closure, reinforcing the need for strengthened governance and continued executive oversight.

1.0 Introduction

This report outlines nursing and midwifery staffing deployment at PAHT during February 2026, demonstrating how safe staffing levels were achieved and maintained. It also sets out governance and workforce management arrangements supporting this position.

2.0 Background

Monthly staffing data is reviewed against expected levels and quality indicators in line with National Quality Board (NQB, 2016) guidance. The Trust remains committed to identifying improvements, addressing risks promptly, and sustaining high-quality patient care.

3.0 Inpatient Wards Fill Rate and Redeployment

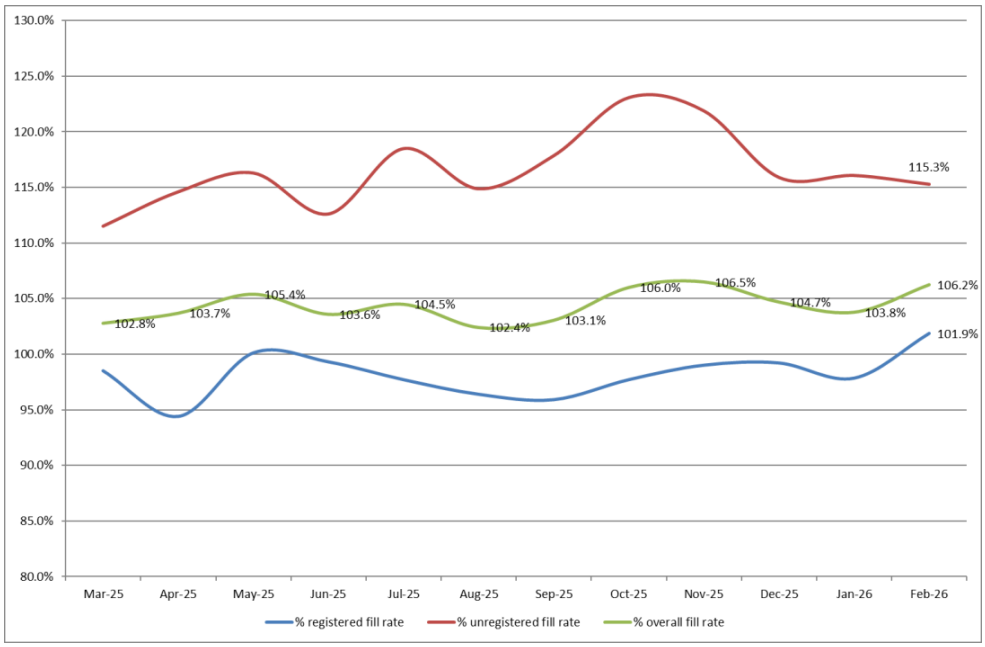
The Trust's safer staffing submission for February 2026 was submitted to NHS Digital within the required data submission timeframe. Table 1 presents a summary of the overall fill rate for the month, while Table 2 provides the overall fill rate percentages across a rolling 12-month period.

Table 1. Overall fill rate

Average day fill rate - registered nurses/mid wives	Average day fill rate - care staff	Average night fill rate - registered nurses/mid wives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
101.7%	104.2%	102.0%	128.5%	101.9%	115.3%	106.2%

The Princess Alexandra Hospital NHS Trust

Table 2. Inpatient fill rate including Maternity Wards Trend



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

Trust wide – Recruitment activity remained positive in February 2026, with 7 registered nurses and midwives and 7 healthcare support workers joining the Trust. Further recruitment events are planned for Spring and Summer 2026, including targeted events for newly qualified graduates and a rolling programme of HCSW recruitment, with the first event well attended.

The end-of-year establishment review, covering adult and paediatric inpatient wards, assessment units and Emergency Departments, was approved by the Board in February 2026. A Mid-Year establishment review will commence from 2 March 2026 to further assess acuity-driven pressures, including those identified through CHPPD benchmarking and enhanced care demand, and will inform future roster templates.

John Snow Ward – Apparent low HCSW fill rates reflect a template mismatch rather than unmet staffing, with the ward consistently staffed to one HCSW per shift, which is fully delivered. The HCSW establishment will reduce accordingly from May 2026 following formal review through the September 2025 SNCT submission.

Maternity – Registered midwife fill rates improved across the division in February, though some areas remain amber due to vacancies and sickness absence. Twice-weekly staffing reviews and deployment adjustments continue to support safe staffing, overseen by matrons and specialist midwives.

Emergency Departments – Although Emergency Departments are excluded from national safer staffing reporting, local Adult and Paediatric ED data continues to be reported for assurance purposes **(Appendix 1, Tables 1b and 1c)**. Both departments maintained stable overall and registered nurse fill rates in February. However, Paediatric ED experienced a further approximate 3% reduction in HCSW fill, highlighting ongoing fragility.

Enhanced Care – Enhanced care demand remains structurally misaligned with the current workforce model, with registered ETOC hours continuing to rely on temporary staffing and no

substantive registered establishment aligned to this activity. Historically, unregistered enhanced care hours have been partially unmet and absorbed by substantive ward teams, resulting in internal workforce displacement and increased workload intensity, with implications for operational resilience and staff wellbeing **(Appendix 1, Table 1d).**

In February 2026, the Board approved an increase to the substantive unregistered ETOC establishment, providing a mechanism to reduce reliance on bank staffing and associated cost pressures (noting that agency usage applies only to registered staff). A Task and Finish Group has been established, with agreed terms of reference, to oversee delivery of a sustainable enhanced care workforce model.

Actions – The Task and Finish Group will finalise and implement a sustainable ETOC model, including recruitment planning for the unregistered ETOC workforce, transition towards substantive capacity, strengthened governance around request, approval and closure processes, and reduced reliance on bank staffing through clearer risk criteria, training and improved rostering.

3.1 Wards with < 75% average fill rate

No wards recorded an average fill rate below 75% during February 2026.

3.2 Wards with > 100% average fill rate

Harvey and Saunders fill rates remain over 100% for registered staff during February 2026 because of needing prolonged registered mental health nurses and is therefore not concerning.

4.0 Redeployment

Appendix 2 outlines the data and trends for this month.

Redeployment continued to support safe staffing through daily safety huddles and real-time acuity review. In February 2026, substantive redeployment increased to 1.43% of total hours worked (January: 1.17%); however, overall redeployment reduced to 1.75% (January: 1.99%), indicating improved baseline staffing availability.

An emerging feature was the redeployment of 409 hours to the Site Management and Patient Flow Team, primarily to support discharge lounge activity and temporary escalation spaces, reflecting system flow mitigation rather than ward-level staffing shortfalls. John Snow Ward remained the largest net giver of staff, while the Adult Emergency Department continued to be the largest net receiver. All redeployments were clinically risk-assessed and governed through daily safety huddles and SafeCare.

5.0 Care Hours Per Patient Day (CHPPD)

CHPPD measures staffing input rather than patient need. It is a simple calculation based on staff hours worked and patient numbers and does not account for skill mix, acuity or dependency. As such, it reflects the estimated care time available, not the level of care required, and should be considered alongside fill rates, acuity indicators, Red Flags and quality outcomes for assurance.

Appendix 3 provides the ward and divisional CHPPD breakdown and a planned versus actual comparison to identify areas where staffing deployment may not align with demand.

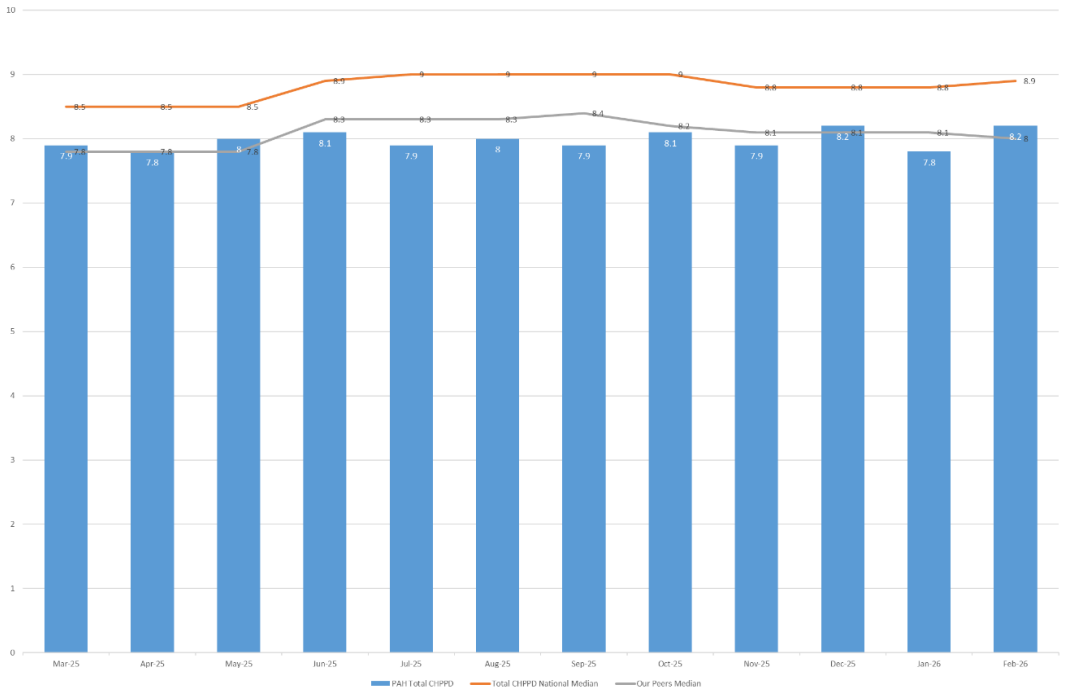
Variance between planned and actual CHPPD during February reflects changes in patient dependency and periods of enhanced care demand rather than patient numbers, as shown in **Table 2** for AAU, Nightingale and John Snow, with staffing flexed, often through bank unregistered hours, to maintain safety.

Table 3. Overall Care Hours Per Patient Day (CHPPD) February 2026

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.3	2.9	8.2

Appendix 3 provides a detailed breakdown of CHPPD by ward and division for February 2026.

Table 4. CHPPD Trend and benchmarking with peer and national data



Peer organisations are: East and North Hertfordshire NHS Trust and West Hertfordshire Teaching Hospitals NHS Trust. The Trust's CHPPD remains similar to peers but below national median benchmarks. The value has increased in February 2026.

6.0 Quality Indicators

6.1 Red Flags and Incident Reports Relating to Staffing

Appendix 4 outlines data and trends for Nursing Red Flags and staffing-related incidents.

Two distinct Red Flag mechanisms are used within the Trust. Automatic Red Flags, generated through the national safer staffing dataset when registered staffing falls below 75% of template, reduced in February compared to January, indicating improved compliance with minimum staffing thresholds. Locally raised Red Flags, recorded via SafeCare to reflect real-time operational risk, include the six NICE (2014) indicators alongside two locally agreed flags: inability to provide enhanced care and, from February, shortfall of unregistered (HCSW) staffing. These SafeCare Red Flags continued to relate predominantly to registered nurse shortfalls and enhanced care demand within high-acuity areas.

While reporting remains consistent, the majority of SafeCare Red Flags remain unactioned or unresolved, limiting assurance that risks were mitigated at the point of escalation and constraining ward-to-board visibility. Oversight continues through daily safety huddles, supported by local leadership and development programmes. Staffing-related incidents reported via Datix remained

broadly consistent with January and provide complementary assurance alongside Red Flag and redeployment data.

6.2 Falls, pressure ulcers and complaints, PALS and compliments

February data demonstrates overall improvement across several quality indicators, though variation remains in areas of sustained acuity.

Falls reduced to 65 (January: 76), with unwitnessed falls continuing to decrease and falls resulting in harm reducing to 17. Falls activity remained concentrated within a small number of wards, with targeted support and training ongoing. Mandatory training compliance remains high (>97%).

Pressure ulcers reduced to 31 (January: 40), although skin integrity concerns continue to require close oversight. Pressure ulcer activity remains concentrated within a small number of wards, with enhanced surveillance and strengthened tissue viability governance in place.

Patient experience broadly stable. Complaints increased marginally to 28, while PALS contacts reduced to 74, with recurring themes of delays and communication, predominantly within Emergency and other high-acuity areas. Compliment capture improved to 6, though remains inconsistent and continues to limit opportunities to share positive feedback.

Overall, quality indicators in February show signs of improvement; however, fragility persists in areas experiencing sustained acuity and enhanced care demand. Continued leadership oversight and triangulation of staffing, acuity and quality data remain essential to embedding improvement.

Data and trends of quality indicators is provided in **Appendix 5.**

7.0 Conclusion: Assurance and Governance

The Trust maintained a sustained registered nurse fill rate above 95% in February, with further improvement in overall staffing resilience, providing assurance that nursing and midwifery staffing levels remained safe. However, acuity-driven pressures persist, particularly in relation to enhanced care demand, continuing to challenge workforce sustainability and requiring active mitigation.

Throughout February, staffing risks were managed through established governance controls, including daily SafeCare huddles and real-time acuity review, senior clinical oversight in high-risk areas, and proportionate use of temporary staffing where required. Redeployment remained a key mitigation, with increased use of substantive staff alongside reduced overall redeployment, indicating improved baseline staffing availability.

Red Flag, CHPPD, redeployment and quality data were reviewed in combination to support ward-to-board assurance. While improvements are evident across several indicators, inconsistent actioning and closure of SafeCare Red Flags continues to constrain assurance on real-time risk mitigation, reinforcing the need for strengthened governance and continued executive oversight.

8.0 Recommendation

The Board is asked to note the contents of this report, which provide assurance on the management and mitigation of nursing and midwifery staffing risks during February 2026, and to support continued focus on strengthened governance arrangements for enhanced care delivery and Red Flag assurance.

The Princess Alexandra Hospital NHS Trust

Appendix 1: Fill Rates

Table 1a: Ward level data – fill rates February 2026 *(Adjusted Standard Planned Ward Demand)*

>100%	95 – 100%	75-95%	<75%

	Day		Night				
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**% Registered overall fill rate**	**% HCSW overall fill rate**	**% Overall fill rate**
Harvey	117.4%	134.9%	134.6%	151.8%	124.4%	143.0%	131.1%
Henry Moore	92.9%	93.9%	129.7%	101.2%	106.7%	97.4%	102.8%
ITU & HDU	92.3%	101.4%	99.7%	119.5%	96.0%	110.1%	97.2%
John Snow	112.3%	68.9%	96.9%	51.2%	104.9%	60.5%	90.1%
Penn	105.7%	111.1%	99.1%	167.5%	102.9%	132.5%	113.5%
Saunders	106.8%	110.0%	124.4%	176.3%	113.4%	135.2%	121.6%
Planned Pathways Total	***101.5%***	***106.6%***	***110.3%***	***133.2%***	***105.4%***	***118.2%***	***109.2%***
Fleming	95.4%	83.7%	100.9%	103.4%	97.8%	93.1%	96.3%
Harold	96.6%	104.5%	101.2%	127.3%	98.6%	115.4%	103.9%
Kingsmoor	96.7%	113.0%	102.5%	153.8%	98.9%	132.5%	111.4%
Lister	101.8%	110.5%	98.3%	128.5%	100.3%	119.1%	107.8%
Locke	104.5%	107.0%	100.0%	137.7%	102.6%	121.7%	110.2%
Nightingale	125.2%	60.7%	100.0%	96.4%	113.2%	77.8%	95.5%
Opal	124.5%	126.7%	99.1%	138.8%	112.3%	132.5%	120.4%
Ray	106.5%	95.1%	105.4%	172.5%	106.0%	124.4%	112.6%
Tye Green	99.3%	104.8%	95.8%	144.1%	97.7%	120.8%	106.7%
Winter	103.5%	115.5%	99.9%	144.9%	102.0%	129.6%	113.0%
AAU	94.0%	156.7%	102.3%	157.5%	97.7%	157.1%	110.2%
Charnley	96.7%	169.9%	97.1%	187.0%	96.9%	178.1%	120.1%
Integrated Emergency and Medical Pathways Total	***101.1%***	***111.0%***	***100.3%***	***140.7%***	***100.7%***	***124.7%***	***109.2%***
Birthing	107.3%	95.1%	95.6%	92.9%	101.7%	94.0%	99.1%
Chamberlen	101.9%	66.2%	101.6%	82.1%	101.7%	73.8%	94.8%
Dolphin	96.8%	62.2%	98.9%	97.8%	97.7%	74.1%	91.8%
Labour	105.0%	82.9%	93.2%	78.6%	99.3%	80.8%	95.2%
Neo-Natal Unit	103.3%	96.4%	98.6%	82.1%	101.0%	89.3%	99.0%
Samson	110.8%	86.3%	95.2%	90.2%	103.4%	88.2%	94.7%
Family, Diagnostics and community Total	***103.6%***	***81.3%***	***96.8%***	***87.3%***	***100.4%***	***84.1%***	***95.5%***
Total	***101.7%***	***104.2%***	***102.0%***	***128.5%***	***101.9%***	***115.3%***	***106.2%***

Table 1b: ED data – fill rates February 2026 *(Standard Planned Demand)*

Average day fill rate - registered nurses/midwives	Average day fill rate - care staff	Average night fill rate - registered nurses/midwives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
111.0%	100.3%	116.6%	120.7%	113.5%	109.4%	112.2%

Table 1c: Paediatric ED data – fill rates February 2026 *(Standard Planned Demand)*

Average day fill rate - registered nurses/midwives	Average day fill rate - care staff	Average night fill rate - registered nurses/midwives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
128.0%	51.5%	139.1%	86.9%	132.9%	69.2%	113.3%

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Table 1d: Enhanced Care Data Demand Vs. Fill Rates February 2026

Registered	Hours
Overall number of ETOC hours provided in month	1313
Number of ETOC hours provided by **substantive staff**	0
Number of ETOC hours provided by **bank staff**	1313
Number of ETOC hours provided by **agency staff**	0
Number of unfilled hours for staff relating to ETOC	0
Unregistered	
Overall number of ETOC hours provided in month	7388
Number of ETOC hours provided by **substantive staff**	774.5
Number of ETOC hours provided by **bank staff**	6614
Number of ETOC hours provided by **agency staff**	0
Number of unfilled hours for staff relating to ETOC	9600

Appendix 2: Redeployment and trend data

Table 1. Hours of substantive staff redeployed Feb-26

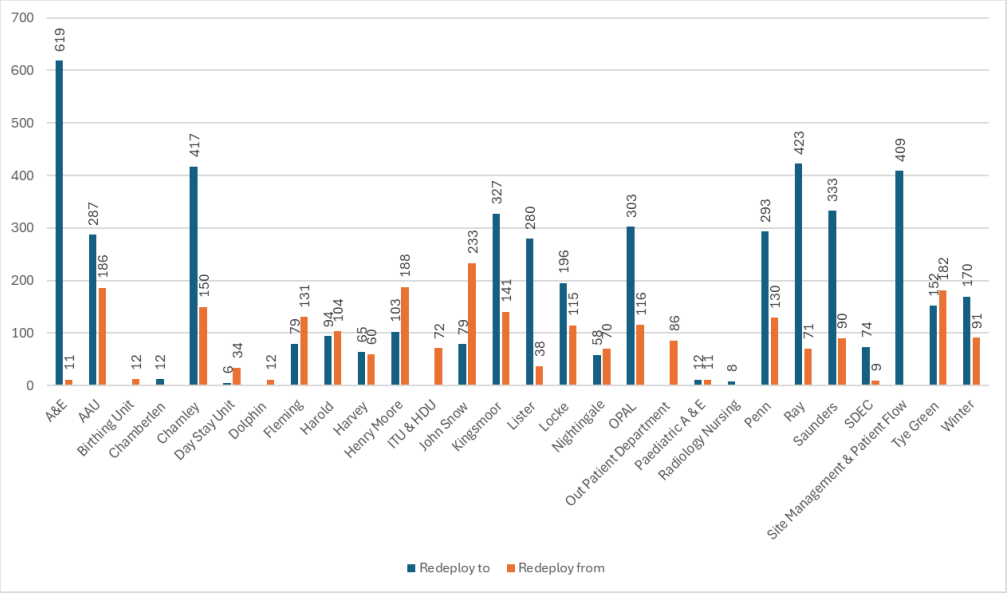

Table 2. Substantive staff redeployment ocasions trend Mar-25 – Feb-26

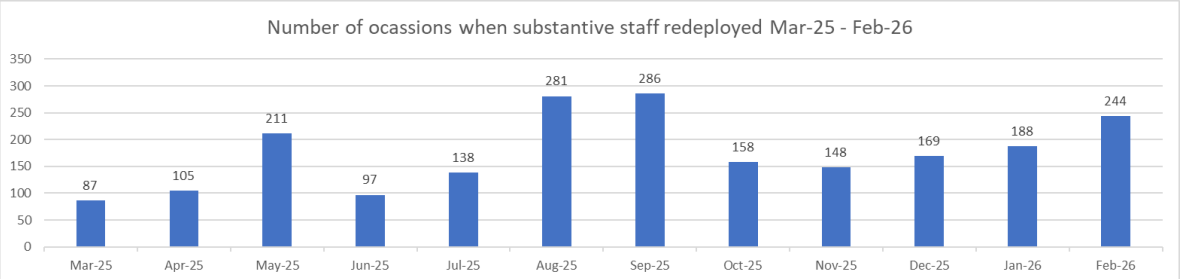

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Table 3. % of substantive staff redeployed as % of total hours worked

Substantive staff hours redeployed	Total hours worked (inc. bank and agency)	% of total hours worked / substantive staff redeployed
1914	133842	1.43% (Jan - 1.17%)

Table 4. % of staff redeployed as % of total hours worked

All staff hours redeployed (including bank and agency but excluding Enhanced Care Team, Bank Pool and Rapid Response Pool)	Total hours worked (inc. bank and agency)	% of total hours worked / staff redeployed (including bank and agency but excluding Enhanced Care Team, Bank Pool and Rapid Response Pool)
2338.41	133842	1.75% (Jan - 1.99%)

Appendix 3: CHPPD

Table 1. Ward level data: CHPPD February 2026

Care Hours Per Patient Day (CHPPD)			
Ward/Unit	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total	5.3	2.9	8.2
Harvey	5.1	3.3	8.5
Henry Moore	3.9	2.5	6.4
ITU & HDU	18.5	2.1	20.6
John Snow	6.0	1.7	7.7
Penn	3.9	2.8	6.7
Saunders	4.0	2.9	6.9
Planned Pathways Total	5.7	2.7	8.4
Fleming	3.9	1.7	5.6
Harold	4.7	2.5	7.2
Kingsmoor	3.6	2.9	6.5
Lister	3.8	3.0	6.8
Locke	3.8	3.0	6.9
Nightingale	3.9	2.7	6.6
Opal	4.9	3.8	8.7
Ray	4.0	2.6	6.5
Tye Green	4.1	3.2	7.2
Winter	3.8	3.2	7.0
AAU	6.3	2.7	9.0
Charnley	4.2	3.1	7.3
Integrated Emergency and Medical Pathways Total	4.2	2.8	7.1
Birthing Unit	17.9	8.3	26.2
Chamberlen	7.9	1.9	9.8
Dolphin	9.9	2.5	12.4
Labour	24.9	5.8	30.7
Neo-Natal	13.6	2.4	16.0
Samson	3.6	4.1	7.8
Family, Diagnostics and community Total	10.1	3.6	13.7

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Table 2. Planned Vs. Actual CHPPD needs 1.2.26 – 28.2.26

John Snow

AAU

Nightingale

The Princess Alexandra Hospital NHS Trust

Appendix 4. Nursing Red Flags (NICE 2014), Incident Reports and Trend Data

Box 2: Nursing red flags

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach.
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Note: other red flag events may be agreed locally.

Staffing Red Flags and Trend Data

Table 1. Occasions when registered staffing fell below 75% of standard template Feb-26

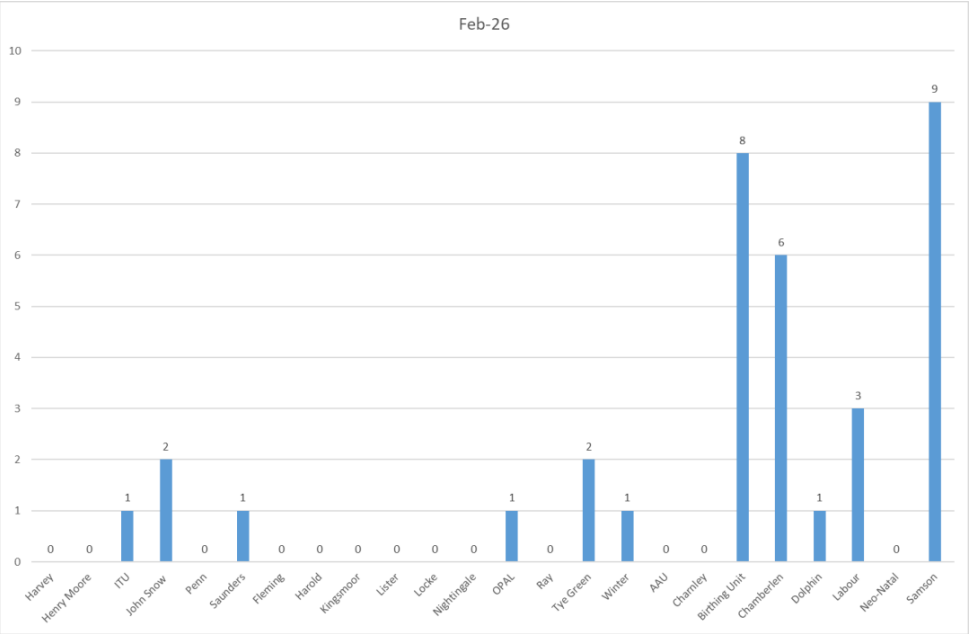

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Table 2a. Occasions when all registered staffing fell below 75% of standard template. Trend Data Mar-25 – Feb-26

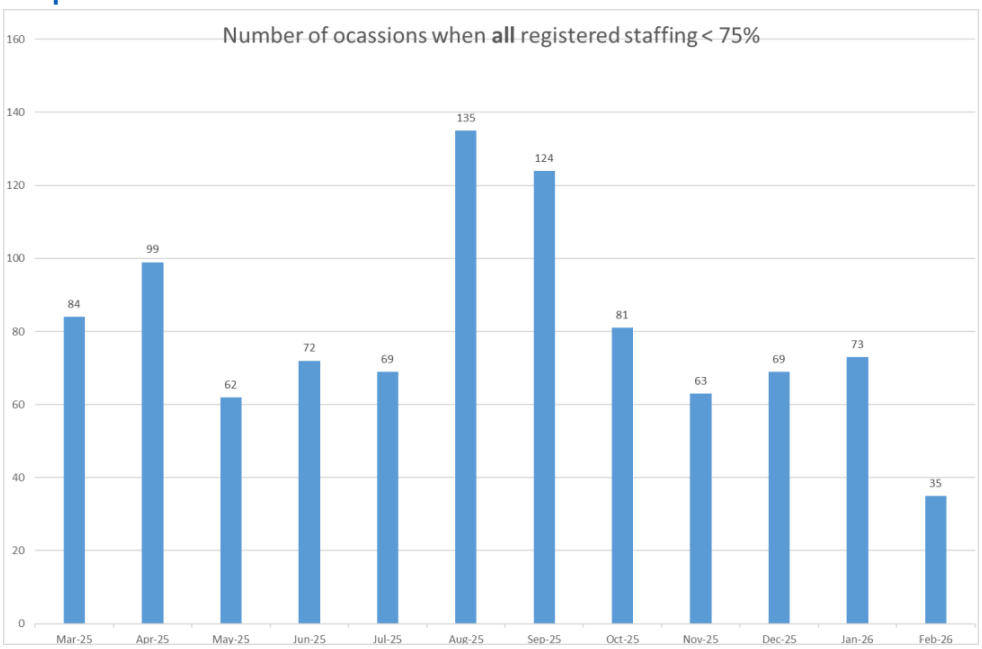

Table 2b. Occasions when registered maternity staffing fell below 75% of standard template. Trend Data Jan-25 – Feb-26

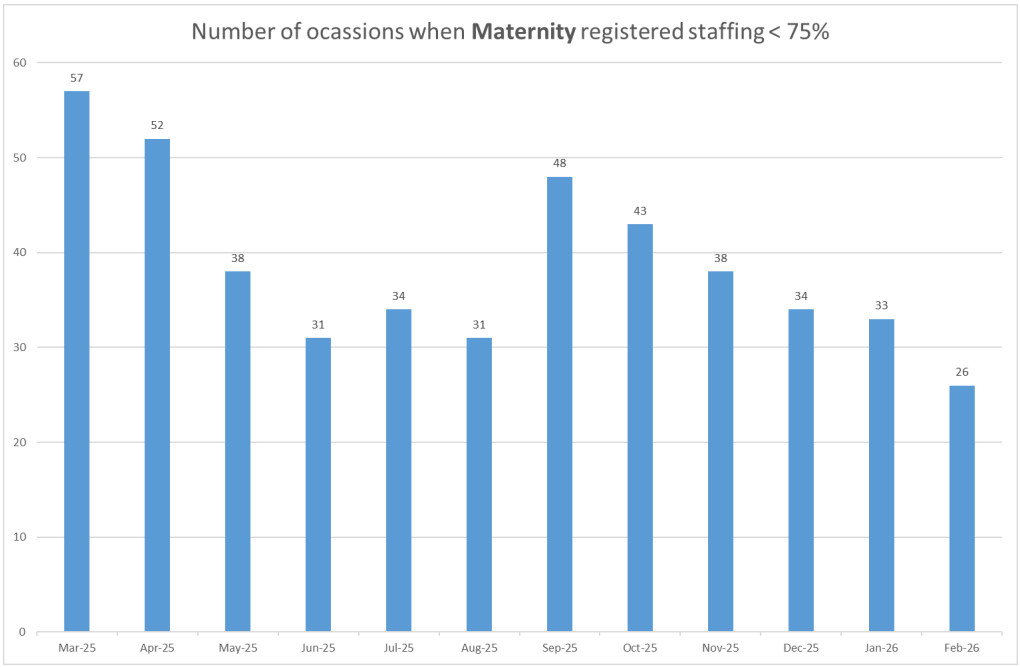

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Table 3a. Red Flags raised via SafeCare Feb-26

Row Labels	Delay in providing pain relief	Less than 2 RNs on shift	Missed 'intentional rounding'	Shortfall in RN time	Shortfall Unregistered time	Unable to provide Enhanced Care	Grand Total
A&E Nursing		1				3	4
AAU		1	1	3	1	3	9
Charnley Ward				2		4	6
Fleming Ward				1		1	2
Harold Ward						1	1
Harvey Ward				1		5	6
Kingsmoor General				1		1	2
Locke Ward		1		11	1	5	18
OPAL Unit		1		3		2	6
Penn Ward				3	1	3	7
Ray Ward				1		4	5
Saunders Unit	1			7		11	19
SDEC				4			4
Tye Green Ward	1		5	12	3	19	40
Winter Ward						1	1
Grand Total	**2**	**4**	**6**	**49**	**6**	**63**	**130**

Table 3b. Red Flags raised via SafeCare trend Mar-25 – Feb-26

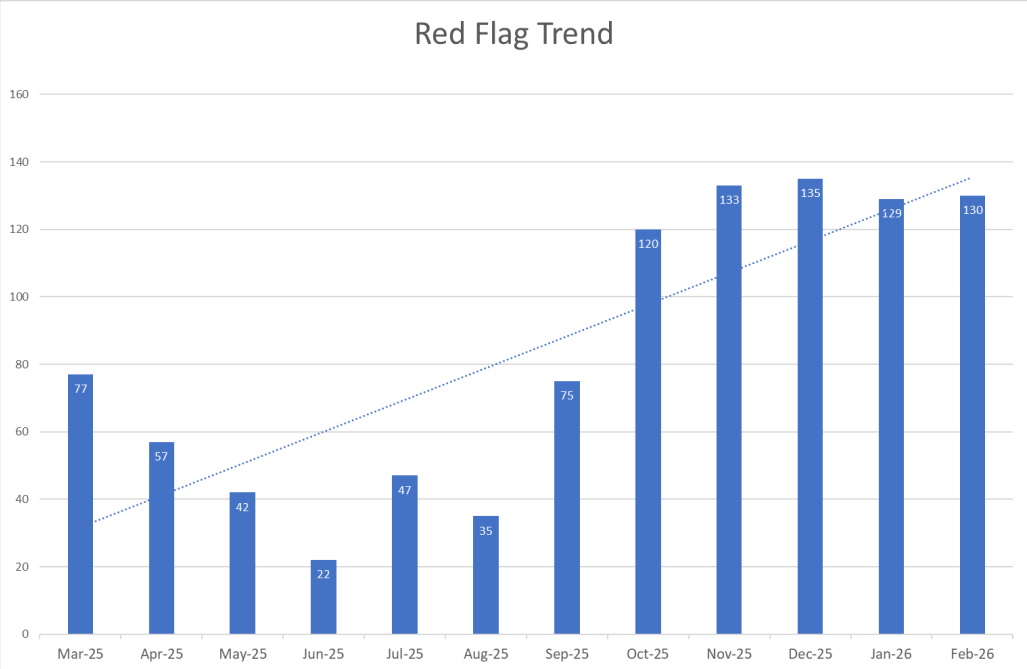

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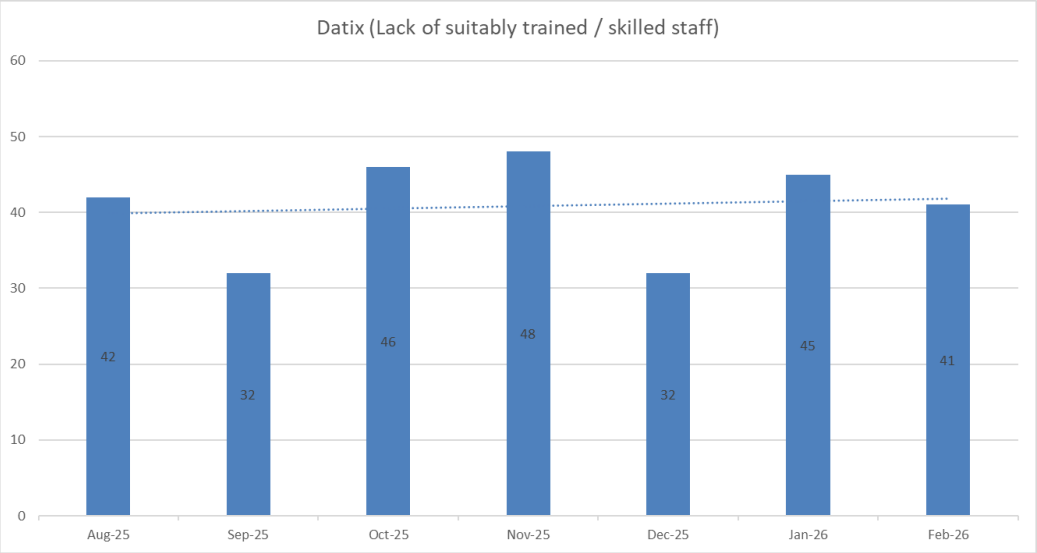
Table 3c. Datix for lack of suitably trained / skilled staff Aug-25 – Feb-26



Appendix 5: Nursing quality indicators

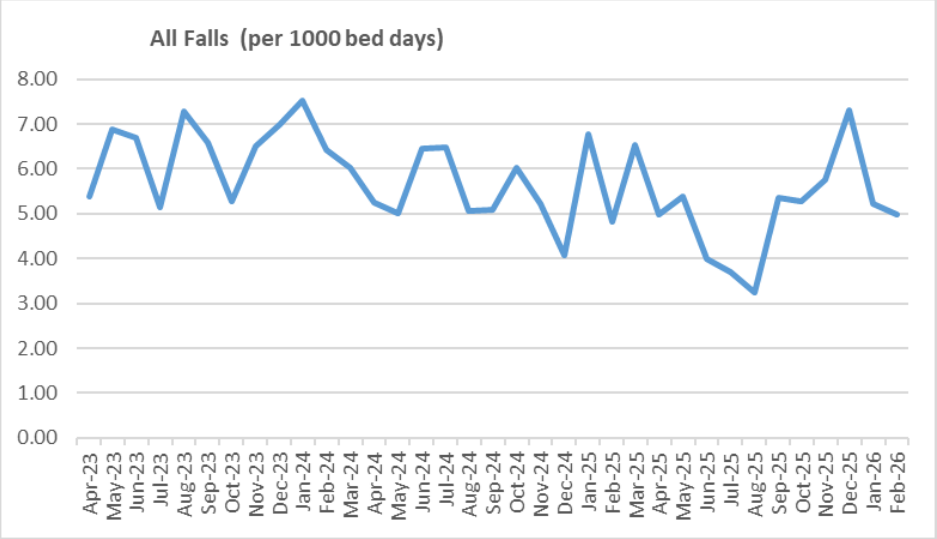
Falls

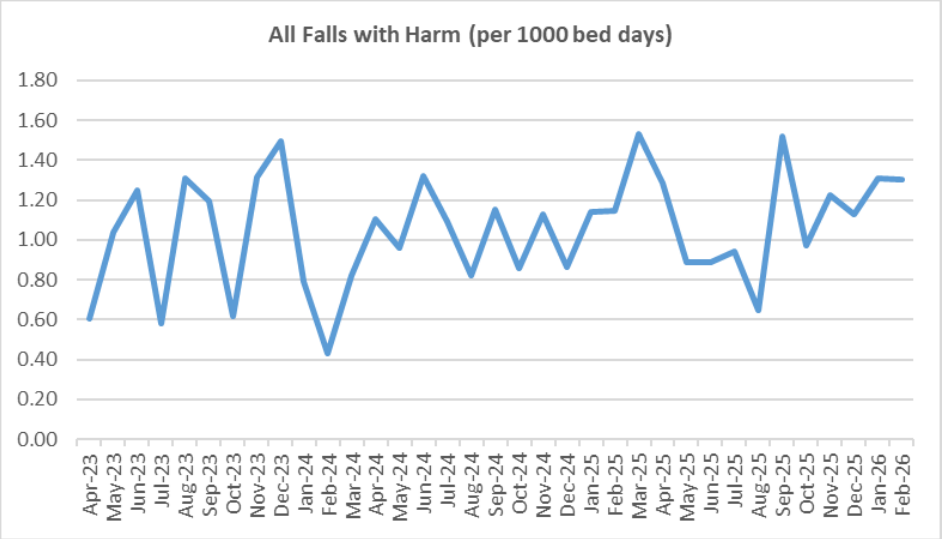
Table 1. Number of falls and categories in February 2026, with the top 3 wards highlighted.

	Total falls in month	Top 3 wards		
Total falls	65	Harold – 8	Ray – 8	Kingsmoor – 7
Unwitnessed falls	46	Ray – 6	Other (A&E and PAHT) – 5	Harold, Kingsmoor, AAU, Charnley, Fleming & Saunders – 4
Falls with harm *	17	Harold – 3	Other (A&E and PAHT), Kingsmoor, AAU, Charnley – 2	

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

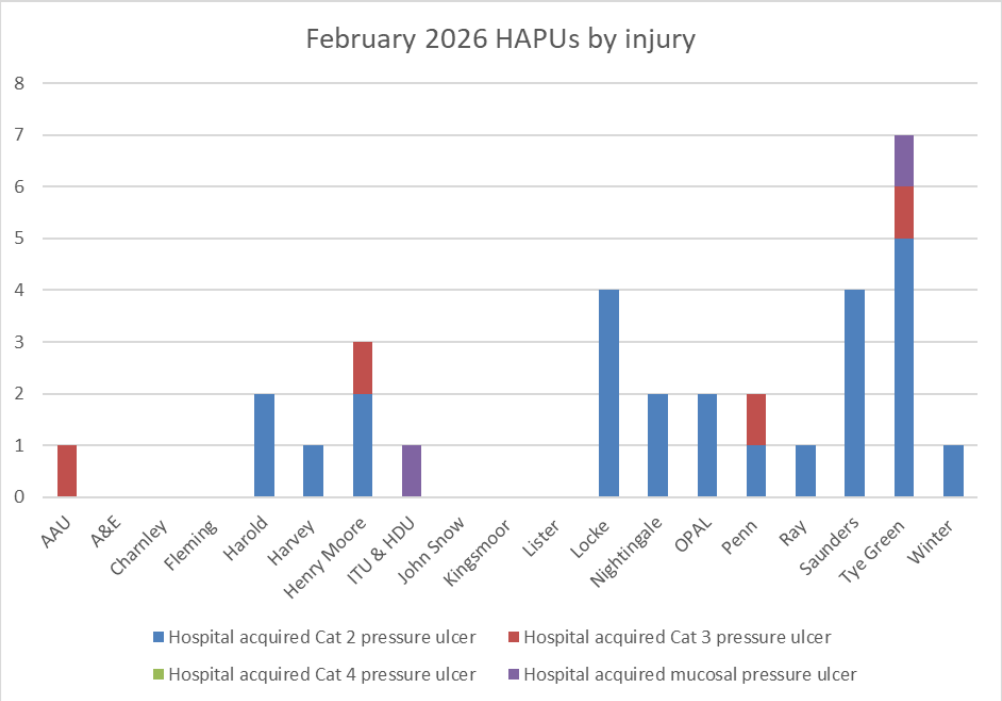
Falls Rate per 1000 bed days February 2026 data





Pressure Ulcers

Table 2a. Number of Hospital Acquired Pressure Ulcers (HAPU) Cat 2, 3 and 4



	Total in month	Top Departments		
Total skin changes	80	Tye Green – 11	Saunders – 10	Locke – 9
Reportable HAPU's	31	Tye Green – 7	Saunders – 4	Locke – 4

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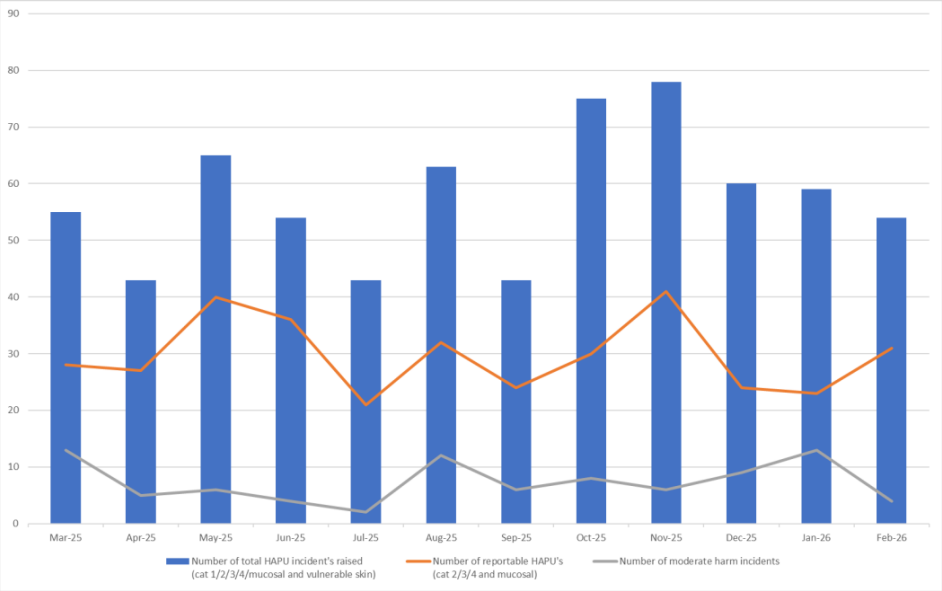
Table 2b. Reported Incidents and Actual Hospital Acquired Pressure Ulcers February 2026



Complaints, PALS and Compliments Trend Data Sep-25 – Feb-26

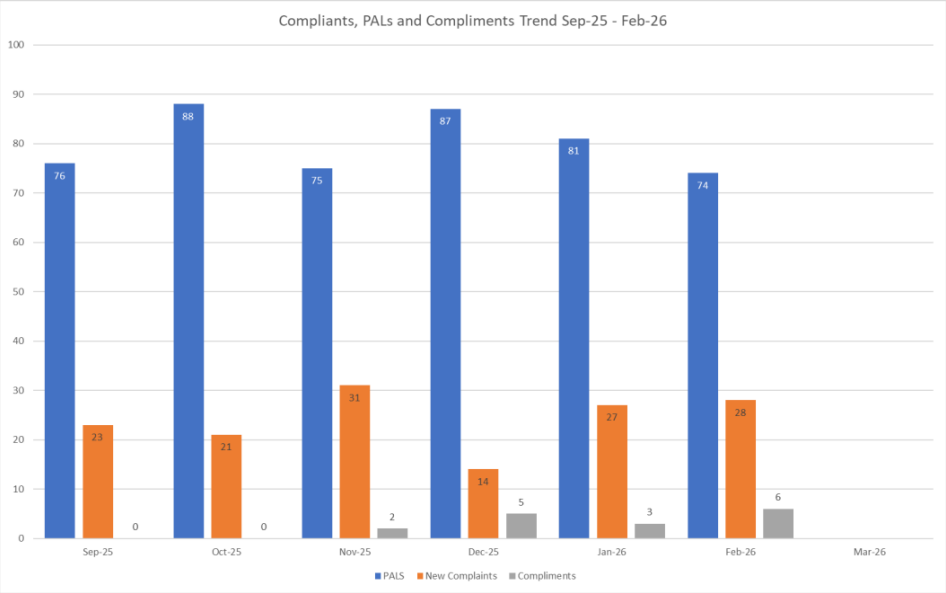


Table 3. Number of new Complaints, PALS and Compliments in February 2026 with top three wards highlighted

	Total in month	Top Departments		
New complaints	28	A&E – 7	Samson – 4	Kingsmoor, Saunders & Labour – 3
PALs	74	A&E – 19	Harold & Ray – 7	Kingsmoor – 6
Compliments	6	A&E – 5	Charnley – 1	

Complaints: main themes: Medical care – 23.62%, Nursing care – 16.54%, Communication – 15.75%
PALS: main themes: Delay – 39.73%, Communication – 23.96%, Cancellations – 8.68%
Compliments: themes not provided – data capture remains inconsistent.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 April 2026

Agenda item:	4.4							
Presented by:	Andrew Kelso | Chief Medical Officer							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Andrew Kelso | Chief Medical Officer							
Date prepared:	16th March 2026							
Subject / title:	Learning from Deaths and Mortality Paper							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
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: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	✓	✓	✓		

Previously considered by:	Strategic Learning From Death Group and QSC.27.03.26
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

The Princess Alexandra Hospital NHS Trust

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. This report also forms the formal Chair's escalation to QSC.

2 Background

PAHT has a learning from death process that meets national requirements. The Strategic Learning from Deaths Group (SLfDG) was held on 12th March 2026.

3 Mortality Indicators

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

3.1 Headline statistics

3.1.1 Hospital standardised mortality ratio (HSMR) overview

3.1.2 HSMR+ for Oct-25 is 110.32 and "within expected", based on 1681 superspells and 71 deaths (crude rate 4.22%). *Figure 1*.

HSMR+ for the period Nov-24 to Oct-25 is 113.19 and "higher-than-expected", based on 18,512 superspells and 786 deaths (crude rate 4.25%). Figure 2

3.1.3 Standardised Mortality Ratio (SMR) overview

3.1.4 SMR for Oct-25 is 101.8 and "within expected", based on 6287 superspells and 88 deaths (crude rate 1.3%). *Figure 3*

3.1.5 SMR for the period Nov-24 to Oct-25 is 114.38 and "higher-than-expected", based on 68,466 superspells and 988 deaths (crude rate 1.44%). *Figure 4*

3.1.6 PAH Emergency Weekend HSMR+

3.1.7 Emergency Weekend HSMR+ and Emergency Weekday HSMR+ are "higher-than-expected". This is similar to the national position and the trust is not statistically different from peers. *Figure 5*

3.2 Narrative analysis

3.2.1 Coding Backlog & Impact

- The volume of patient superspells with a primary diagnosis of 'residual codes, unclassified' has risen in Oct-25.
- Most deaths have been fully coded, allowing for robust insights into crude mortality, however with the clinical coding backlog impacting 20% of spells, the case mix of the Trust's expected deaths is diluted

3.2.2 Outliers & CUSUM Reviews

- One new HSMR+ outlier: Other liver diseases:
  Reviews confirm no care or treatment issues; flags driven by episode structure and presentation of symptoms where new metastatic cancers were diagnosed during admission.

- One new CUSUM alert: Skull and face fractures:
  Error within coding and inaccurate case flagged. Neither case diagnosed or treated for skull and face fracture.

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 improving coding completeness and documentation clarity. Reviews of flagged outliers and CUSUM alerts have found no patient safety concerns. All patients that die are subject to a robust mortality review process. Current SMR and HSRM+ performance has not been shown to reflect deficiencies in care.

Work to reduce the number of consultant episodes in the Acute Medicine service has been reconvened. The department have been invited to implement a revised process in April 2026.

4 Mortality Programme Updates

4.1 Learning from Deaths

91 deaths recorded in February 2026. 12 cases were referred for Structured Judgement Reviews (SJRs). 111 SJRs remain outstanding (>6 weeks post-death). Divisional Directors receive monthly reports on outstanding SJRs and are performance managed on timely completion through Divisional review meetings.

4.2 Themes from Reviews

- Thoughtful, accurate and prompt early assessment and clinical decision-making
- Appropriate and prompt referral pathways and multidisciplinary coordination
- Challenges identified with identifying the source of sepsis and infection
- The requirements for considering patients' frailty and baseline vulnerability
- Missed opportunities for Advance Care Planning (ACP) and End-of-Life Considerations
- The challenges of continuity of care across specialities and ward/team changes

4.3 Cases Awaiting Second Review Panel

Unplanned Care Pathway 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

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

4.5 New Cases Highlighted:

Unplanned Care Pathway: PAweb179152– missed massive PE and DVT, highlighted on post-mortem. Under consideration with the Incident Management Group.

5 Medical Examiner

100% of deaths were scrutinised by 6 Medical Examiners. 93.3% of MCCDs were issued within 72 hours in February 2026; national target is 95%.

6 Risks

There were no changes made to the risk register.

7 Recommendation

To note the work of the Learning from Deaths programme.

8 Figures

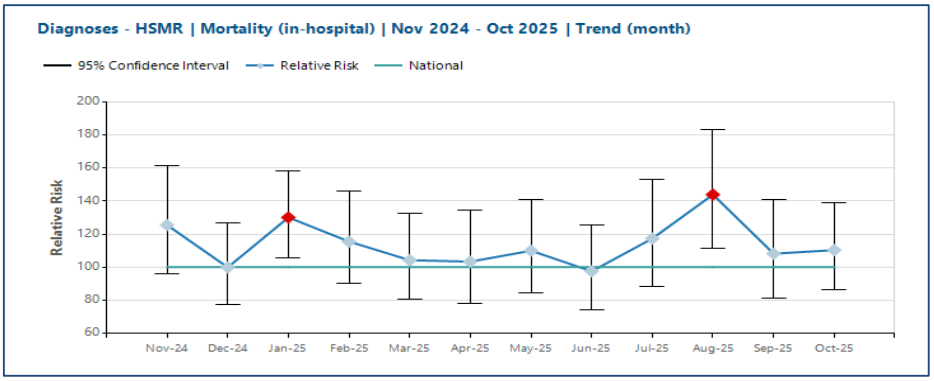


Figure 1 HSMR Monthly Trend Nov 24 – Oct 25

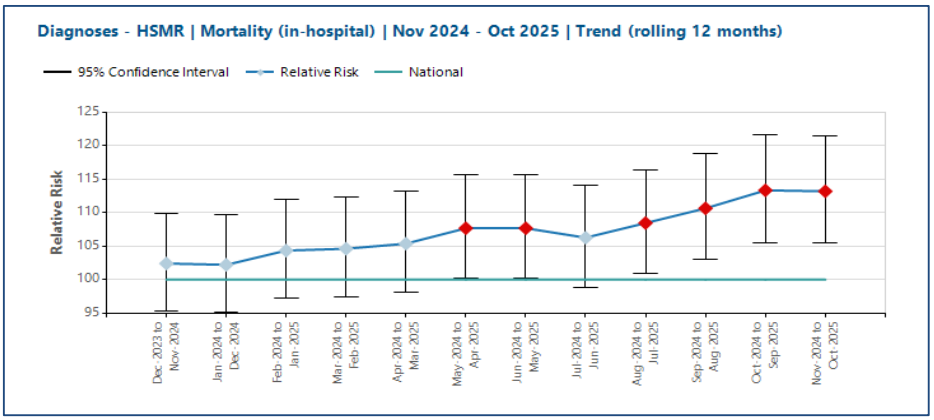


Figure 2 HSMR 12 month rolling trend Nov 24 – Oct 25

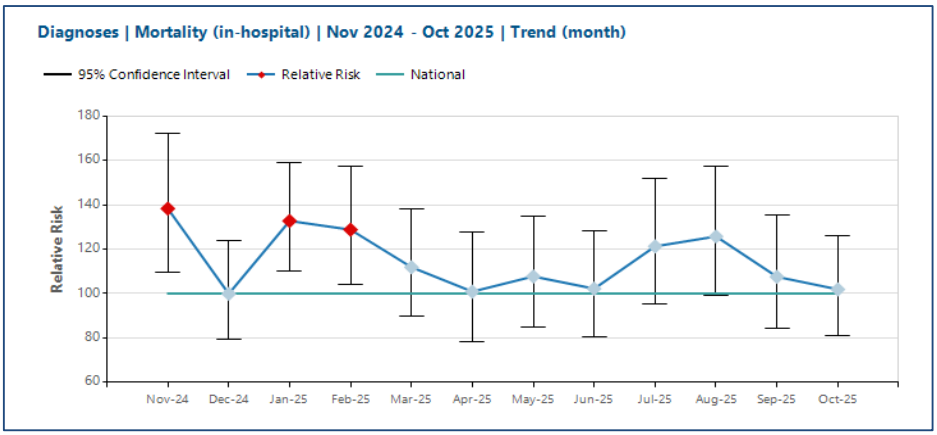


Figure 3 SMR Monthly Trend

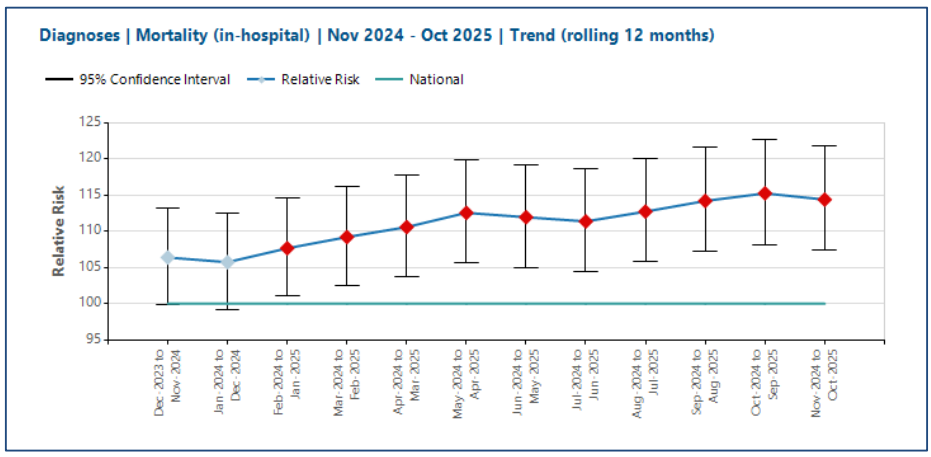


Figure 4 12 month rolling SMR

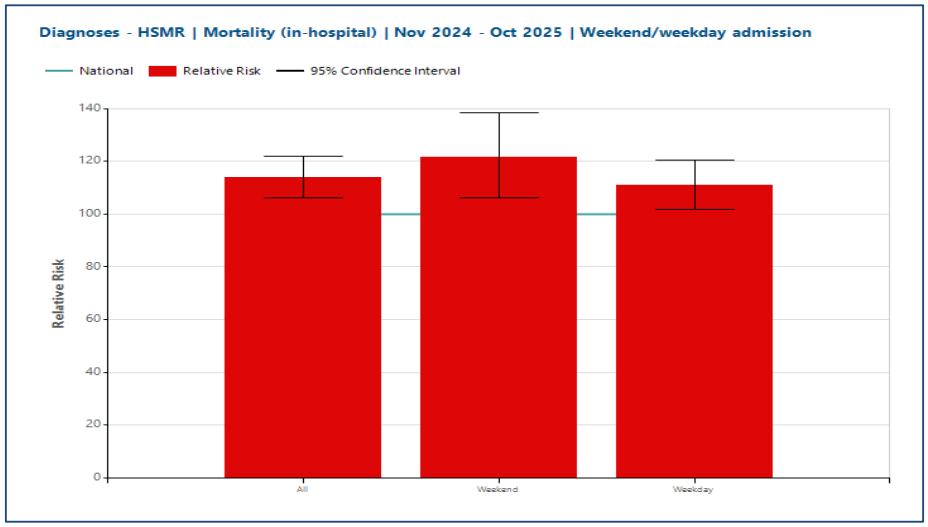


Figure 5 HSMR Weekend/Weekday Admissions Emergency only

9 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.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - Public 2 April 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: 30 March 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. Overall workforce performance was reported as stable, with positive trends including sickness absence below target and continued improvement in turnover. However, the Committee highlighted key risks, including a reduction in workforce stability despite improved voluntary turnover, variation in sickness absence across staff groups that is not visible in headline metrics, and continued concern regarding long-term agency spend. The Committee requested stronger executive narrative to support interpretation of data. Additionally, the Committee raised concerns about the length of time taken to resolve complex employee relations cases and the impact this has on staff morale and experience. While policy timelines exist, these are difficult to achieve in complex cases, particularly where external agencies are involved. Work is underway to develop a clearer “what to expect” framework to improve communication with staff. The Committee will receive an update on the framework at a future meeting.
2.2 Learning & OD Update	Yes	No	No	Key highlights included: • Mandatory training compliance sustained above 90%.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS: Trust Board - Public 2 April 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: 30 March 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				• Appraisal completion rates have declined, with particular concern about the quality and consistency of appraisals; it was emphasised that simply achieving compliance is not sufficient if the process does not add value or support staff development. As of 30/03/26 compliance was 78.3% • There was concern that compliance with the Oliver McGowan mandatory training is low, and the Committee stressed the need for action to improve uptake and ensure the Trust meets statutory requirements. • CPD utilisation and apprenticeships performing strongly, supporting workforce sustainability. • Apprenticeship levy utilisation has improved significantly, with no levy loss reported.
2.3 Staff Survey	Yes	Yes	No	Highlights included: • Record response rate (64%), significantly above national average, strengthening confidence in results. • Benchmarking shows PAHT is now closer to the national average across most domains, with improvements in several areas, but scores remain below average in eight out of nine People Promise metrics. Key gaps are in staff engagement,

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BOARD OF DIRECTORS: Trust Board - Public 2 April 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: 30 March 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				compassionate and inclusive culture, and feeling recognised and rewarded • Engagement had improved; however, structural pressures (capacity, fatigue, recovery time) persist. • Five Trust-wide priorities for 2026–27 agreed, aligned to CQC Well-Led and BAF risks: o Improve the care we deliver o Local recognition and reward o Violence and aggression programme o Strengthen staff networks and embed EDIB o Wellbeing of our people This report is on the Board agenda.
2.4 WRES and WDES Action Plan Progress Report	Yes	Yes	No	The Committee undertook a detailed review of WRES/WDES action plans, noting bullying, harassment and discrimination rates above national averages, particularly affecting disabled staff, minority ethnic staff. Under-reporting remains a concern, with options to increase declaration being explored. Actions include bringing WRES and WDES reporting forward to enable earlier intervention and strengthening links between violence, harassment and staff experience work.
2.5 Safer Nurse Staffing	Yes	Yes	No	Registered nurse fill rates sustained above 95%; no wards below 75%. However, the Committee noted inconsistent evidence of red flag mitigation and acknowledged that enhanced care demand can distort staffing narratives. There

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

DATE OF COMMITTEE MEETING: 30 March 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				remains a disconnect between data and staff experience, requiring clearer triangulation and explanation.
2.6 Nursing Pay Progression	Yes	Yes	No	The Committee received an update on the national review of Band 5–6 progression. Significant financial, workforce and retention implications are anticipated, although national funding arrangements remain unclear. The Trust is preparing for potential implementation.
2.7 Chaperone Policy	Yes	No	No	The Committee noted that the Chaperone Policy has been updated to reflect new national sexual safety requirements. This ensures compliance with strengthened safeguarding standards, with no immediate risks identified.
2.8 Safe Learning Environment Charter Gap Analysis	Yes	Yes	No	Progress against the Safe Learning Environment Charter was reported as strong overall. Amber areas remain in relation to International Medical Graduate induction and education space constraints. With national enhanced IMG induction support ceasing, the Trust is developing its own enhanced programme for July and August intakes.
2.9 Report from Medical Workforce Group	Yes	No	No	The Committee noted an increase in MHPS cases and noted actions to expand trained investigator and case manager capacity. Medical agency spend is not reducing in line with the wider Trust position and was highlighted as a significant financial concern. Compliance with medical statutory and mandatory training required improvement.
2.10 People Team Consultation	Yes	Yes	No	A People Directorate consultation is underway as part of a wider programme of corporate restructures. The Committee stressed the importance of fairness, transparency, objective

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BOARD OF DIRECTORS: Trust Board - Public 2 April 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: 30 March 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				assessment and effective redeployment. Concerns were raised that the planned restructures across multiple directorates may lead to change fatigue and cumulative workforce impact, with the Committee emphasising the need for clear sequencing, transparent communication, and robust support for affected staff.
2.11 BAF Risk 2.1 Staff Engagement and Morale	Yes	Yes	No	In line with the recommendation, it was agreed that the risk score would remain at 16. Members discussed whether the target score of 12 was achievable by the target date of December. This would be reviewed offline and discussed further at the next meeting.
2.12 Horizon scanning	Yes	Yes	No	The horizon-scanning update highlighted several upcoming national workforce changes with potential financial and operational impact. The Committee requested clearer analysis of likely implications so the Trust can prepare proactively.
2.12 Raising Concerns Communications	Yes	No	No	A communications campaign has been developed to clarify the routes for raising concerns, grievances and whistleblowing, including anonymous options. The Committee emphasised the importance of repeated messaging and visible feedback to staff to reinforce trust in the process.
2.13 Violence and Aggression	Yes	Yes	No	Sustained levels of incidents continue to impact staff wellbeing. Governance arrangements for violence and aggression have been strengthened through re-establishment of working and operational groups.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS: Trust Board - Public 2 April 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: 30 March 2026

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				Training capacity has been expanded, including de-escalation and customer service training, and further mitigations such as body-worn cameras are being explored. While governance has improved, violence and aggression remains a high-risk issue due to its impact on staff safety and morale.

Trust Board – 2 April 2026

Agenda item:	NHS Annual Staff Survey 2025: national benchmarking scores and priorities							
Presented by:	Giovanna Leeks, Chief People Officer							
Prepared by:	Clare Fisher, Senior OD Partner							
Date prepared:	20-03-26							
Subject / title:	NHS Annual Staff Survey 2025: national benchmarking scores							
Purpose:	Approval	x	Decision		Information	x	Assurance	
Key issues:	This paper sets out the results for the Annual Staff Survey 2025, benchmarked against all other acute/acute and community combined Trusts. It defines our five strategic priorities and next steps in using this data to drive improvement. It does not contain Trust and divisional actions as they are now being devised (months of April and May) and will be reported back to People Committee at the May meeting.							
Recommendation:	Review and discuss results, endorse the proposed top three improvement priorities, and support Feedback to Action 2.0.							

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

Previously considered by:	PC in March 2026
Risk / links with the BAF:	2.3 Inability to recruit and retain our people
Legislation, regulatory, equality, diversity and dignity	CQC - KLOE well led
Appendices:	Appendix 1-Response rates by division and staff group 2025 versus 2024

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Introduction

This paper sets out our Annual Staff Survey 2025 results, benchmarked nationally, Trust-wide priorities for 2026-7 and proposes a timeline for communication and action planning.

2.0 Background

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

People Promise results provide an easily understood, consistent, and standardised way of talking about, measuring, and improving employee experience at PAHT.

The results enable us to compare our progress with NHS organisations nationally and, crucially, assess our own progress from previous years and incorporate the findings into the development of our 2026-27 priorities.

3.0 Guidance on the national benchmark report

- PAHT is benchmarked against 121 trusts (acute, and acute and community combined).
- Most questions are aligned (where possible) with the NHS People Promise and/or ‘staff engagement’ and ‘morale’.
- Some questions are not benchmarked because of incomparable data.
- The results comprise best, average and worst scores for similar organisations.

4.0 Benchmarked response rate

PAHT overall response rate

In 2025 PAHT achieved a response rate of **64%**.

This result is:

- **17% above average** to the median response rate of the comparison group (47%)
- a **15% increase** compared with our response rate of 49% in 2024; and represents the highest response rate the Trust has achieved in the last 5 years, strengthening confidence that the results reflect staff experience across the Trust.

Divisional and staff group response rate

Highest response rates (divisions):

- **78.8%** corporate services
- **69.7%** clinical support services

And notably:

- Medicine achieved an impressive **+21.4%** increase on 2024
- Surgery & critical care achieved an impressive **+21.8%** increase on 2024

Highest response rates (staff groups):

- 79.5% of healthcare scientists **+27.4%** increase on 2024
- 79.3% of add prof scientific and technic **+26.5%** increase on 2024

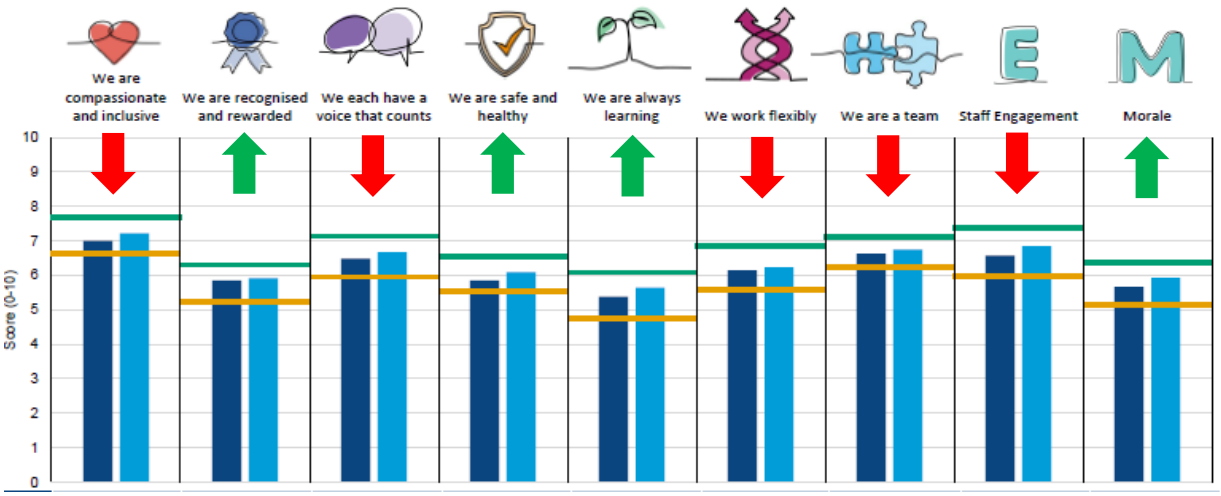
Response rates by division and staff group can be found in Appendix 1.

5.0 Results headlines

The below picture provides the overview comparison for PAHT NSS25 results compared to NSS24**.** It is evident that PAHT have improved in four of the domains, with some further work to improve in the remaining areas.

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

Locally compared to last year, morale scores remain stable, and there are no statistically significant changes across the NHS People Promise compared with 2024.



6.0 Benchmark Context PAHT vs. peer NHS Trusts

It is important to note that the National Benchmark report uses weighted scores for comparison.

Metric	PAH Score	National Avg	Best Trust	Worst Trust	vs. Avg	vs. National Avg
Compassionate & Inclusive	7.11	7.28	7.71	6.71	-0.17	▼ Below avg
Recognised & Rewarded	5.82	5.87	6.34	5.27	-0.05	▼ Below avg
Voice That Counts	6.50	6.60	7.12	5.93	-0.10	▼ Below avg
Safe & Healthy	5.94	6.07	6.58	5.51	-0.13	▼ Below avg
Always Learning	5.57	5.57	6.21	4.98	+0.00	● On par
Works Flexibly	6.12	6.22	6.74	5.69	-0.10	▼ Below avg
We Are a Team	6.69	6.75	7.14	6.29	-0.06	▼ Below avg
Staff Engagement	6.56	6.74	7.36	5.92	-0.18	▼ Below avg
Morale	5.72	5.84	6.42	5.06	-0.12	▼ Below avg

PAH is below the national average in 8 out of 9 People Promise metrics, with only Always Learning matching the national average exactly.

- Strengths:
  - Always Learning is the standout and is exactly on par with the national average (5.57). This is positive, given the time pressures on development and training.
- Areas of concern:
  - Staff Engagement has the largest gap (−0.18). This is significant as it is a composite indicator of how motivated, involved and committed staff feel. Poor engagement typically signals wider cultural and operational issues.
  - Compassionate & Inclusive is the second largest gap (−0.17). This may be particularly sensitive given its links to inclusion, psychological safety and leadership behaviours.
  - Recognised & Rewarded (−0.05) and We Are a Team (−0.06) are the closest to the average, and, could be realistic short-term improvement targets.

7.0 Priorities from previous year (2024-25)

Through discussion at senior leadership level, three priorities were set to support the 2024/25 Trust-wide strategic, operational and people objectives outcomes:

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

8.0 Setting priorities for upcoming year (2026-7)

In a departure from previous years where high-level People Promise themes were set as the priorities, this year the executive team requested a more in-depth analysis of the data. In addition to closely reviewing the National Benchmarking data, a staff experience and workforce readiness analysis was conducted.

The staff experience analysis, workforce readiness assessment, and qualitative themes from the NHS Staff Survey 2025 clearly show that our organisational challenges are predominantly structural rather than motivational. This insight provided a strong and credible foundation for the PAHT priorities.

The additional analysis that helped shape this year's priorities, and the mapping of the priorities to CQC Well-Led expectations and Board Assurance Framework risks, are: -

- Staff experience evidence aligned to PAHT priorities
- Workforce readiness and three strategic shifts analysis
- CQC Well-Led and Board Assurance Framework alignment

Based on the patterns and themes in the data, the senior leadership team have set five integrated priorities for 2026-27.

Priority 1: Improve the care we deliver

The analysis highlighted persistent capacity pressures, workload friction, and reduced recovery time across multiple staff groups. These pressures directly affect the delivery of fundamentals of care, RTT, cancer pathways, and urgent care performance. Our workforce insight confirms that stabilising core delivery is essential to creating the headroom required for improvement and transformation.

Priority 2: Recognition and reward (local focus)

The evidence shows a sustained decline in feeling valued and inconsistent recognition at team level. This has a clear impact on discretionary effort, morale, and retention. A strengthened, localised recognition model directly addresses these findings and supports the People Strategy ambition of creating a culture where appreciation is routine, meaningful, and connected to everyday work.

Priority 3: Violence and aggression programme

Qualitative feedback demonstrated that psychological safety is being eroded by incidents of aggression and a lack of visible follow-through. A Trust-wide programme which includes will protect staff, reinforce safety culture, and build confidence that the organisation will act quickly and consistently to safeguard its people.

Priority 4: Strengthen staff networks and embed EDIB

The workforce analysis identified gaps in follow-through on staff voice and concerns regarding fairness, inclusion, and recruitment equity. Strengthening staff networks and embedding EDIB across all activities aligns with this insight and positions the organisation to deliver the inclusive leadership expectations set out in the People Strategy.

Priority 5: Wellbeing of our people

Declining energy, fatigue, and reduced recovery were among the strongest themes in the workforce evidence. These issues are structural and require a system-level response. Prioritising wellbeing, including access to nutrition during shifts, supports staff sustainability and enables progress across the 10-year plan's three strategic shifts.

10.0 Alignment to assurance and governance

The Trust-wide evidence base clearly shows that our biggest barriers to performance, wellbeing, and transformation are structural in nature: capacity, recovery, recognition, psychological safety, and inclusion. The PAHT priorities directly target these conditions. By basing these priorities on the lived experience of our people and aligning them with CQC Well-Led expectations, we ensure that our organisational focus is both evidence-led and assurance-driven. This creates a coherent framework for delivering high-quality care today and the strategic shifts required for improved health care delivery.

11.0 Responding to the results

March 25	Receive national results; submit Executive Cabinet paper
	Executive cabinet confirm top improvement priorities, communicate trust-wide and incorporate into Leadership appraisal goals
	Divisions schedule results workshops for all managers
April 25	Divisional leads bring together managers in the division alongside representatives across roles, professions and levels to share the Trust-wide priorities and key themes arising in the divisional / departmental survey findings Divisional leads define divisional priorities on the engagement plan
May 2025	Divisions begin monthly updates at DRMs and through local governance
June 25 – ongoing	Action improvements outlined in divisional engagement plan; discuss, update and prioritise actions at monthly board meetings
	Share positive change stories for communication ahead of NSS26
October 25	Annual Staff Survey 2026 opens

11.0 Recommendation

Trust Board is asked to note the results, the supporting staff experience and endorse the priorities and response approach/ timeline for 2026-27.

Appendix 1 - Response rates by division and staff group 2025 versus 2024

Division	Response rate 2025	Response rate 2024	Variance 2025-2024
Child Health & Women's Services	63.5%	48.2%	+15.3%
Clinical Support Services	69.7%	53.4%	+16.3%
Corporate Services	78.8%	70.6%	+8.2%
Estates & Facilities*	58.2%	68.4%	- 10.2%
Medicine	62.9%	41.5%	+21.4%
Surgery & Critical Care	54.0%	32.2%	+21.8%
Urgent And Emergency Care	59.3%	45.0%	+14.3%
TRUSTWIDE	**63.54%**	**49.3%**	+14.24

*Although there was a decline in Estates & Facilities this still represents an excellent response rate, particularly with paper surveys

Staff Group	Response Rate 2025	Response rate 2024	Variance 2024-25
Add Prof Scientific And Technic	79.3%	52.80%	26.5%
Additional Clinical Services	59.8%	40.60%	19.2%
Administrative And Clerical	76.9%	65.10%	11.8%
Allied Health Professionals	63.8%	50.00%	13.8%
Estates And Ancillary	54.8%	63.70%	- 8.9%
Healthcare Scientists	79.5%	52.10%	27.4%
Medical And Dental	44.7%	28.50%	16.2%
Nursing And Midwifery Registered	66.5%	47.90%	17.6%

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**David Baines - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 March 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M11 Integrated Finance Report	Y	Y	N	The Trust declared a deficit of £0.8m in M11 of 25/26 therefore achieving the plan in-month. The 2025-26 full year plan included £5.3m of deficit support funding and £15m of income from the ICB to achieve a breakeven position. The expectation is that PAHT will be required to deliver additional stretch of £4.7m to support closing the ICS gap. At M11 £3.8m has been delivered through non-recurrent measures with £0.9m remaining for M12. The capital plan for 25/26 is £42.2m with expenditure to date of £26.7m. A paper will be presented to April Executive Board on the future of the Vanguard Unit.
2.2 Operating Plan	Y	Y	N	The original planning submission in February 2026 achieved constitutional standards but incurred a deficit of £15.0m. The Trust was asked to improve this plan and submitted an improved position of £12.9m. Due to the national position being off balance, another request was made to improve plans further which included additional funding to achieve an £8.0m deficit. PAF was advised of further discussions with NHSE and a verbal update will be provided at the Board meeting.

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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**	**AGENDA ITEM: 6.1**
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REPORT FROM:	**David Baines - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 March 2026**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 PQP Update				The PQP target of £2.7m in M11 was delivered and the PQP plan is delivering YTD. Planning for the coming year is currently underway.
2.4 BAF Risk 5.1 (Finance – Revenue 25/26)				In line with the recommendation, it was agreed that the risk score would reduce from 16 to 12. Members discussed whether the risk could be reduced to the target score of 8 based on M11 results but agreed to wait for M12 results.
2.5 BAF Risk 5.2 (Finance – Revenue 26/27 – 28/29)				This is a new forward look finance risk, which was discussed at March Board. The proposal is for the risk score to be 16 which PAF endorsed.
3.1 New Hospital Update	Y	Y	N	The report provided an update on activity and timeframes for decision-making on the potential switch of strategic direction for the New Hospital Programme.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**David Baines - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 March 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.2 Estates & Facilities Quarterly Update	Partially	Y	N	Strong progress has been made across Estates and Facilities this quarter and workforce capacity in critical engineering roles continues to improve. The Trust has also secured two years of Estates Safety Funding. While ageing infrastructure and limited decant space continue to present challenges, targeted programmes are underway to reduce these risks. A continued focus on statutory compliance, shutdown planning and sitewide compartmentation will be essential to sustain progress and future planning. PAF took partial assurance from the report and requested that future iterations of the paper include a summary of the work plan, with timelines and associated progress against the areas of work.
3.3 BAF Risk 3.1 Estate & Infrastructure	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20. It was also agreed that the narrative of the risk would be revised to reflect that whilst some elements of risk were now reduced (fire risk), the general condition of the estate itself would make it difficult to reduce the overall risk score of 20.

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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**David Baines - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 March 2026**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 M11 Integrated Performance Report (IPR)	Y	Y	N	Metrics with **concerning** variations at M11 are: Complaints, ED Admitted Percentage, ED Non-Admitted Percentage, Capital Spend, Diagnostic Times (patients seen within 6 weeks) and Mortality (SHMI). Metrics showing an **improving** variation are: Voluntary Staff Turnover, CTG Training Compliance (midwives), Bank Spend, Mental Health Patient Incidents, C-diff Hospital Onset Cases, Friend & Family Test, Statutory/Mandatory Training, Appointment Slot Issues and PQP.
4.2 Access Performance Report	Y	Y	N	PAF noted sustained pressures across RTT, cancer, urgent care and diagnostics pathways, alongside key risks linked to reporting readiness and validation activity, all of which may influence delivery trajectories through Q4.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26 March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.3 Patient Flow Review (BDO Report)	Y	Y	N	**A Review of Best Practice of Waiting List Management and Discharge Processes 2025 (BDO) – A Gap Analysis Against PAH Current Practice**: The BDO report highlighted a number of examples of good practice and demonstrated where the Trust could be improving flow – for both Waiting List Management and Discharge. The Trust has a good understanding of where the gaps are and the recommended good practice in most part aligns to where the Trust improvement programmes will be focussed for 26/27. Elements in the paper would now be linked to improvement projects and timelines added.
4.4 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.

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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**David Baines - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 March 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.5 Digital Update	Y	Y	N	Key headlines: • Essex COIN – Essex NHS Data Network contract is coming to an end and replacement version being procured. • Identification of a solution for IBD still required to enable the decommissioning of Infoflex. • Migration of Alex Health to Oracle Cloud to start in October and expected to take 7 months. Assurance around the adoption of Alex Health, will be presented to PAF/Board.
4.6 BAF Risk 1.4 (EHR)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
4.7 BAF Risk 1.5 (Cyber)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.
5.1 Business Case: CDC Isilon Upgrade and Licences	Y	Y	N	PAF endorsed the Isilon upgrade from available CDC funds given the substantial risk to not only the CDC but also the whole Trust imaging provision.
5.1 Business Case: Core Network Replacement	Y	Y	N	PAF endorsed the business case to replace the core network at PAHT.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Private) – 2 April 2026**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**David Baines - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26 March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
5.1 Business Case: Temporary Agency Validation and Booking Resource	Y	Y	N	PAF supported Option 1, enabling the deployment of temporary validation and booking resource to support the review and resolution of up to 50,000 patients within the Pending Requests cohort in Alex Health.

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 April 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:	24 March 2026								
Subject / title:	Month 11 Financial Performance								
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	X	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Trust declared a deficit of £0.8m in month 11 of 25/26 therefore achieving the plan in month, 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 £2.7m in month 11 which was delivered, the PQP plan is delivering YTD. The capital plan for 25/26 is £42.2m with expenditure to date of £26.7m. The Trust has submitted a plan for 26/27 of £8m deficit. Further discussions with NHS England are ongoing and an update will be provided at Board.								
Recommendation:	The Board is asked to note the month 11 financial position.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	X	X	X	X	X				

Previously considered by:	PAF – 26 April 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.

Trust Board

The Princess Alexandra Hospital NHS Trust

February - Month 11

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a deficit of £0.8m in month 11 of 25/26 therefore achieving the plan in month, this is a positive continuation of achievement of the plan from the start of the financial year, with PQP delivering in month and YTD.

- Non-pay costs remain high, with a £1.2m adverse variance in month. A large proportion of the month 11 overspend is offset by income, Pathology consumable costs of £0.2m, pass through costs of £0.5m and outsourcing linked to operational performance of £0.6m funded via sprint funding.

- Pay spend was high in month relating to operational performance costs which are offset by Income and continuation of winter related costs

- The Trust had a PQP target of £2.7m in month 11 which was delivered, the PQP plan is delivering YTD. There is a large proportion of YTD delivery that is non recurrent.

- The capital plan for 25/26 is £42.3m with expenditure to date of £26.7m.

Summary financial results

The Princess Alexandra Hospital NHS Trust

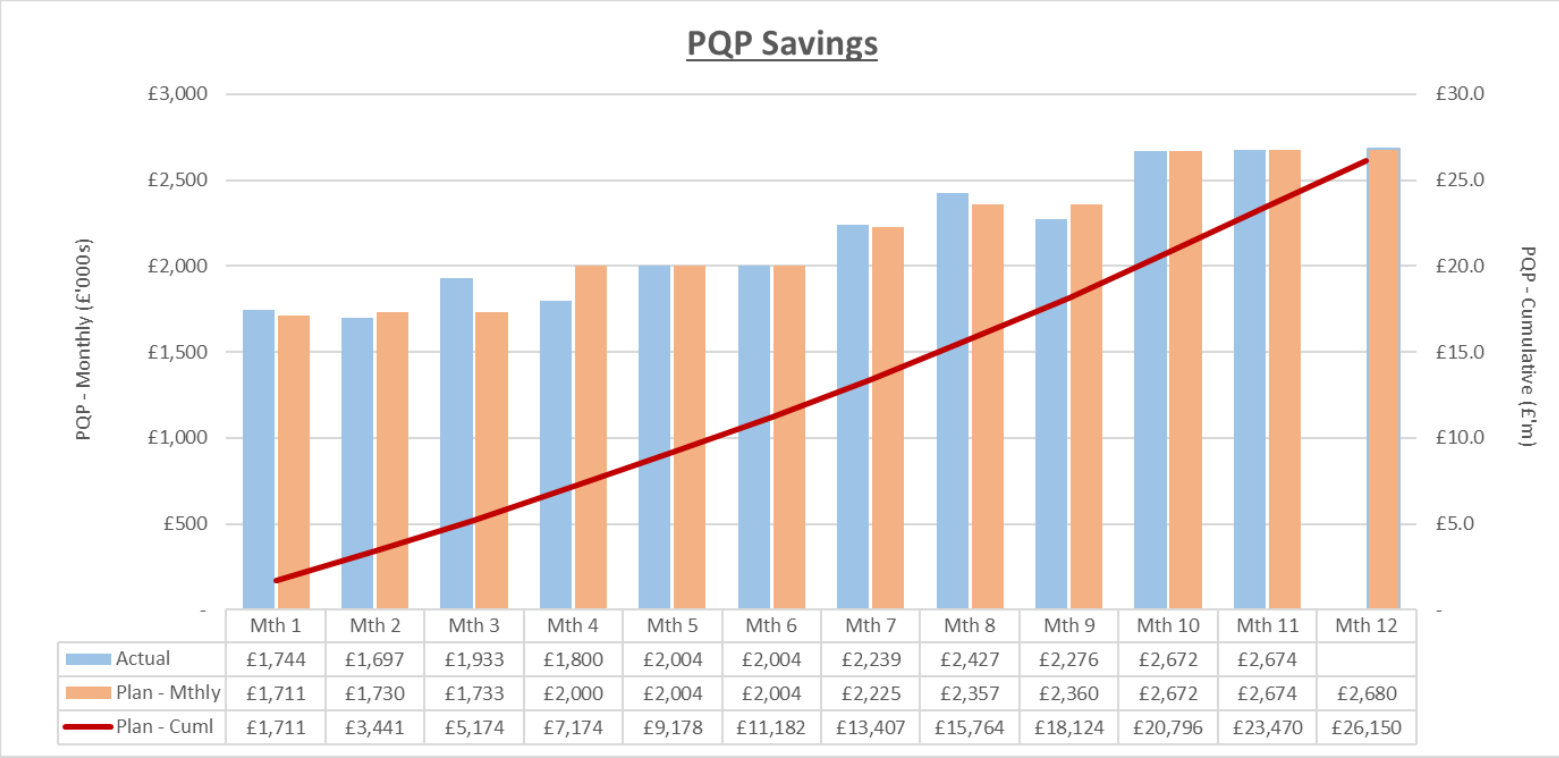
	FY Budget	Feb-26			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS & non-NHS Income	411.1	33.2	35.0	1.8	375.6	381.7	6.0
Pass through Income	20.3	1.7	1.6	(0.1)	18.6	18.6	0.0
Income Total	**431.4**	**34.9**	**36.6**	**1.7**	**394.3**	**400.3**	**6.1**
Pay							
Substantive	(276.0)	(22.9)	(21.1)	1.8	(253.2)	(229.1)	24.1
Bank	(7.1)	(0.6)	(2.5)	(1.9)	(6.5)	(26.6)	(20.1)
Agency	(3.3)	(0.3)	(0.5)	(0.2)	(3.0)	(4.6)	(1.5)
Pay Total	**(286.4)**	**(23.7)**	**(24.1)**	**(0.3)**	**(262.7)**	**(260.3)**	**2.4**
Non-Pay							
Drugs & Medical Gases	(11.5)	(1.0)	(0.9)	0.2	(10.4)	(9.5)	0.9
Pass through expenditure	(20.7)	(1.7)	(1.6)	0.1	(19.0)	(19.0)	(0.0)
Supplies & Services - Clinical	(14.3)	(1.2)	(1.4)	(0.2)	(13.1)	(16.9)	(3.8)
Supplies & Services - General	(6.3)	(0.5)	(0.4)	0.1	(5.7)	(4.7)	1.0
All other non pay costs	(69.3)	(5.6)	(7.0)	(1.4)	(63.6)	(70.2)	(6.6)
Non-Pay Total	**(122.0)**	**(10.1)**	**(11.3)**	**(1.2)**	**(111.8)**	**(120.2)**	**(8.4)**
Financing & Depn							
Depreciation	(17.8)	(1.5)	(1.6)	(0.2)	(16.3)	(16.8)	(0.5)
PDC & Interest	(5.5)	(0.5)	(0.4)	0.0	(5.0)	(4.7)	0.4
Financing & Depn Total	**(23.3)**	**(1.9)**	**(2.1)**	**(0.2)**	**(21.4)**	**(21.5)**	**(0.1)**
Total	**(0.3)**	**(0.9)**	**(0.9)**	**(0.0)**	**(1.7)**	**(1.7)**	**0.0**
Technical Adjustment	0.3	0.0	0.0	(0.0)	0.3	0.3	0.0
Grand Total	**0.0**	**(0.8)**	**(0.8)**	**(0.0)**	**(1.4)**	**(1.4)**	**0.0**
Non recurrent system transformation funding	(15.1)	(1.3)	(1.3)	0.0	(13.8)	(13.8)	0.0
Non recurrent deficit support funding	(5.3)	(0.4)	(0.4)	0.0	(4.8)	(4.8)	0.0
Non recurrent efficiency	(14.0)	(1.4)	(1.4)	0.0	(12.6)	(12.6)	0.0
25/26 Underlying position	**(34.4)**	**(3.9)**	**(3.9)**	**(0.0)**	**(32.6)**	**(32.6)**	**0.0**

PQP

The Princess Alexandra Hospital NHS Trust

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

In month 11, the Trust delivered £2.7m PQP against a plan of £2.7m, therefore meeting plan YTD. We are on track to deliver the PQP plan at month 12 and have shifted focus to identifying PQP for 26/27 where we have another challenging target of £26.5m.



	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	£2,672	£2,674	
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

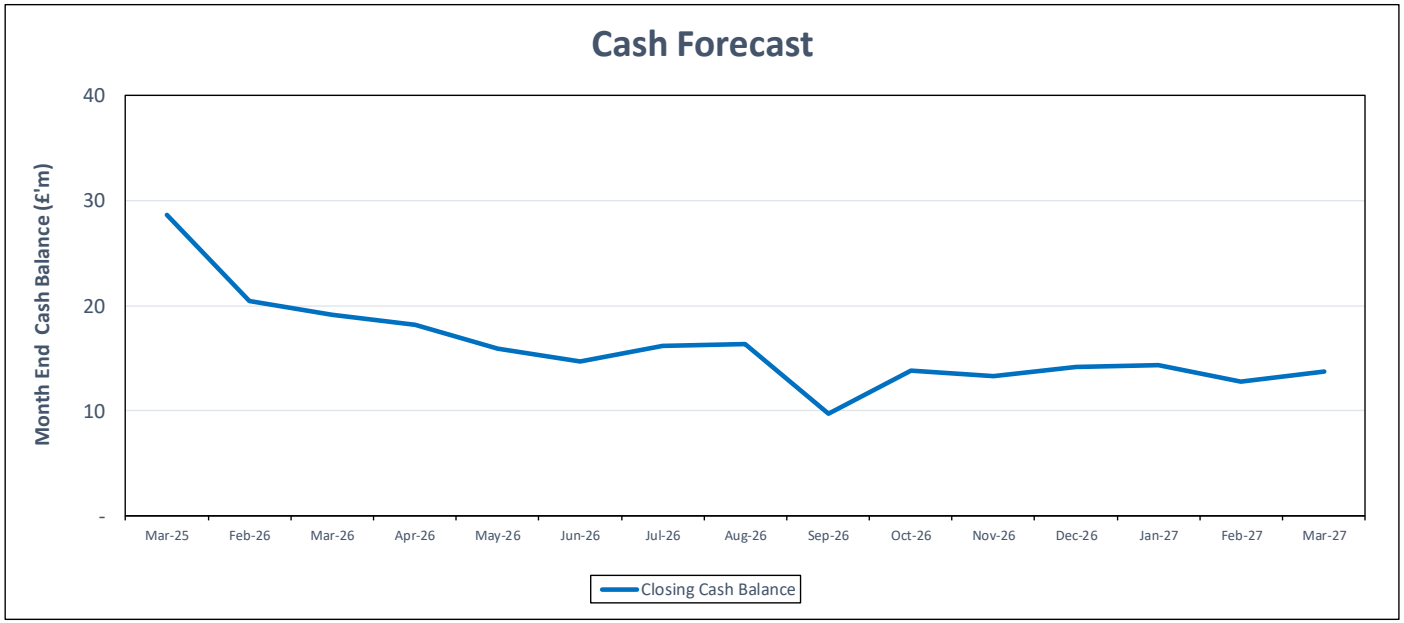
The Princess Alexandra Hospital NHS Trust

Statement of Financial Position	Mar-25	Jan-26	Feb-26	Movement In Month	Movement YTD
	£'m	£'m	£'m	£'m	£'m
Non-current assets					
Property, plant & equipment	189.1	198.4	201.8	3.5	12.8
Right of use assets	43.1	41.3	41.0	(0.2)	(2.1)
Intangible assets	32.1	31.5	31.7	0.2	(0.4)
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**265.4**	**272.2**	**275.6**	**3.4**	**10.3**
Current assets					
Inventories	4.2	4.2	4.2	-	-
Trade & other receivables	10.5	20.0	15.9	(4.0)	5.4
Cash & cash equivalents	28.6	18.4	20.4	2.0	(8.2)
Current assets	**43.3**	**42.5**	**40.5**	**(2.0)**	**(2.8)**
Total assets	**308.7**	**314.7**	**316.2**	**1.4**	**7.5**
Current liabilities					
Trade & other payables	(46.1)	(43.8)	(44.1)	(0.3)	1.9
Provisions	(1.2)	(1.1)	(1.1)	-	0
Borrowings	(2.7)	(3.3)	(3.3)	-	-
Current liabilities	**(50.0)**	**(48.2)**	**(48.5)**	**(0.3)**	**2.0**
Net current assets/ (liabilities)	**(6.6)**	**(5.6)**	**(8.0)**	**(2.4)**	**(0.8)**
Total assets less current liabilities	**258.7**	**266.6**	**267.6**	**1.1**	**9.5**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.0)	(1.0)	(1.0)	(0)	-
Borrowings	(40.2)	(38.5)	(38.3)	0.2	1.9
Total non-current liabilities	**(41.2)**	**(39.5)**	**(39.3)**	**0.2**	**1.9**
Total assets employed	**217.5**	**227.1**	**228.4**	**1.3**	**11.4**
Total taxpayers' equity	**217.5**	**227.1**	**228.4**	**1.3**	**10.8**

Cashflow

The Princess Alexandra Hospital NHS Trust

	Actual	Actual	Fcast	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Mar-25	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Opening Cash Balance	22,934	18,388	20,412	19,116	19,184	19,150	20,150	20,224	19,952	22,212	22,558	14,568	14,139	14,362	12,796
Closing Cash Balance	28,628	20,412	19,116	18,217	15,902	14,664	16,202	16,320	9,698	13,801	13,340	14,139	14,362	12,796	13,773



Cash balances increased in month by £2m, largely driven by the receipt of £1.4m in system support funding, as well as net receipts of £3.5m from HSL and the ICB, which exceeded payments to NHSP of £2.9m.

The forecast 25/26 closing cash balance has been revised to reflect the £8.7m system support payment from the ICB which was previously assumed to be non-cash backed and a further £2.4m sprint funding.

26/27 figures reflect the latest planning submission (£8m deficit). No NHSE revenue support is required although the cash balance does reduce due to the planned deficit.

Capital Analysis 25/26

The Princess Alexandra Hospital NHS Trust

	Month 11			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	455	20	(435)	1,850	1,285	(565)	1,259	1,333	(74)
Estates BLM Schemes	874	(0)	(874)	3,013	1,715	(1,298)	1,738	1,738	-
HDU Works	7	-	(7)	7	200	193	-	200	(200)
Phlebotomy to Harvey refurb	244	244	0	397	397	-	-	1,043	(1,043)
Facilities	-	-	-	27	26	(1)	-	122	(122)
CDC									-
CDC	914	914	-	8,545	8,545	-	11,029	9,373	1,656
EHR, ICT & Info									-
ICT & Information Schemes	(13)	(11)	2	522	518	(4)	-	2,690	(2,690)
EHR	99	99	-	1,891	1,890	(1)	770	2,343	(1,573)
Corporate									-
IFRS16 Leased Assets	-	764	764	-	-	-	3,300	(0)	3,300
Other Corporate schemes	-	-	-	-	-	-	-	23	(23)
Medical									-
Medical Equipment (Planned Pathways)	-	-	(0)	52	52	-	-	245	(245)
Medical Software (Medicine)	-	-	-	-	-	-	21	214	(193)
Refurbishment - UTC Works Phase 1 (Medicine)	-	-	-	77	77	-	-	77	(77)
Refurbishment - SMH (CSS)	1	-	(1)	92	91	(1)	-	91	(91)
Medical Equipment (Cardiology)	60	60	-	60	60	-	-	119	(119)
Medical Equipment (CHAWS)	-	-	-	66	66	-	-	1,176	(1,176)
Dispensing Robot (Pharmacy)	(3)	-	3	(4)	(1)	3			-
Equipment (General)	-	-	-	37	37	-	-	2,452	(2,452)
YTD Total	**2,638**	**2,091**	**(549)**	**16,631**	**14,959**	**(1,673)**	**18,117**	**23,238**	**(5,121)**
Externally Funded Schemes									
Fire-CIR- Compartmentation & Fire Doors	272	272	-	705	705	-	1,500	1,500	-
Electrical CIR IPS/UPS and Distribution	131	131	-	672	673	-	1,083	1,083	-
Chidrens ED	1,485	1,373	(112)	2,448	2,336	(112)	2,336	2,448	(112)
Phase 2 UTC Corridor Refurbishment	62	62	-	637	638	-	3,500	2,026	1,474
CDC	-	-	-	3,000	3,000	-	3,000	3,000	-
CDC Pathways Funding	-	-	-	130	130	-	1,883	1,931	(48)
CDC Phase 2	-	-	-	-	-	-	5,758	2,036	3,722
NHP	20	20	0	723	723	-	910	910	-
Gamma Probe - Surgery	(1)	-	1	36	36	-	36	36	-
Image Intensifier - Surgery	-	-	-	65	65	-	66	66	-
Olympus Keymed CF-Q260DL ADU Endoscopy	-	-	-	808	808	-	920	920	-
Flexible Nasal Endoscopy	-	-	-	73	73	-	86	86	-
Redirooms, canopies and Proxide HPV systems	-	-	-	211	211	-	211	211	0
Wayfinder PEP NHS App - ICT	19	19	0	19	19	-	200	19	181
Estates Safety Fund	448	829	381	552	1,705	1,153	2,492	2,492	-
Maternity & Neonatal	-	-	-	-	-	-	162	162	-
YTD spend on External Schemes	**2,436**	**2,707**	**271**	**10,079**	**11,123**	**1,041**	**24,143**	**18,926**	**5,192**
Total - Internal and External	**5,074**	**4,798**	**(278)**	**26,713**	**26,082**	**(631)**	**42,260**	**42,165**	**70**

Plan

Total capital funding approved by the ICS is £42.3m, of which £23.4m relates to external funding.

Actual and Forecast

Year-to-date capital expenditure stands at £26.7m, representing a £1.0m overspend against plan. However, the forecast outturn (FOT) reflects an effective breakeven position.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - 2 April 2026 **AGENDA ITEM: 6.3**

REPORT TO THE BOARD FROM: Charitable Funds Committee

REPORT FROM: Committee Chair- Helen Howe

DATE OF COMMITTEE MEETING: 10 March 2026

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
Recipient Story: NHS Charities Together and PAH Charity funded gardens project.	n/a	n/a	n/a	The Committee received a presentation on the gardens project. Highlights included: • The garden was designed to support patients with dementia, those at end of life and long stay patients and was developed through extensive stakeholder engagement and co production. • Several patient stories were shared demonstrating improved wellbeing, engagement in therapy, dignity and emotional comfort following access to the garden. • Plans were outlined to improve access and awareness of the garden, alongside future aspirations to secure further funding to support ongoing development. The Committee noted the value of patient stories in evidencing the impact of charitable funding and endorsed plans to increase both awareness and use of the garden across the Trust.
2.1 Breast Unit Fundraising Update	Y	N	N	Six fundraising events were approved • Jurassic Trek 15-17 May 2026 • British Vineyard Tour 15 May 2026 • October Awareness Month October 2026 • Christmas Shopping Day 12th November 2026 • Patient Awareness Evening 12th November 2026 • Annual Christmas Party 4th December 2026

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS: Trust Board - 2 April 2026 **AGENDA ITEM: 6.3**

REPORT TO THE BOARD FROM: Charitable Funds Committee

REPORT FROM: Committee Chair- Helen Howe

DATE OF COMMITTEE MEETING: 10 March 2026

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				The Committee agreed to include a standard explanatory note where events carry no financial risk, along with historical performance data where relevant. Discussion reinforced the importance of cultivating new supporters through smaller events alongside established high-value fundraising activities.
2.2 Charity Update	Y	N	N	Highlights included: • Digital platform deployment remains on hold pending confirmation of governance requirements. • The Children's Ward Courtyard project awaits Estates capacity before feasibility work can begin. • Several external funding applications are in progress, including NHS Charities Together (£210k) and the Big Give match-funding campaign. • The Charity Operational Group continues to oversee CRM rollout, fundraising pipeline development and strategic implementation. • No charity-related risks were identified for the corporate register.
3.1 Charitable Funds Finance Report	Y	N	N	At the end of quarter three, total charitable income amounted to approximately £500k, including interest income. Total expenditure, covering fundraising activities, patient welfare and staff welfare, totalled £631k, resulting in an overall charitable funds balance of approximately £834k.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board - 2 April 2026				AGENDA ITEM: 6.3
REPORT TO THE BOARD FROM: Charitable Funds Committee				
REPORT FROM: Committee Chair- Helen Howe				
DATE OF COMMITTEE MEETING: 10 March 2026				
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				Key income contributors included: • £185k from the Holland & Holland Shoot • £18k from House of Commons Dinner • £83k for Neonatal Unit • £52k from Moving Forward activities A historic system-migration issue required a £257k adjustment; this was identified internally and addressed with auditors. Several funds showed negative balances due to legacy overspends or reconciliation issues. A full review is planned to correct these and strengthen fund controls.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 April 2026

Agenda item:	6.4							
Presented by:	Anna Jebb							
Prepared by:	Informatics Team							
Date prepared:	13th March 2026							
Subject / title:	Integrated Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	X
Key issues:	The metrics falling into the concerning variations at month 11 are: • **Patient:** Complaints - New • **Perform.:** ED Admitted Percentage • **Perform.:** ED Non - Admitted Percentage • **Pounds:** Capital Spend • **Pounds**: Surplus (Deficit) • **Perform.:** Diagnostic times - Patients seen within 6 weeks • **Patients:** Mortality - SHMI The metrics which are showing an improving variation are: • **People**: Staff Turnover Voluntary • **Patients:** CTG training compliance Midwives • **Pounds:** Bank Spend • **Patients:** Mental Health Patients: Incidents PAH • **Patient:** C-DIFF hospital onset Healthcare Associated • **Patients:** FFT Patient Satisfaction • **People:** Statutory & Mandatory training • **Perform.:** Appointment Slot Issues (ASIs) • **Pounds:** Cost Improvement Plan The Board is asked to note that the Trust IPR is under-going a review/refresh November 2025 - Feb 2026, 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. 18th March 2026: The above dates have been revised for April 2026 PAF with March 2026 data.							

The Princess Alexandra Hospital NHS Trust

Recommendation:	To review/discuss 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

Previously considered by:	PAF.26.03.26 and QSC.27.03.26
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:	M11 IPR

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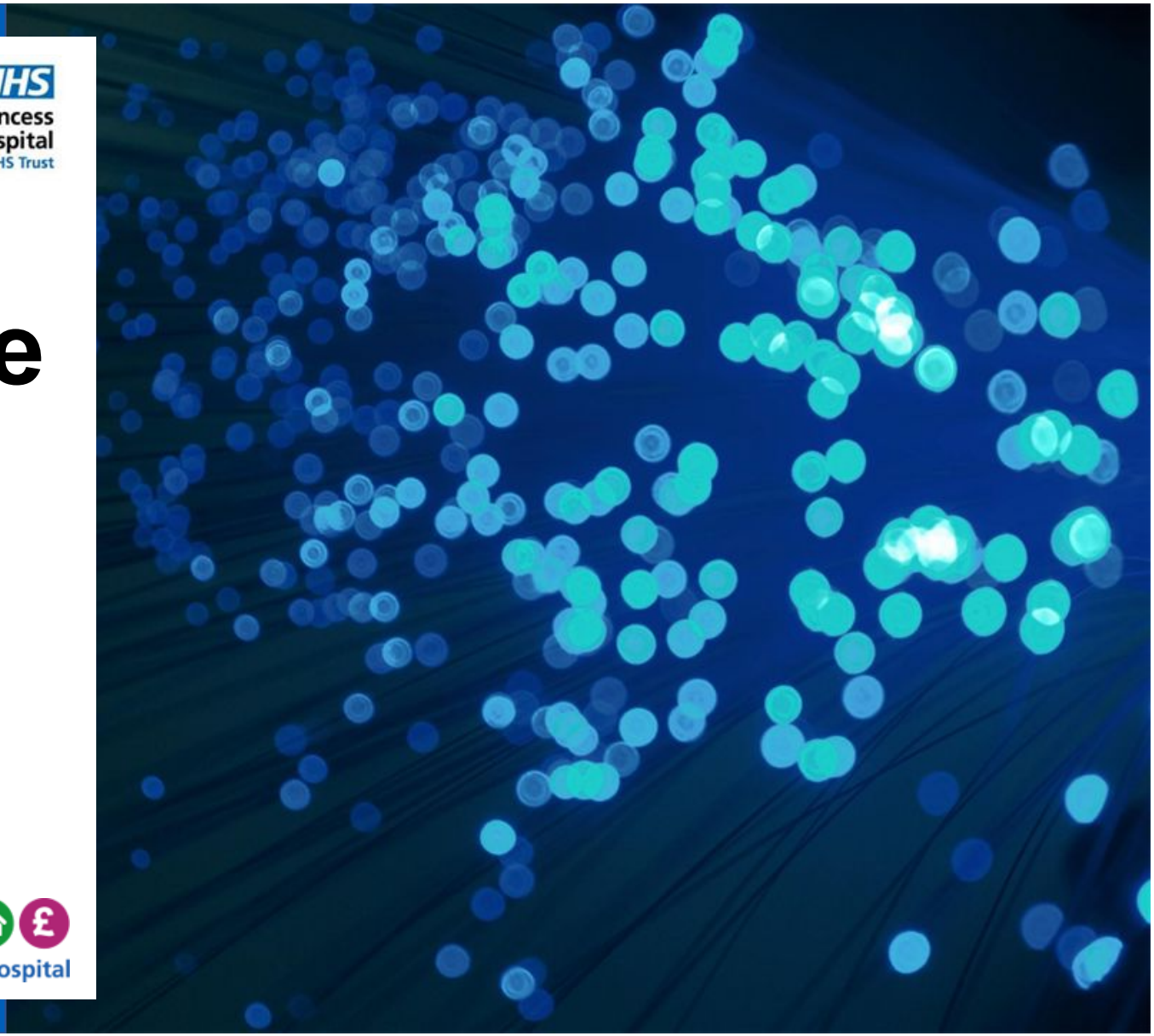
Integrated Performance Report:



February 2026

As at 13/03/2026

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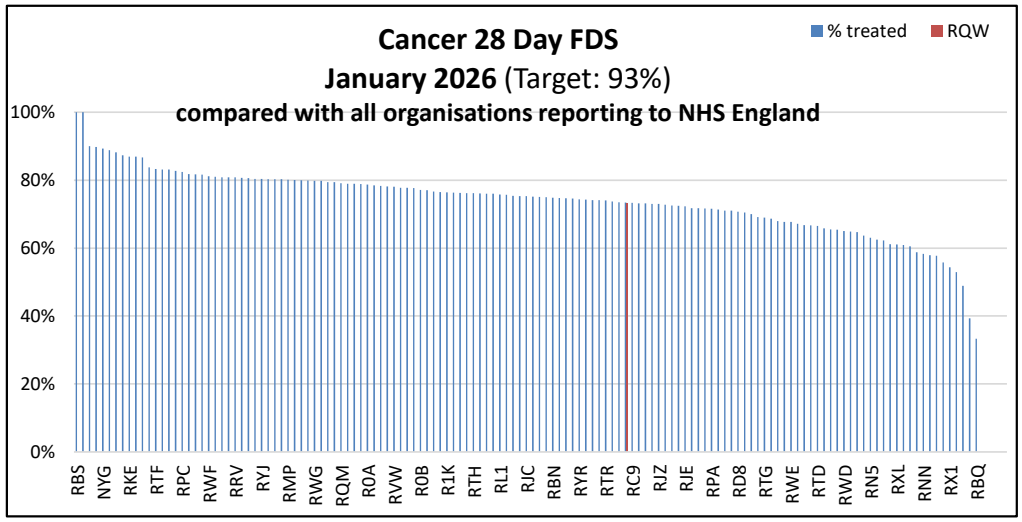

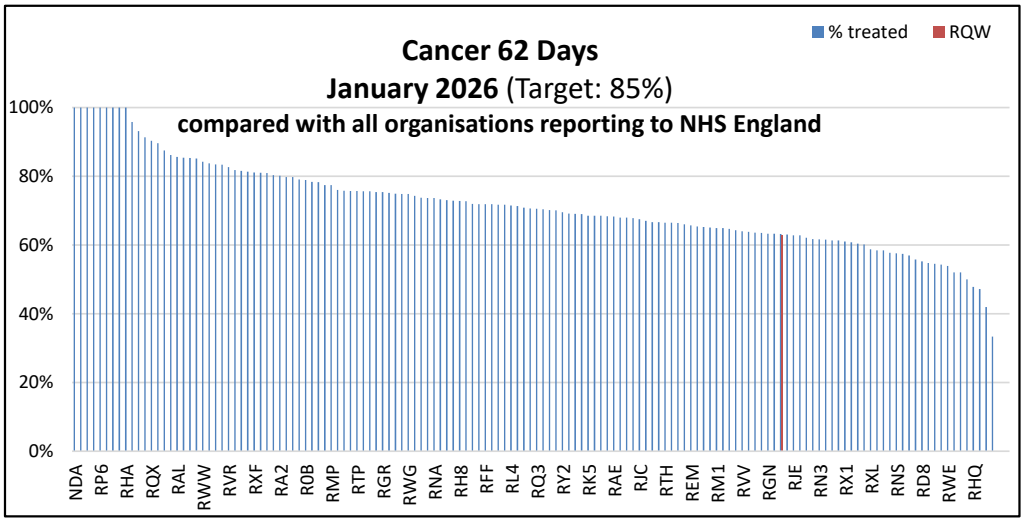

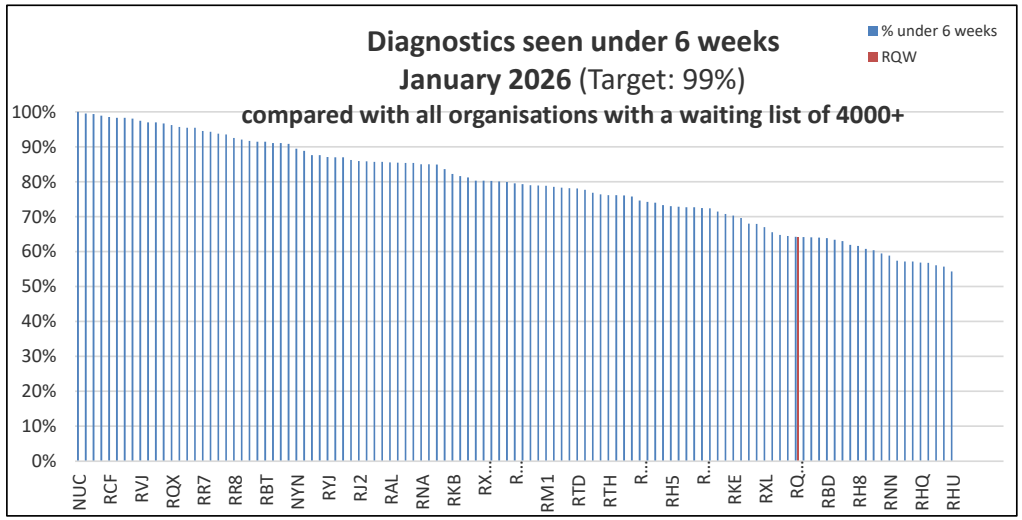

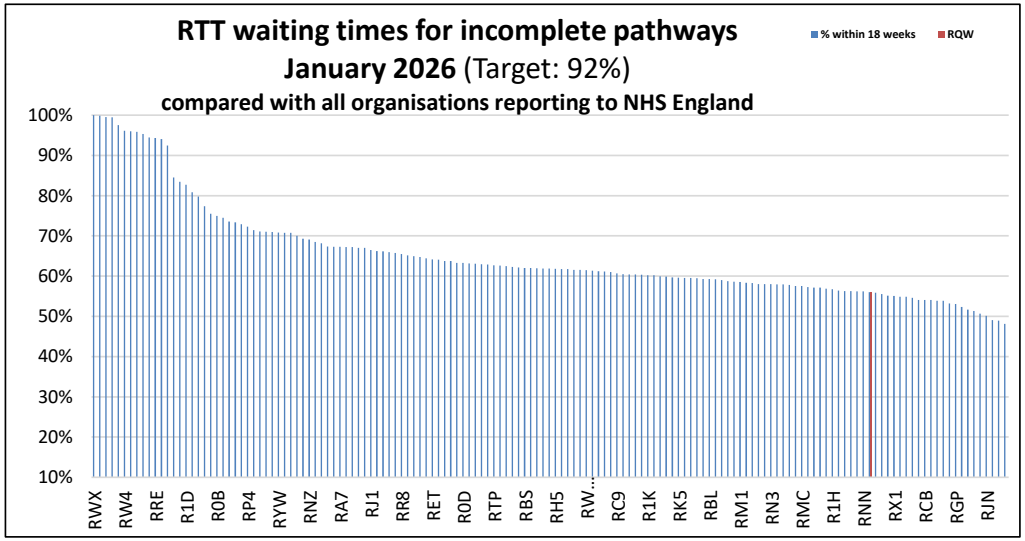

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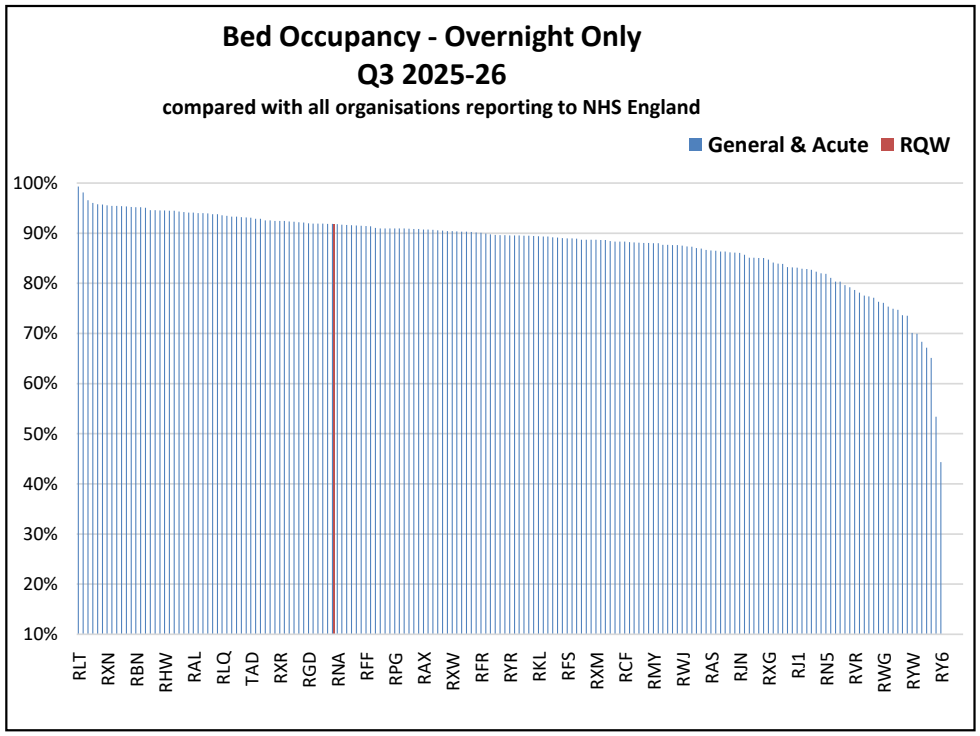

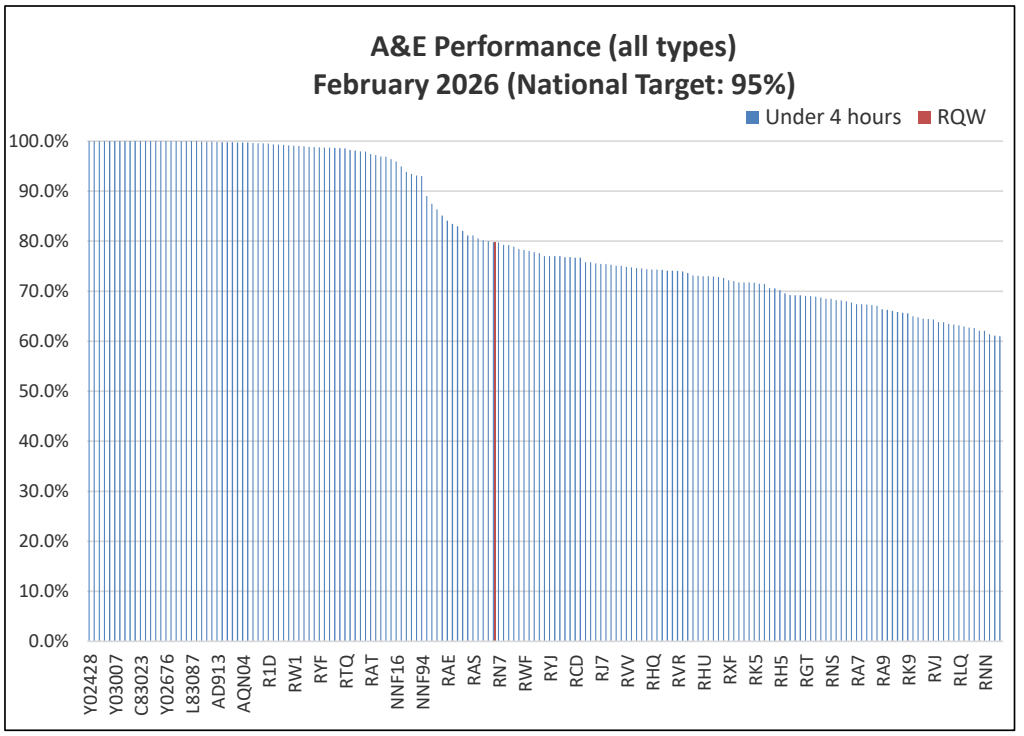

Pillar	KPI	Performance for last reporting month	SPC Trend	Variation	Assurance
Patients	C-DIFF Hospital onset Healthcare Associated	3	Special cause variation-improvement(indicator where low is good)		
Patients	C-DIFF Community onset healthcare associated (Acute Admission within last 4 wks)	2	Common cause variation		
Patients	Tissue Viability - (Pressure Ulcers) per 1000 bed days	3	Common cause variation		
Patients	Total grade 3, 4 & unstageable pressure Ulcers	13	Common cause variation		
Patients	Complaints - New	52	Special cause variation-cause for concern(indicator where high is a concern)		
Patients	Falls - total of Minor, Moderate & Severe	15	Common cause variation		
Patients	FFT Patient Satisfaction	84.0%	Special cause variation-improvement(indicator where high is good)		
Patients	Mortality - SHMI	115	Common cause variation		
Patients	CTG training compliance Midwives	100%	Special cause variation-improvement(indicator where high is good)		
Patients	Mental Health Patients: Incidents PAH	13	Special cause variation-improvement(indicator where low is good)		
People	Appraisals - non medical	68.6%	Common cause variation		
People	Statutory & Mandatory training	90.9%	Special cause variation-improvement(indicator where high is good)		
People	Staff Turnover Voluntary	7.3%	Special cause variation-improvement(indicator where low is good)		
People	Sickness Absence	4.4%	Common cause variation		
People	Bank Staffing Spend	10.3%	Common cause variation		
People	Agency Staffing Spend	2.0%	Common cause variation		
Performance	Proportion of Patient treated within 4 hours in ED	79.8%	Special cause variation-improvement(indicator where high is good)		
Performance	Proportion of Ambulance Handovers less than 15 minutes	18.2%	Common cause variation		
Performance	Proportion of Ambulance Handovers Between 15 & 30 minutes	30.3%	Common cause variation		
Performance	RTT Incomplete Performance	56.0%	Special cause variation-improvement(indicator where high is good)		

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Pillar	KPI	Performance for last reporting month	SPC Trend	Variation	Assurance
Performance	Over 12Hrs ED	1104	Common cause variation		
Performance	Incomplete 52+ Under 18s PTL	12.7%	Common cause variation		
Performance	Appointment Slot Issues (ASIs)	7164	Special cause variation-improvement (indicator where low is good)		
Performance	% Patients Under 18 Weeks Waiting for a 1st OPA	55.7%	Common cause variation		
Performance	ED Admitted Percentage	17.1%	Special cause variation-cause for concern(indicator where high is a concern)		
Performance	ED Non - Admitted Percentage	82.9%	Special cause variation-cause for concern(indicator where low is a concern)		
Performance	Diagnostic times - Patients seen within 6 weeks	64.2%	Common cause variation		
Performance	Cancer two week waits	73.6%	Common cause variation		
Performance	Cancer 28 Day Faster Diagnosis	73.4%	Common cause variation		
Performance	Cancer 62 Day - Shared treatment allocation rules	63.2%	Special cause variation-improvement(indicator where high is good)		
Performance	RTT over 65 week waiters	52	Special cause variation-improvement (indicator where low is good)		
Performance	RTT over 78 week waiters	8	Common cause variation		
Pounds	Cost Improvement Plan	£2,674.00	Special cause variation-improvement(indicator where high is good)		
Pounds	Income	£36,579.00	Common cause variation		
Pounds	Operating Expenditure	-£35,525.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Capital Spend	£2,642.00	Special cause variation-cause for concern(indicator where low is a concern)		
Pounds	Bank Spend	£2,466.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Agency Spend	-£484.00	Special cause variation-improvement (indicator where low is good)		
Pounds	Surplus (Deficit)	-£830.00	Special cause variation-cause for concern(indicator where low is a concern)		
Pounds	Cash Balance Actual	£20,412.00	Common cause variation		

NHS The Princess Alexandra Hospital NHS Trust

Variation		Assurance		
		Will consistently pass if nothing changes	Neither pass or fail consistently	Will consistently fail if nothing changes
	Improving Variation	**People**: Staff Turnover Voluntary **Patients:** CTG training compliance Midwives **Pounds:** Bank Spend	**Patients:** Mental Health Patients: Incidents PAH **Patient:** C-DIFF hospital onset Healthcare Associated **Patients:** FFT Patient Satisfaction **People:** Statutory & Mandatory training **Perform.:** Appointment Slot Issues (ASIs) **Pound:** Cost Improvement Plan	**Perform.:** % Patient treated within 4hrs in ED **Perform.:** RTT Incomplete Performance **Perform.:** Cancer 62 Day - Shared treatment allocation rules **Perform.:** RTT over 65 week waiters **Pounds:** Operating Expenditure **Pounds:** Agency Spend
	No Significant Variation		**Patient:** C-DIFF Community onset healthcare associated (Acute Admission within last 4 wks) **Patient:** Tissue Viability - (Pressure Ulcers) per 1000 bed days **Patient:** Total grade 3, 4 & unstageable pressure **Patient:** Falls - Total of Minor, Moderate & Severe **People**: Appraisals - non medical **People:** Sickness Absence **People:** Bank Staffing Spend **People:** Agency Staffing Spend **Perform.**: Cancer two week wait **Perform.:** Proportion of Ambulance Handovers less than 15 mins **Perform.**: % Ambulance Handovers Between 15 & 30 mins **Perform.:** Over 12Hrs ED **Perform.**: Incomplete 52+ Under 18s PTL **Perform.**: % Patients Under 18 Weeks Waiting for a 1st OPA **Perform.:** Cancer 28 Day Faster Diagnosis **Perform.:** RTT over 78 week waiters **Pounds:** Income **Pounds:** Cash Balance Actual	**Perform.:** Diagnostic times - Patients seen within 6 weeks **Patients:** Mortality - SHMI
	Concerning Variation		**Patient:** Complaints - New **Perform.:** ED Admitted Percentage **Perform.:** ED Non - Admitted Percentage **Pounds:** Capital Spend **Pounds**: Surplus (Deficit)	

PATIENTS PILLAR
SPCs

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

NHS The Princess Alexandra Hospital NHS Trust

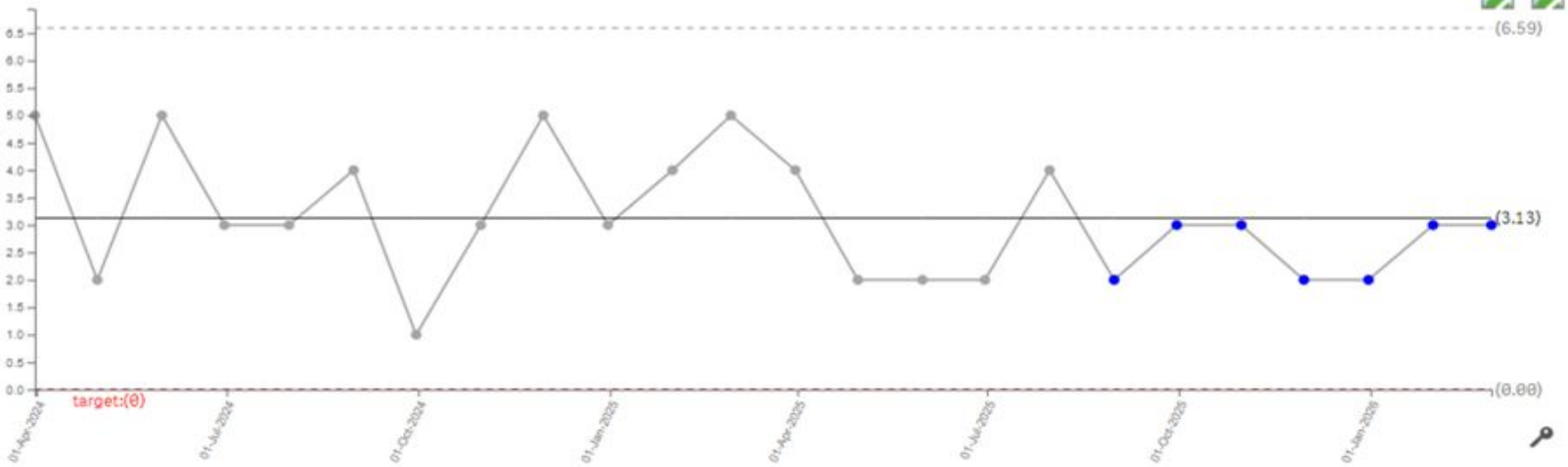
Previous month ...
January-2026

3

Month to date v...
February-2026

3

Target
February-2026
Target is at Trust-wide level



Latest
3
Variance Type
Special cause variation - improvement (indicator where low is good)
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)

NHS The Princess Alexandra Hospital NHS Trust

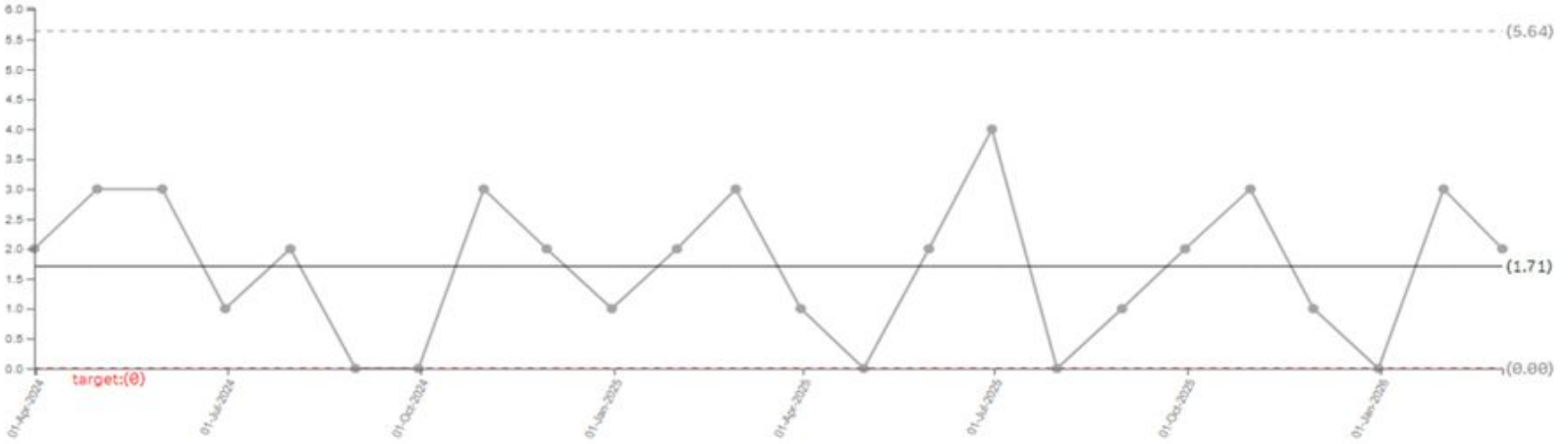
Previous month ...
January-2026

3

Month to date v...
February-2026

2

Target
February-2026
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.14 - Tissue Viability - (Pressure Ulcers) per 1000 bed days

NHS
The Princess Alexandra Hospital
NHS Trust

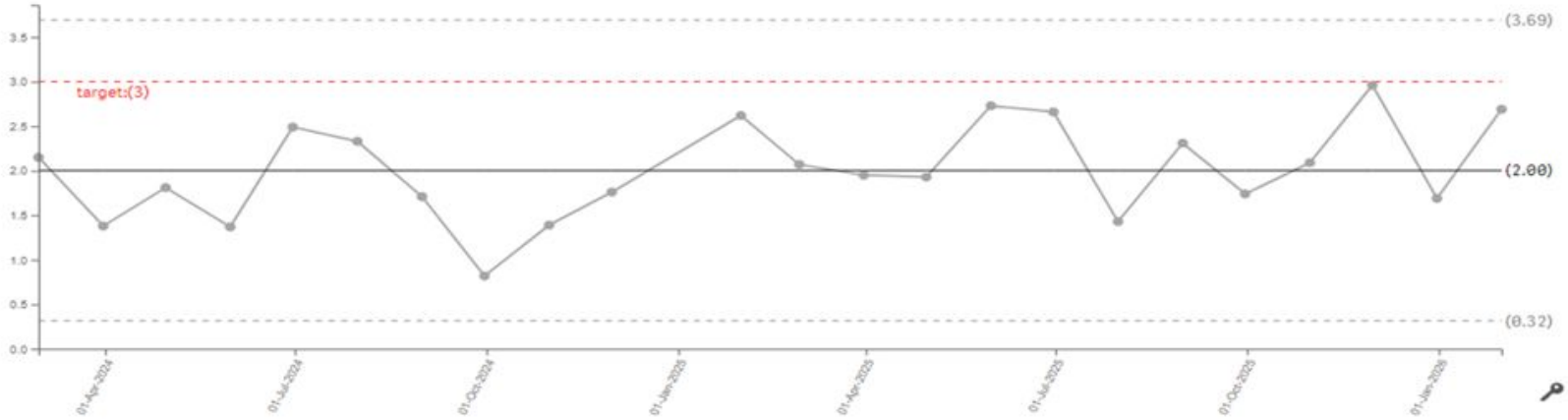
Previous month ...
December-2025

2

Month to date v...
January-2026

3

Target
January-2026
Target is at Trust-wide level



Latest
3
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

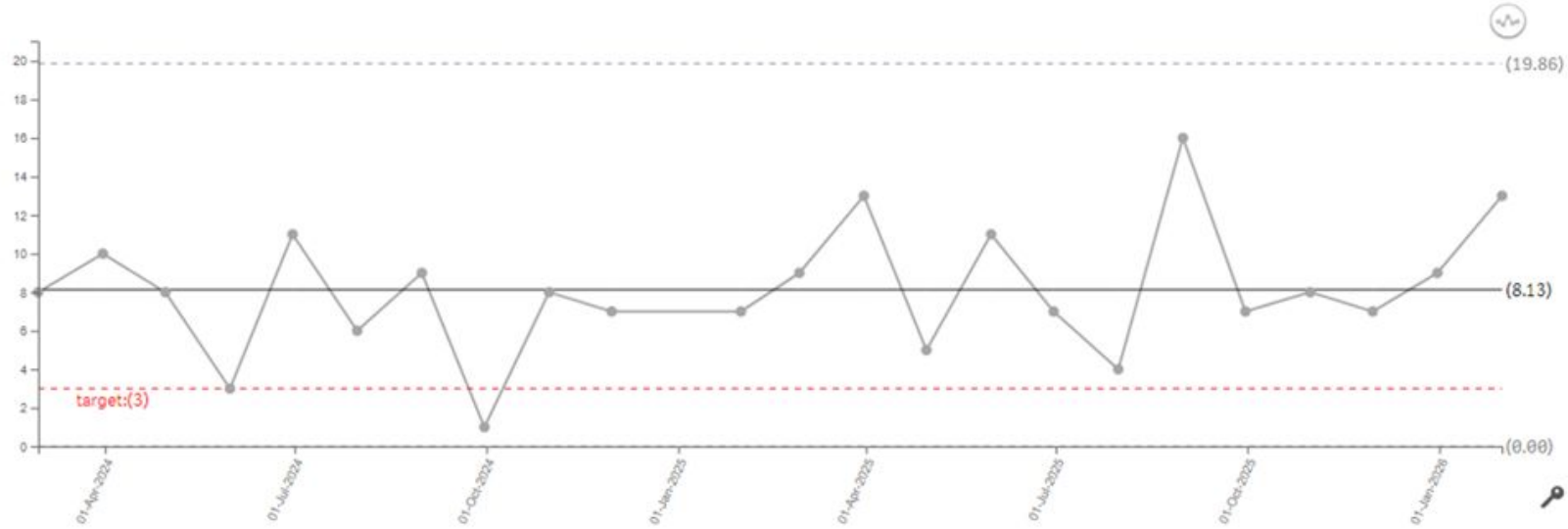
Previous month ...
December-2025

9

Month to date v...
January-2026

13

Target
January-2026
Target is at Trust-wide level



Latest
13
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

NHS The Princess Alexandra Hospital NHS Trust

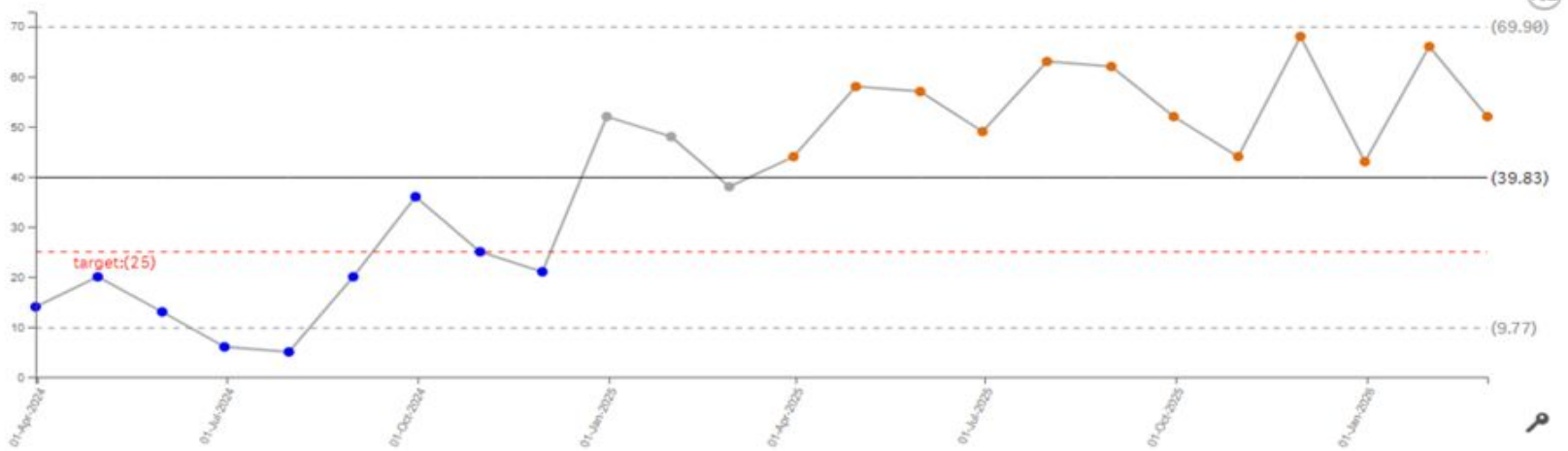
Previous month ...
January-2026

66

Month to date v...
February-2026

52

Target
February-2026
Target is at Trust-wide level



Latest
52
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
25
Target Achievement
The system may achieve or fail the target subject to random variation

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

NHS The Princess Alexandra Hospital NHS Trust

Previous month ...
February-2026

15

Month to date v...
March-2026

3

Target
February-2026
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

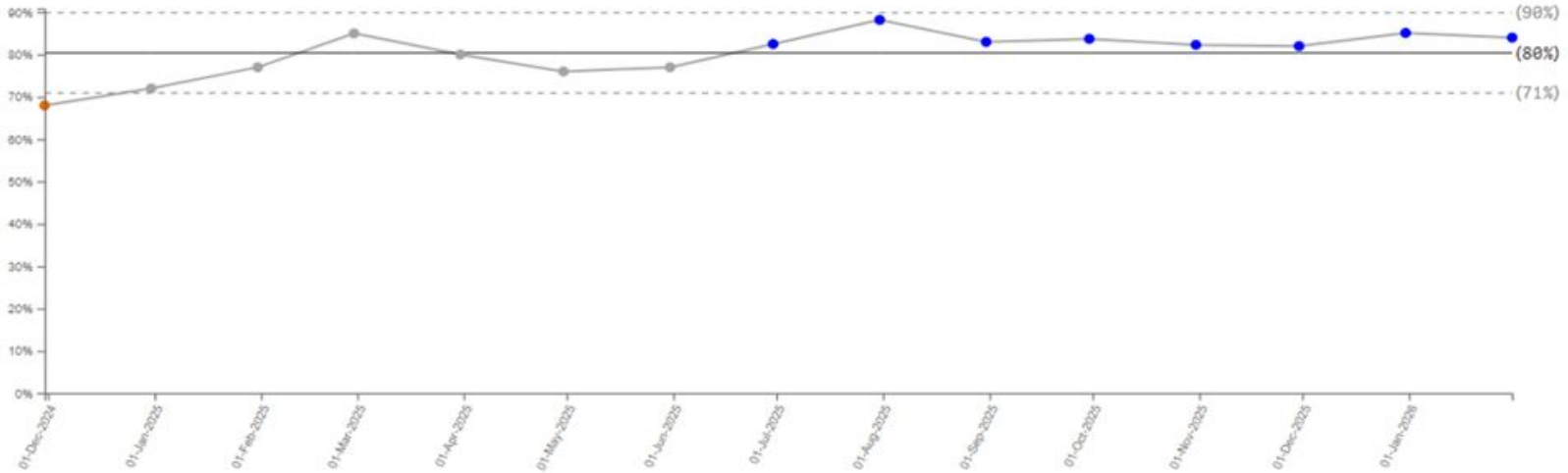
Previous month ...
December-2025

85.1%

Month to date v...
January-2026

84.0%

Target
January-2026
Target is at Trust-wide level



Latest
84.0%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
N/A
Target Achievement
N/A

SPC for D.35 - Mortality - SHMI

NHS The Princess Alexandra Hospital NHS Trust

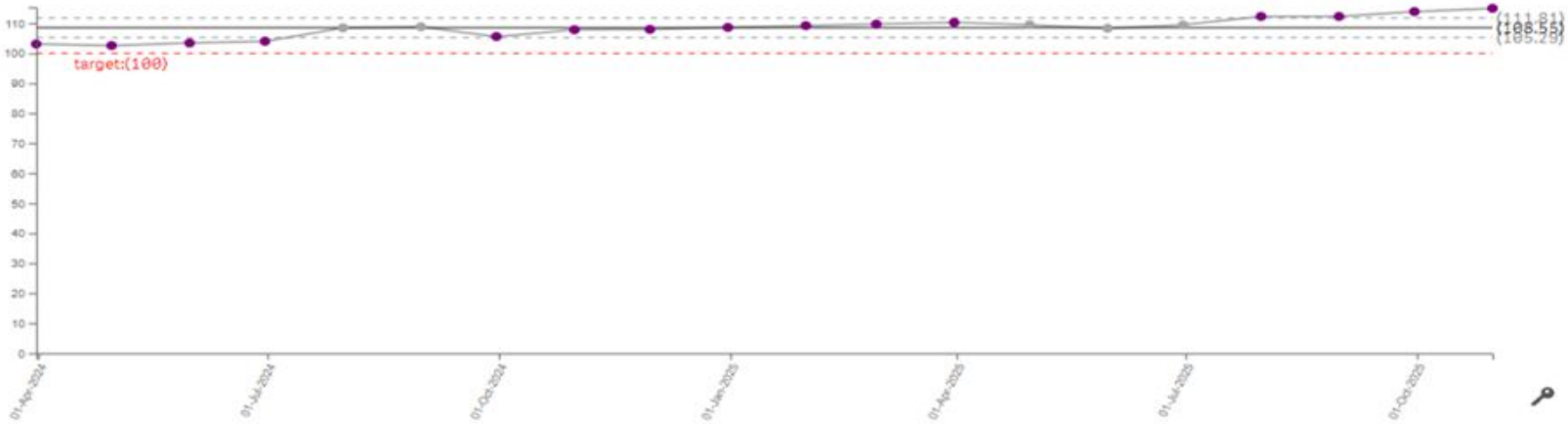
Previous month ...
September-2025

114

Month to date v...
October-2025

115

Target
October-2025
Target is at Trust-wide level



Latest
115
Variance Type
Common cause variation
Target
100
Target Achievement
The system is expected to consistently fail the target

SPC for B.6 - CTG training compliance Midwives

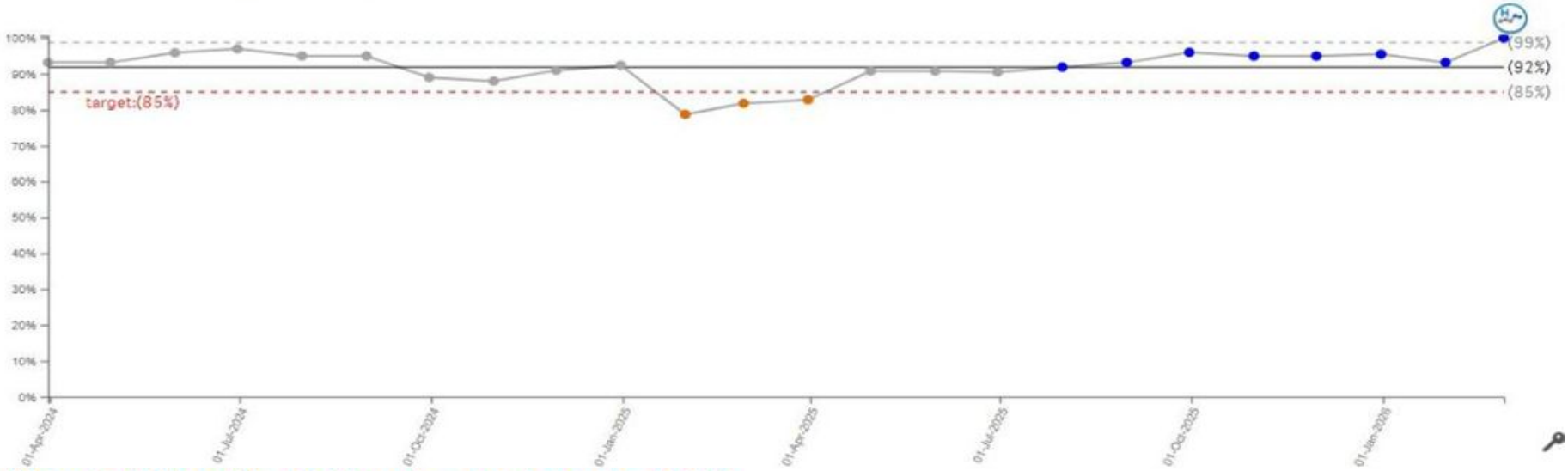
Previous month ...
January-2026

93.2%

Month to date v...
February-2026

100.0%

Target
February-2026
Target is at Trust-wide level



SPC for D.4 - Mental Health Patients: Incidents PAH

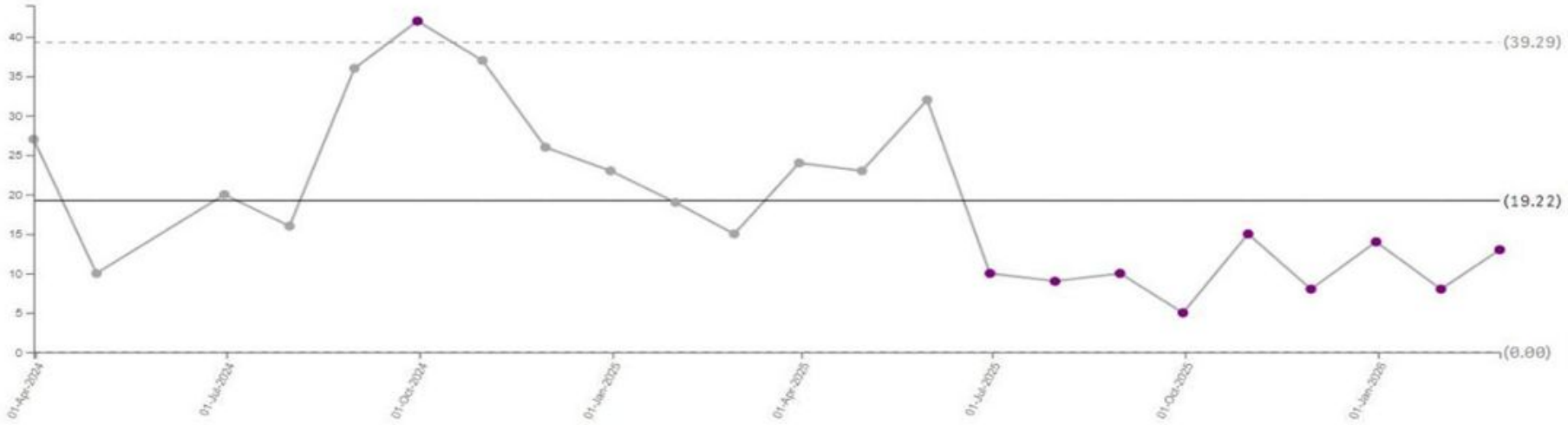
Previous month ...
January-2026

8

Month to date v...
February-2026

13

Target
February-2026
Target is at Trust-wide level



PEOPLE PILLAR
SPCs

SPC for D.23 - Sickness Absence

NHS
The Princess Alexandra Hospital
NHS Trust

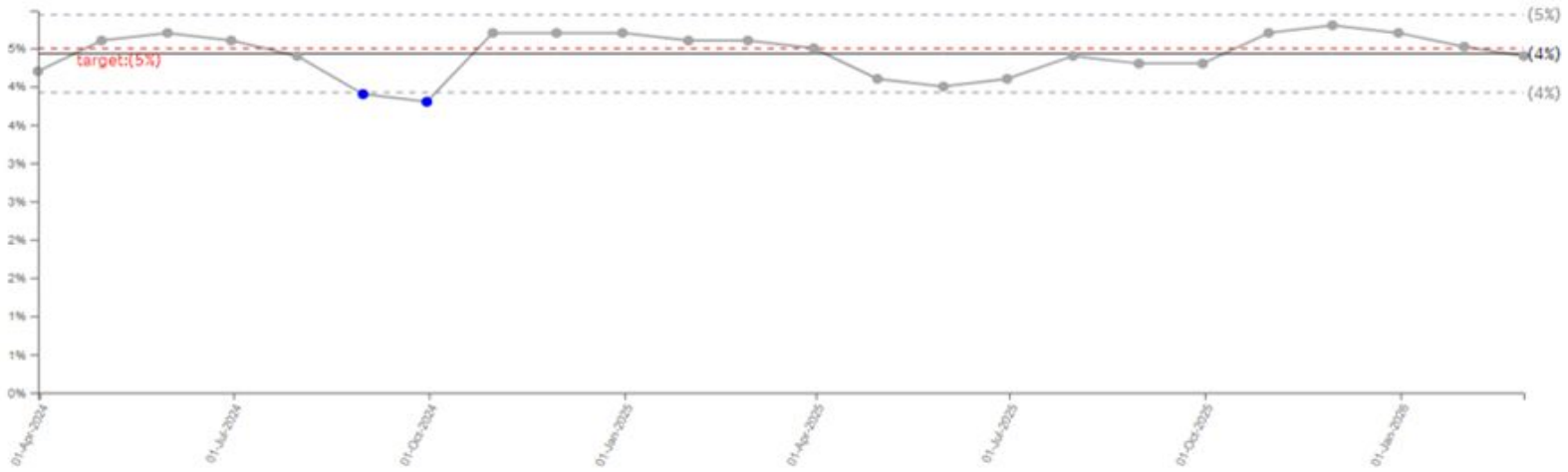
Previous month ...
January-2026

4.5%

Month to date v...
February-2026

4.4%

Target
February-2026
Target is at Trust-wide level



Latest
4.4%
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

NHS
The Princess Alexandra Hospital
NHS Trust

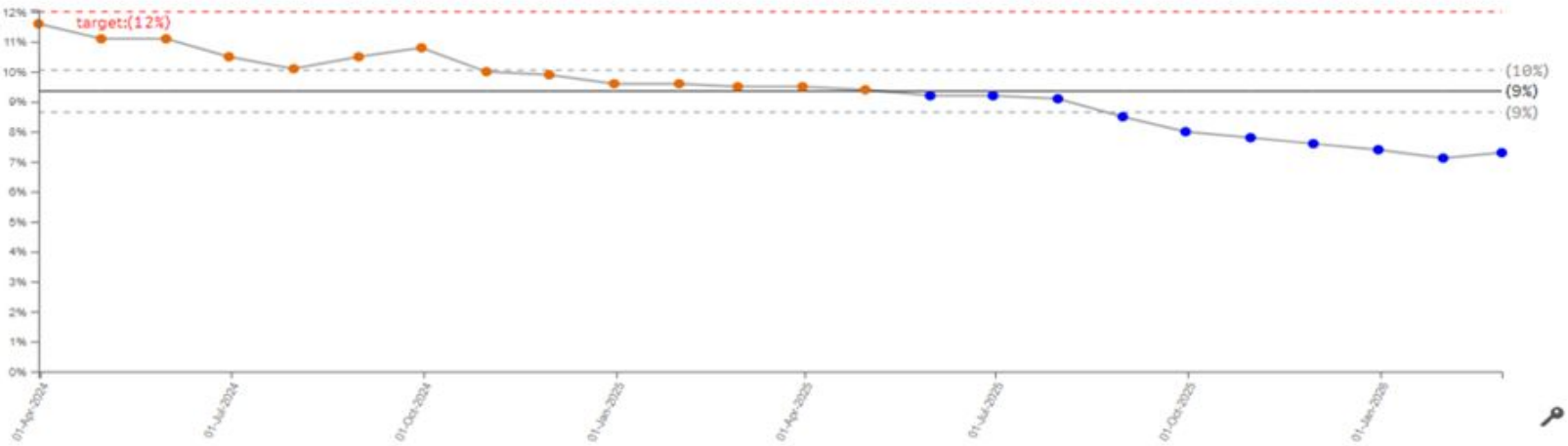
Previous month ...
January-2026

7.1%

Month to date v...
February-2026

7.3%

Target
February-2026
Target is at Trust-wide level



Latest
7.3%
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

NHS The Princess Alexandra Hospital NHS Trust

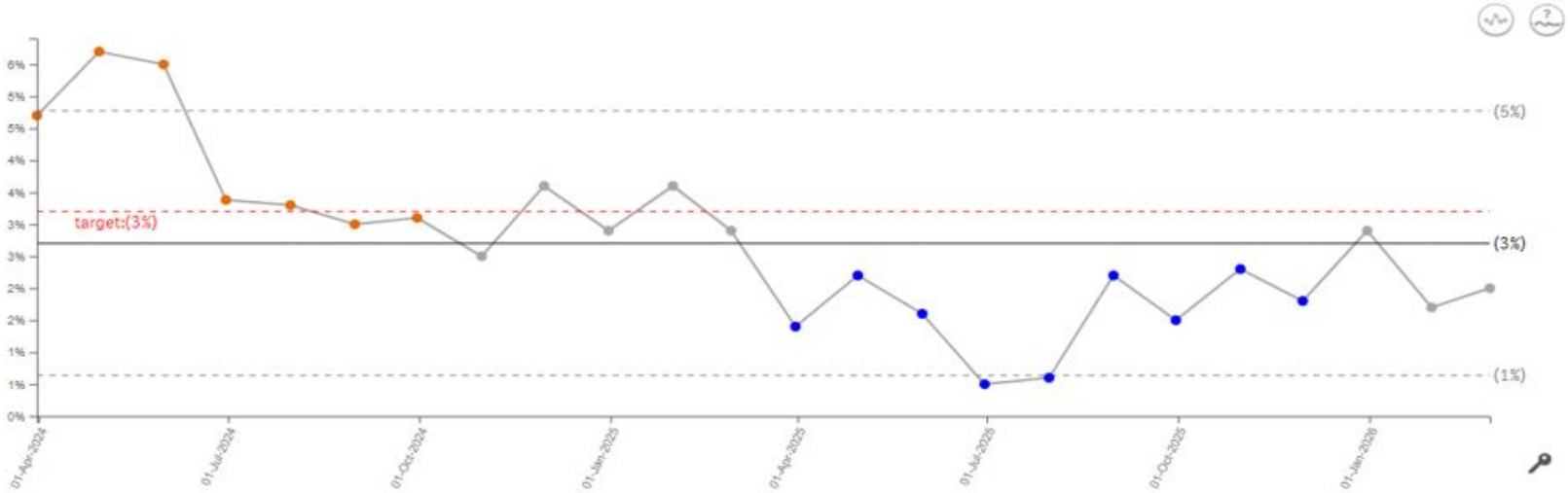
Previous month ...
January-2026

1.7%

Month to date v...
February-2026

2.0%

Target
February-2026
Target is at Trust-wide level



Latest
2.0%
Variance Type
Common cause variation
Target
3%
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for D.28 - Appraisals - non medical

NHS The Princess Alexandra Hospital NHS Trust

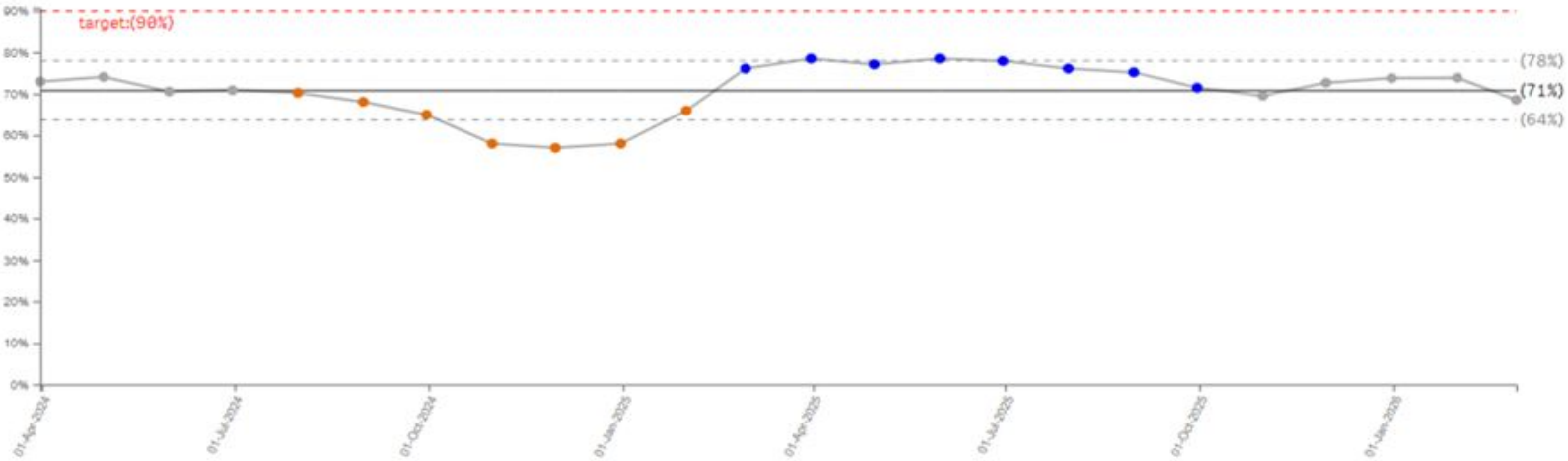
Previous month ...
January-2026

73.9%

Month to date v...
February-2026

68.6%

Target
February-2026
Target is at Trust-wide level



Latest
68.6%
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

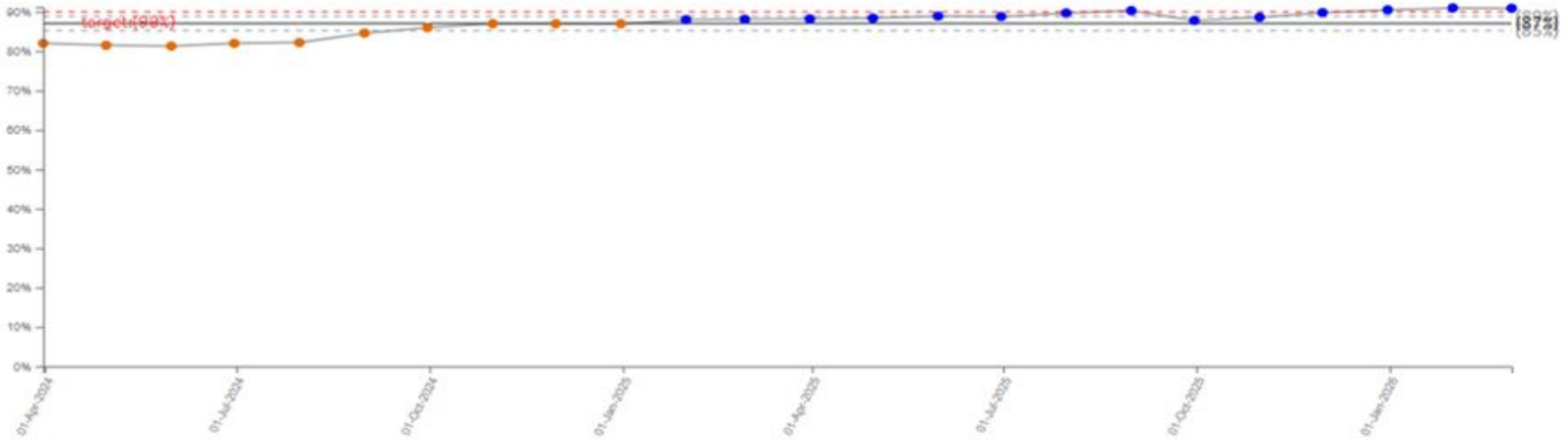
Previous month ...
January-2026

91.0%

Month to date v...
February-2026

90.9%

Target
February-2026
Target is at Trust-wide level



Latest
90.9%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
90%
Target Achievement
The system is expected to consistently fail the target

SPC for D.26 - Bank Staffing Spend

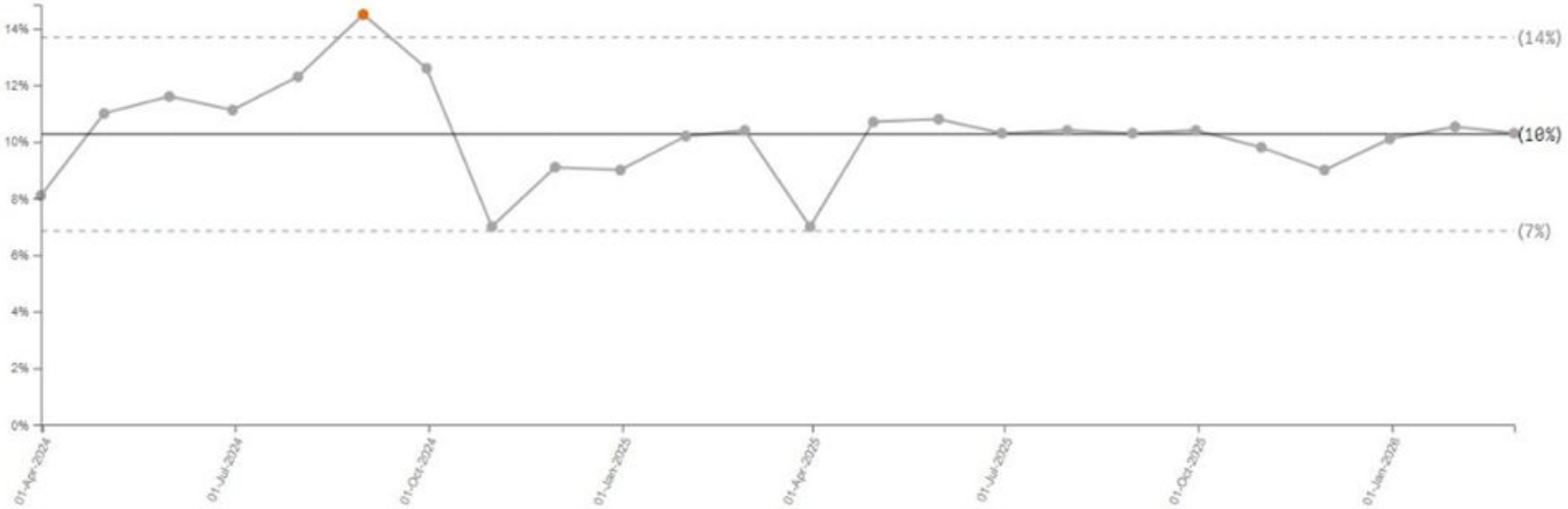
Previous month ...
January-2026

10.5%

Month to date v...
February-2026

10.3%

Target
February-2026
Target is at Trust-wide level



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

PERFORMANCE PILLAR
SPCs

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

NHS
The Princess Alexandra Hospital
NHS Trust

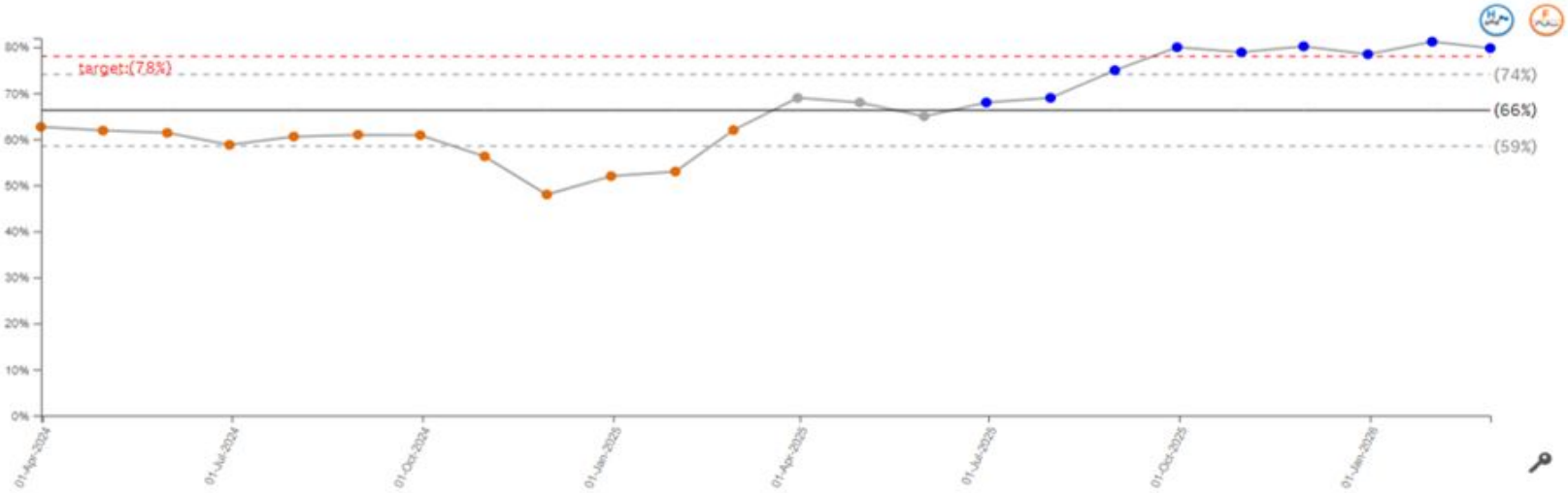
Previous month ...
January-2026

81.2%

Month to date v...
February-2026

79.8%

Target
February-2026
Target is at Trust-wide level



Latest
79.8%
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

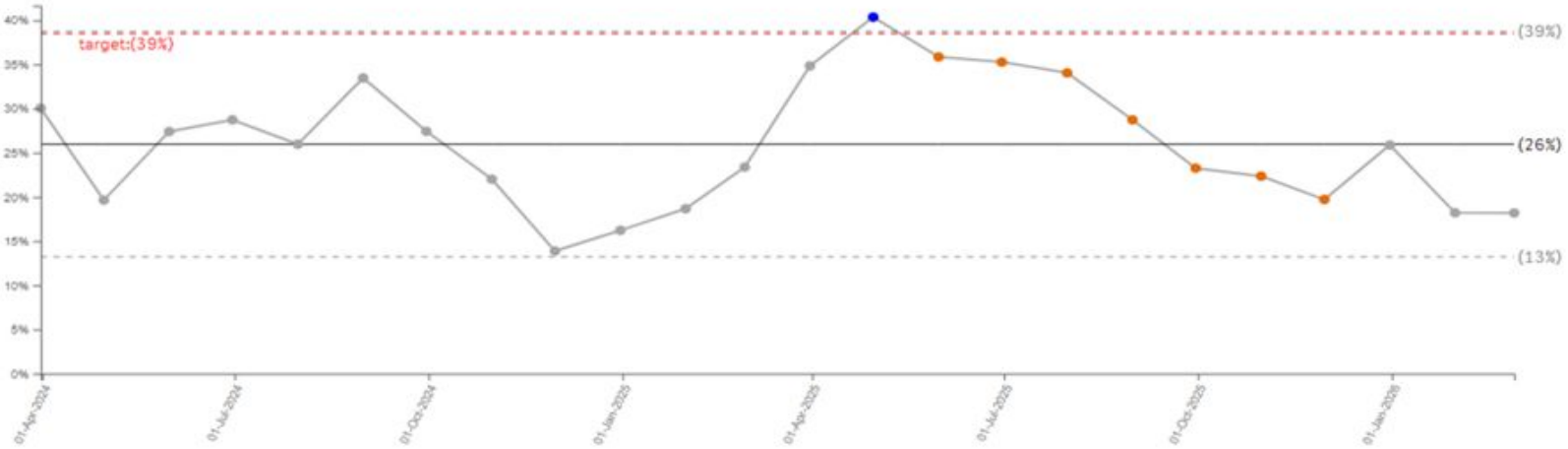
Previous month ...
February-2026

18.2%

Month to date v...
March-2026

21.5%

Target
February-2026
Target is at Trust-wide level



Latest
18.2%
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

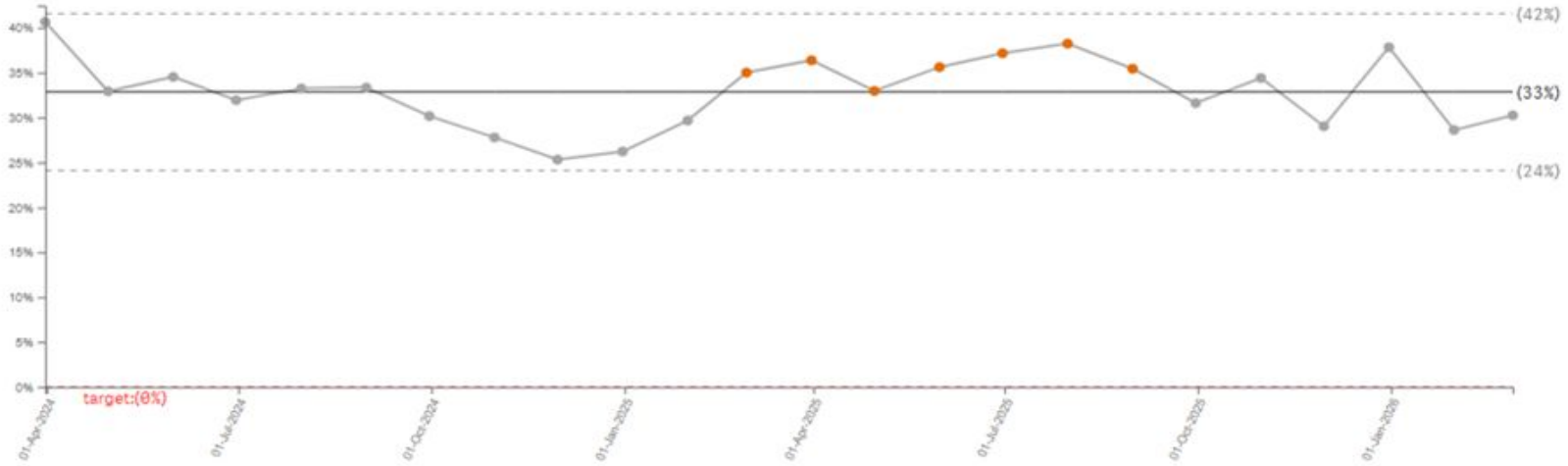
Previous month ...
February-2026

30.3%

Month to date v...
March-2026

32.0%

Target
February-2026
Target is at Trust-wide level



Latest
30.3%
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

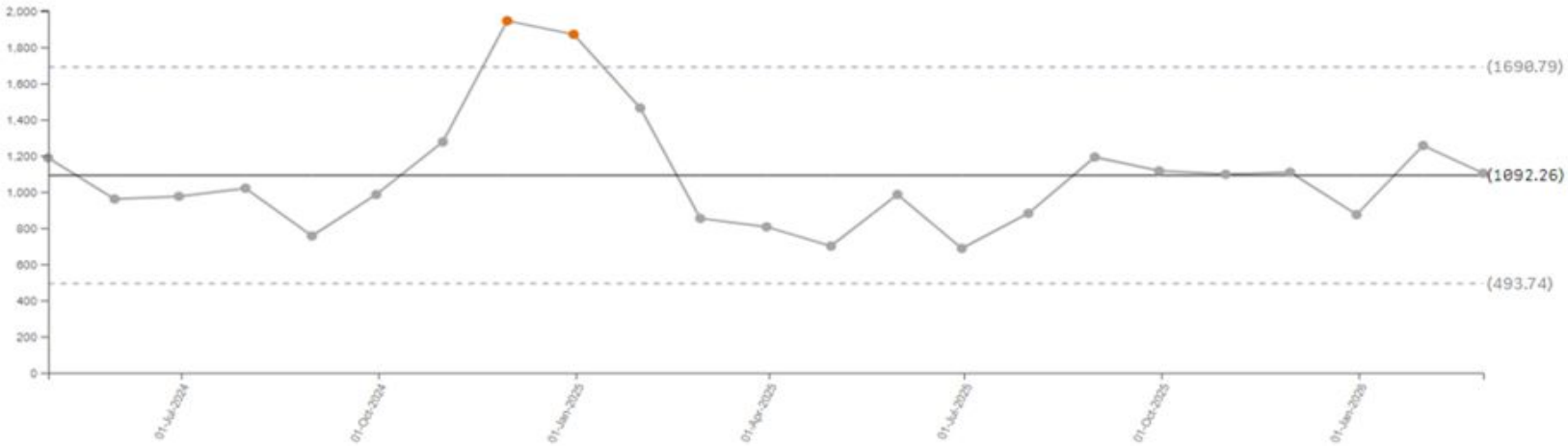
Previous month ...
January-2026

1,257

Month to date v...
February-2026

1,104

Target
February-2026
Target is at Trust-wide level



Latest
1,104
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

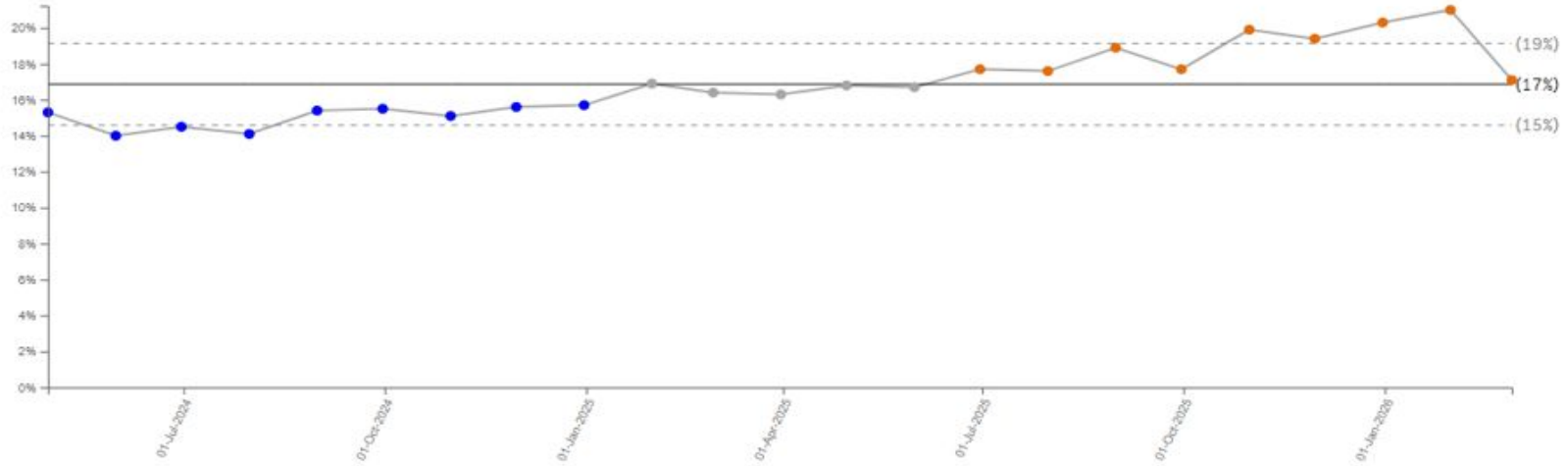
Previous month ...
January-2026

21.0%

Month to date v...
February-2026

17.1%

Target
February-2026
Target is at Trust-wide level



Latest
17.1%
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

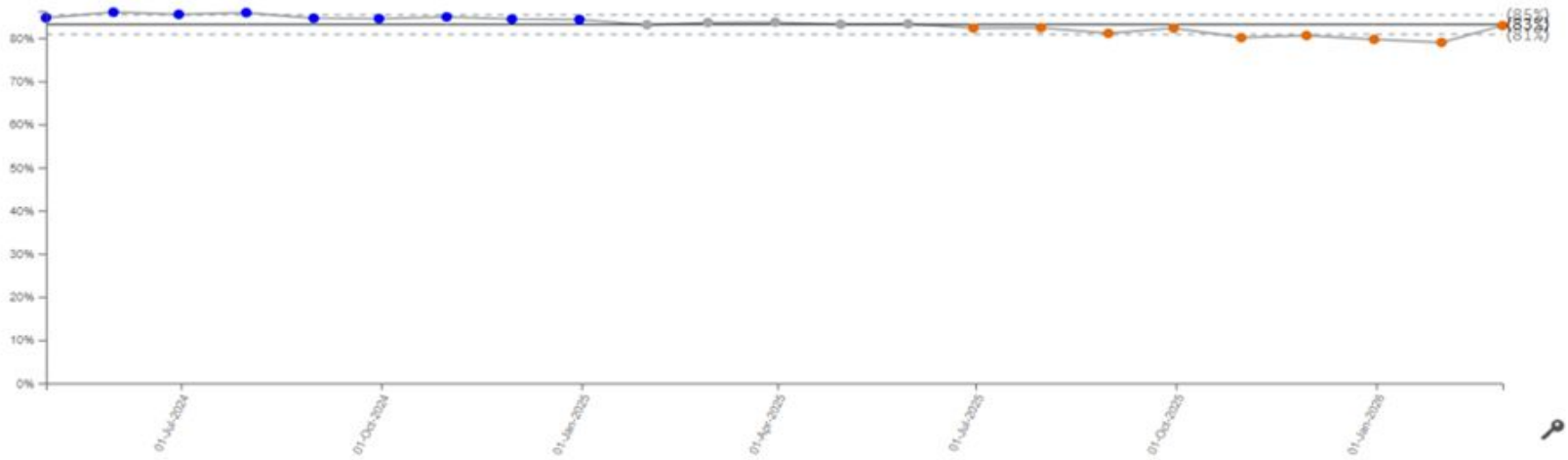
Previous month ...
January-2026

79.0%

Month to date v...
February-2026

82.9%

Target
February-2026
Target is at Trust-wide level



Latest
82.9%
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

NHS
The Princess Alexandra Hospital
NHS Trust

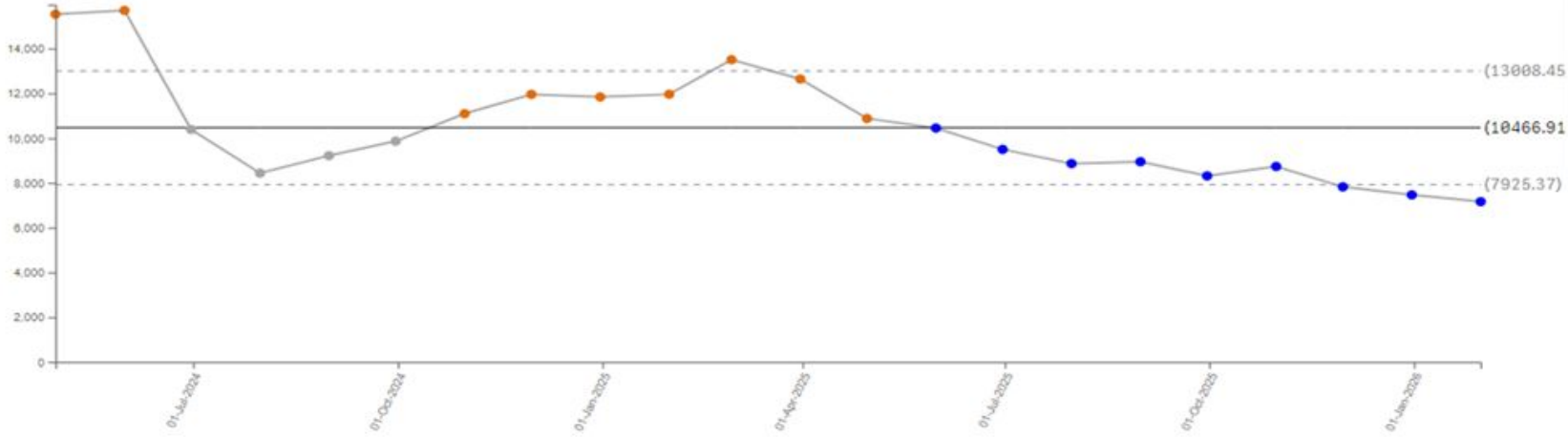
Previous month ...
December-2025

7,467

Month to date v...
January-2026

7,164

Target
January-2026
Target is at Trust-wide level



Latest
7,164
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

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

NHS
The Princess Alexandra Hospital
NHS Trust

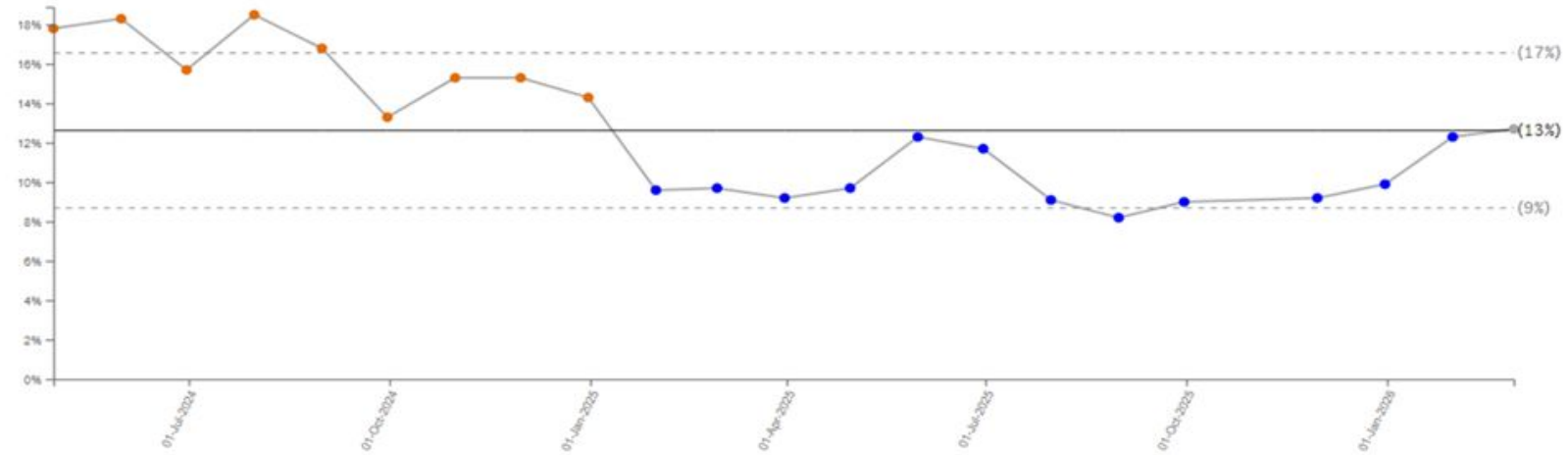
Previous month ...
January-2026

12.3%

Month to date v...
February-2026

12.7%

Target
February-2026
Target is at Trust-wide level



Latest
12.7%
Variance Type
Common cause variation
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

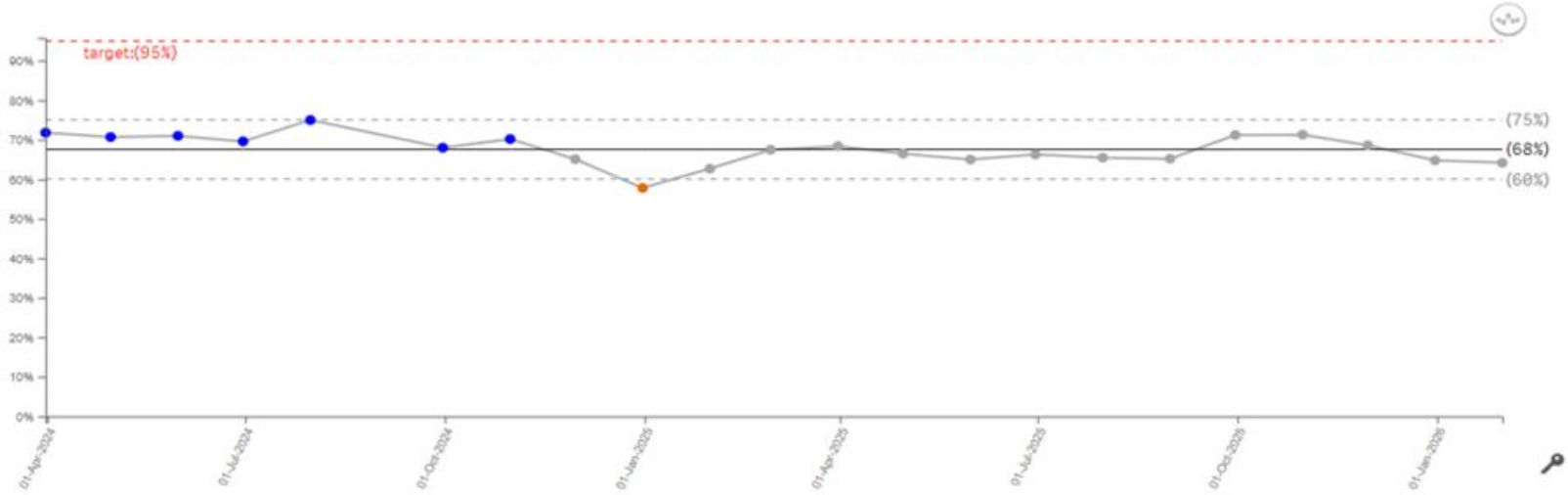
Previous month ...
December-2025

64.8%

Month to date v...
January-2026

64.2%

Target
January-2026
Target is at Trust-wide level



Latest
64.2%
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

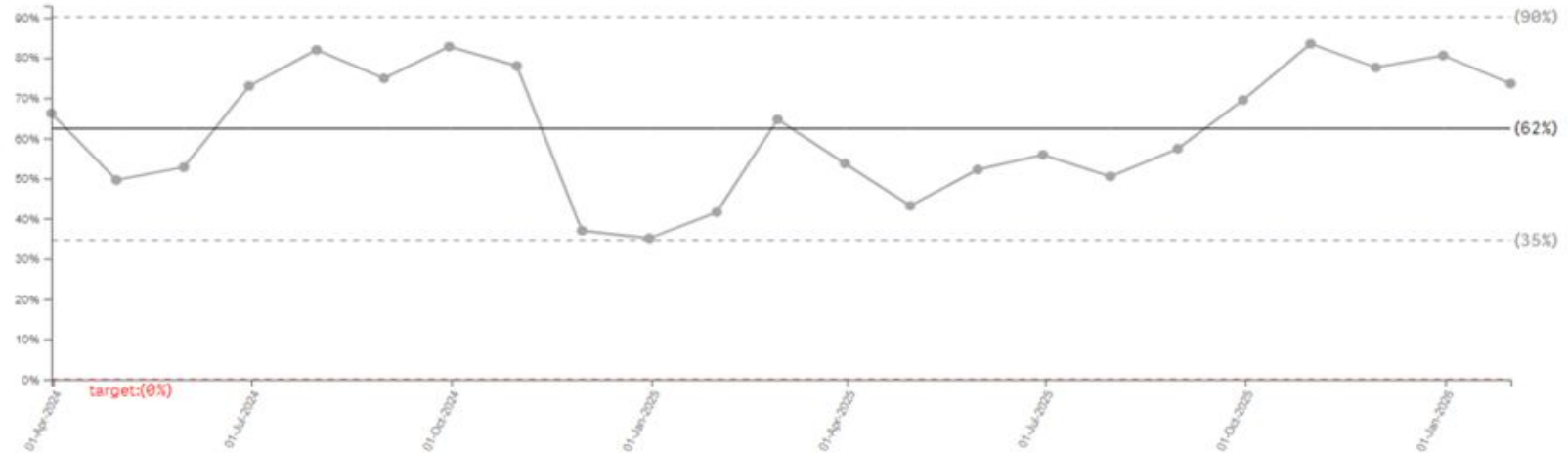
Previous month ...
December-2025

80.6%

Month to date v...
January-2026

73.6%

Target
January-2026
Target is at Trust-wide level



Latest
73.6%
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

NHS
The Princess Alexandra Hospital
NHS Trust

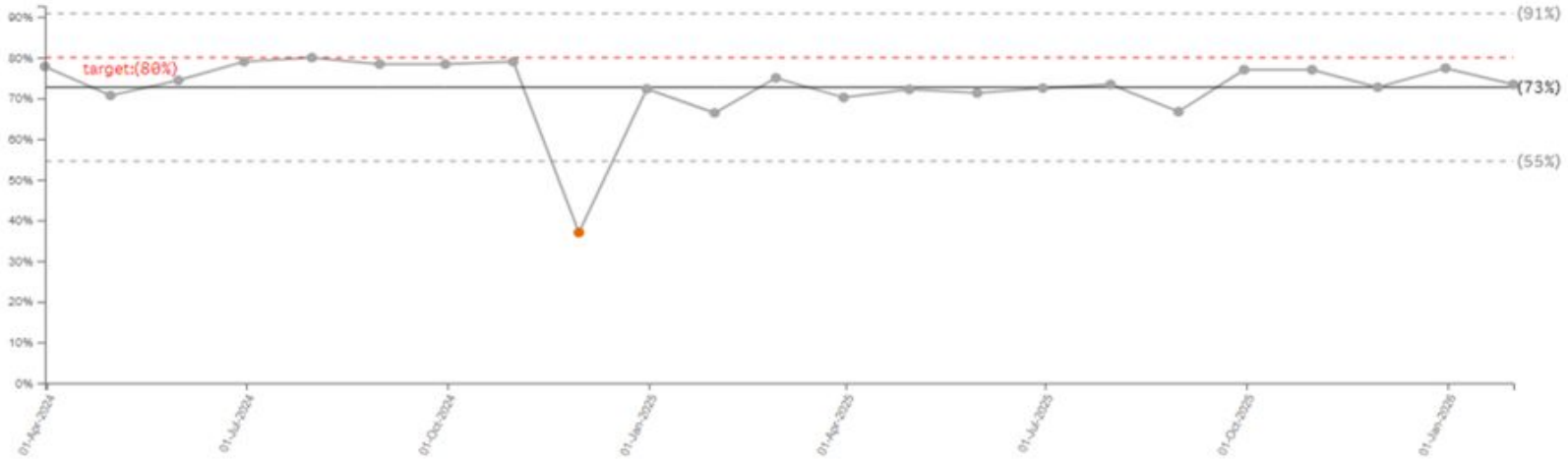
Previous month ...
December-2025

77.4%

Month to date v...
January-2026

73.4%

Target
January-2026
Target is at Trust-wide level



Latest
73.4%
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

NHS
The Princess Alexandra Hospital
NHS Trust

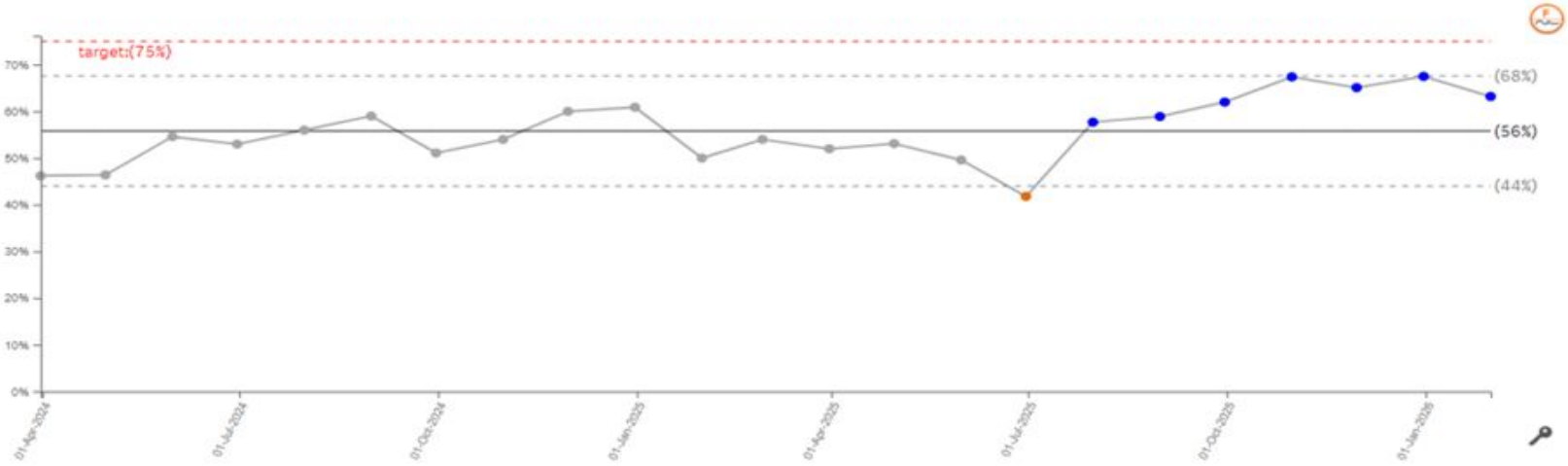
Previous month ...
December-2025

67.5%

Month to date v...
January-2026

63.2%

Target
January-2026
Target is at Trust-wide level



Latest
63.2%
Variance Type
Special cause variation - improvement (indicator where high is good)
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 ...
December-2025

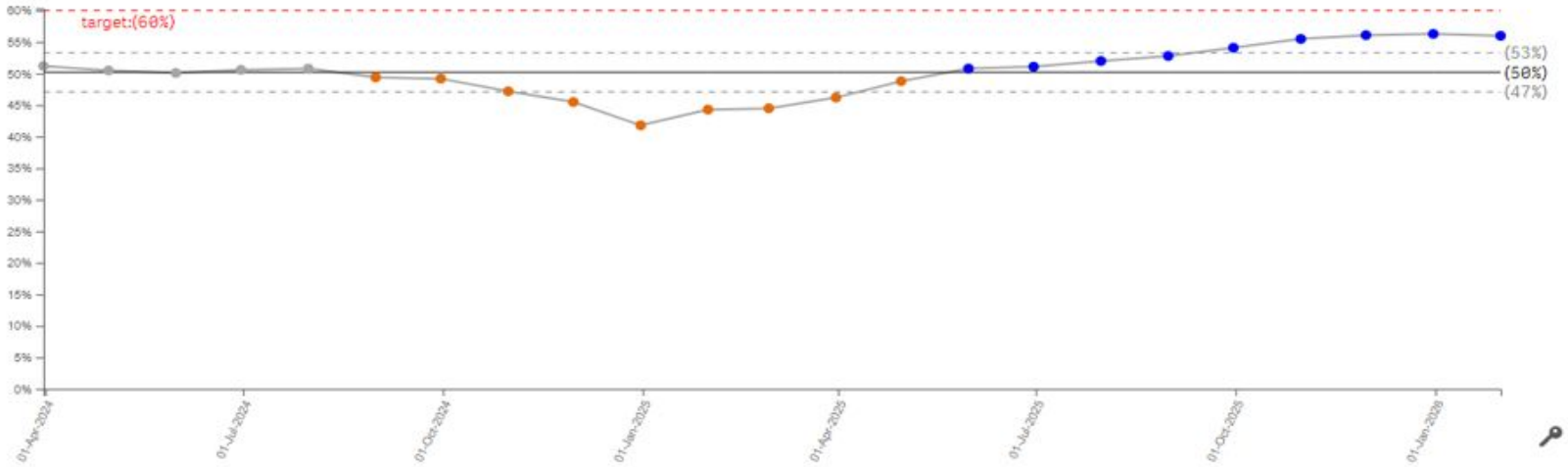
56.3%

Month to date v...
January-2026

56.0%

Target
January-2026

Target is at Trust-wide level



Latest
56.0%
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 ...
January-2026

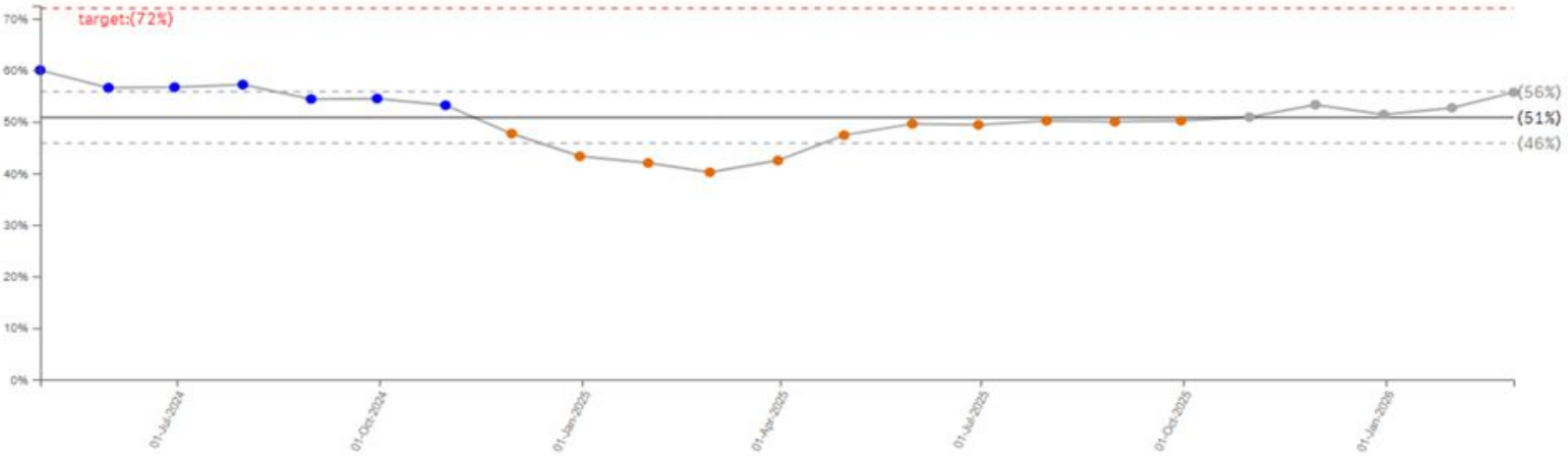
52.7%

Month to date v...
February-2026

55.7%

Target
February-2026

Target is at Trust-wide level



Latest
55.7%
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

NHS The Princess Alexandra Hospital NHS Trust

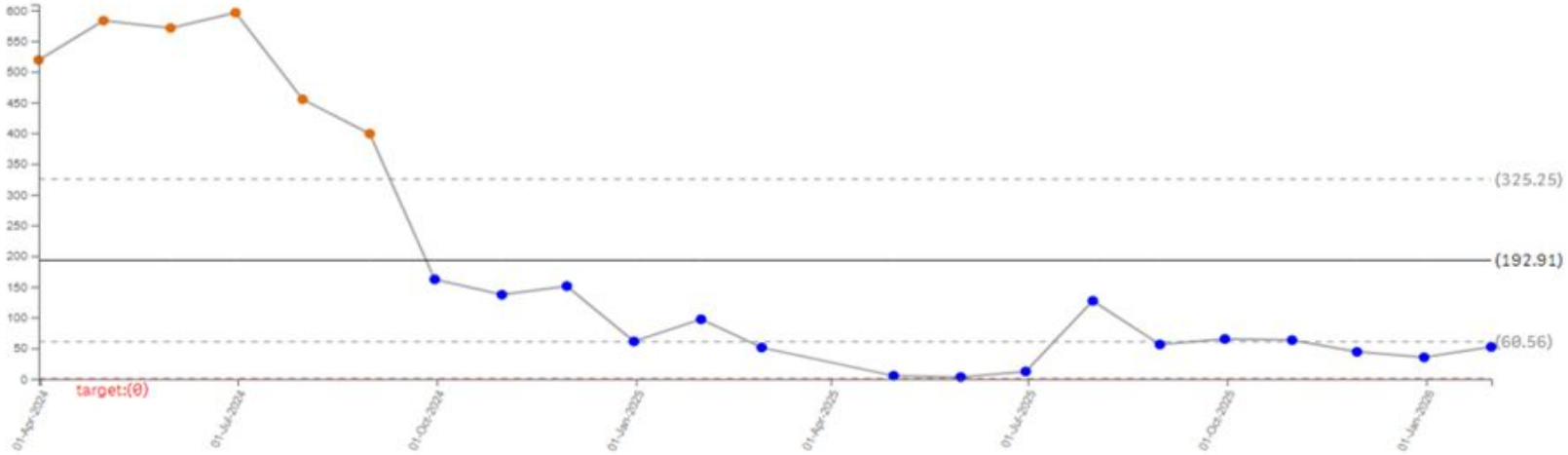
Previous month ...
December-2025

35

Month to date v...
January-2026

52

Target
January-2026
Target is at Trust-wide level



Latest
52
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system is expected to consistently fail the target

SPC for D.37 - RTT over 78 week waiters

NHS The Princess Alexandra Hospital NHS Trust

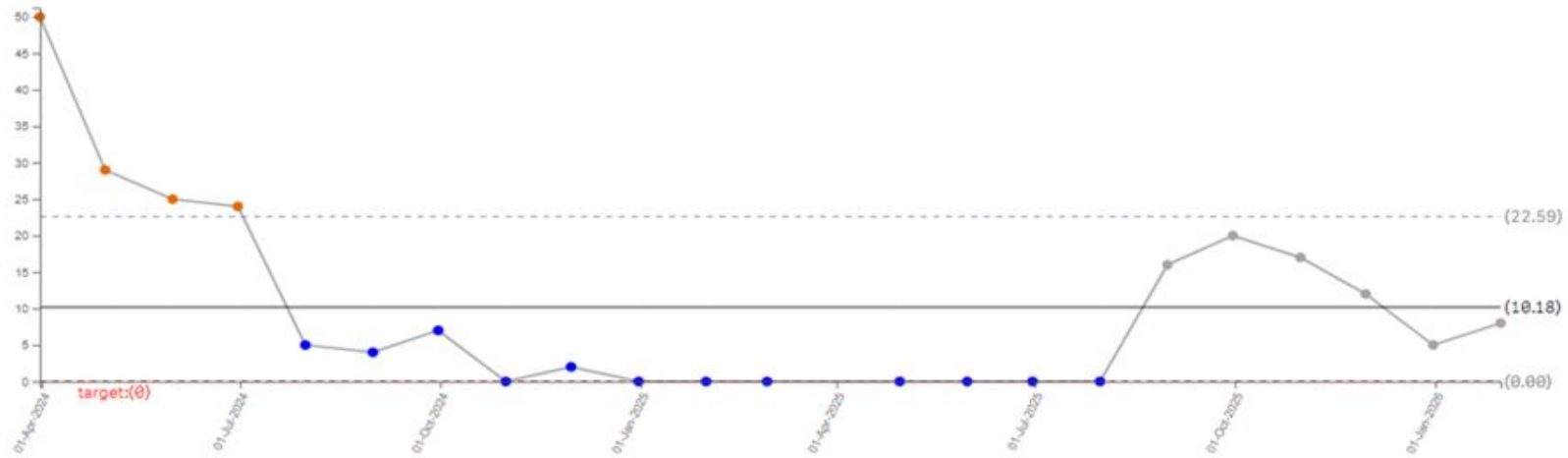
Previous month ...
December-2025

5

Month to date v...
January-2026

8

Target
January-2026
Target is at Trust-wide level



Latest
8
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

POUNDS PILLAR
SPCs

SPC for F.1 - Surplus / (Deficit)

NHS
The Princess Alexandra Hospital
NHS Trust

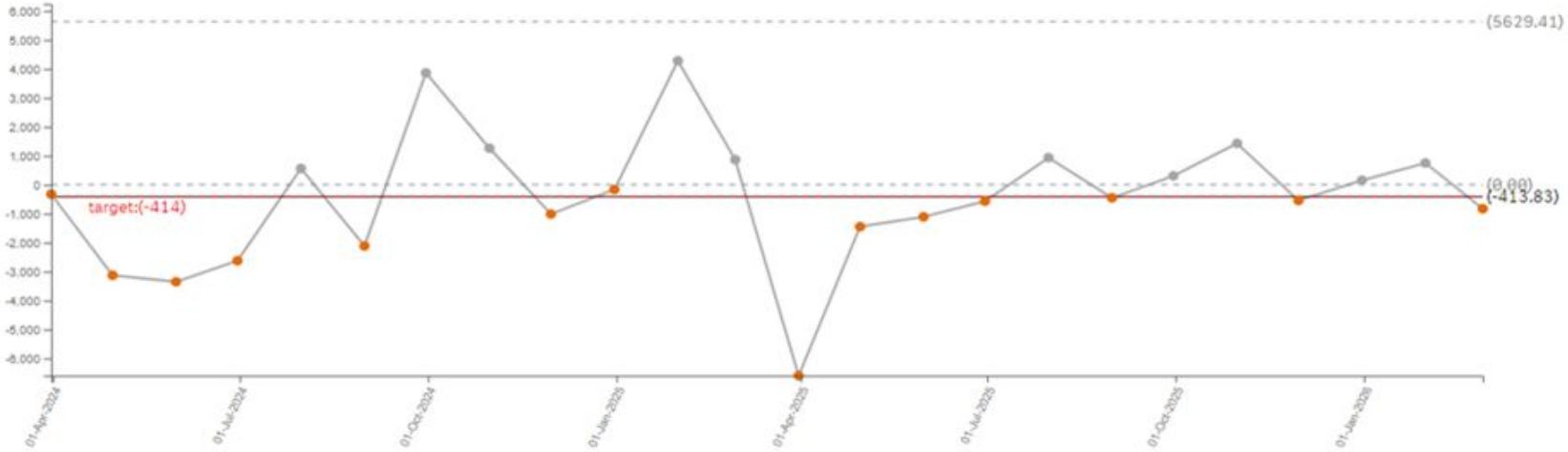
Previous month ...
January-2026

746

Month to date v...
February-2026

-830

Target
February-2026
Target is at Trust-wide level



Latest
-830
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
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

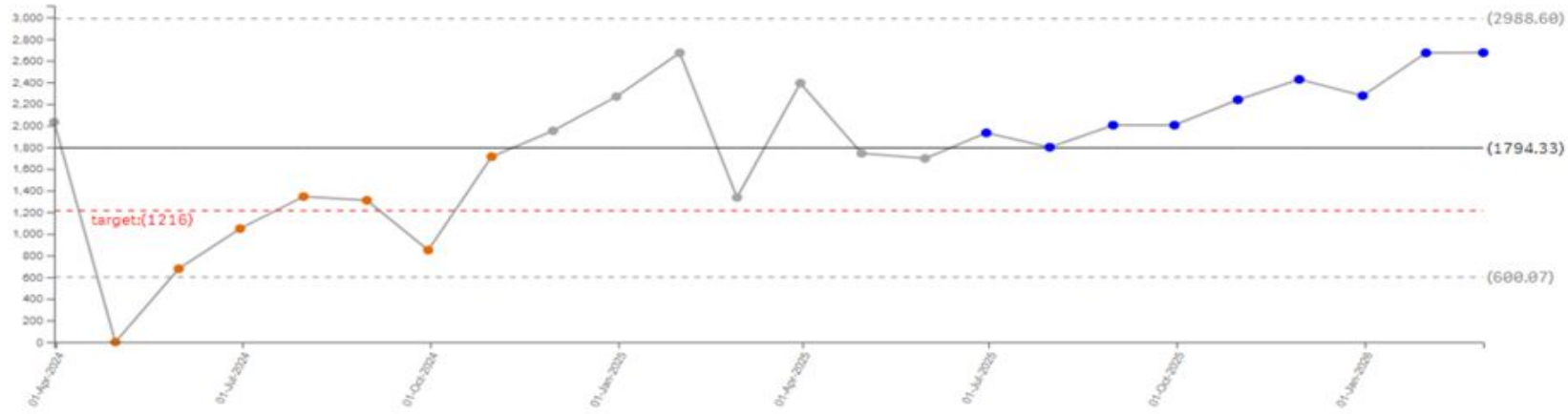
Previous month ...
January-2026

2,672

Month to date v...
February-2026

2,674

Target
February-2026
Target is at Trust-wide level



Latest
2,674
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

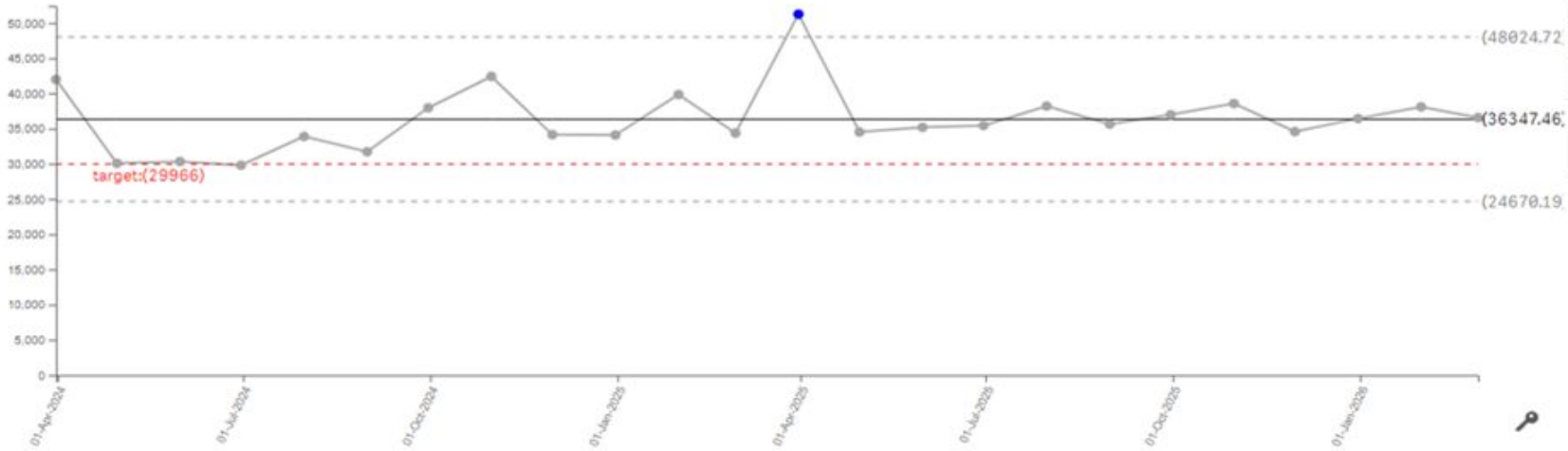
Previous month ...
January-2026

38,106

Month to date v...
February-2026

36,579

Target
February-2026
Target is at Trust-wide level



Latest
36,579
Variance Type
Common cause variation
Target
29966
Target Achievement
The system may achieve or fail the target subject to random variation

SPC for F.4 - Operating Expenditure

NHS
The Princess Alexandra Hospital
NHS Trust

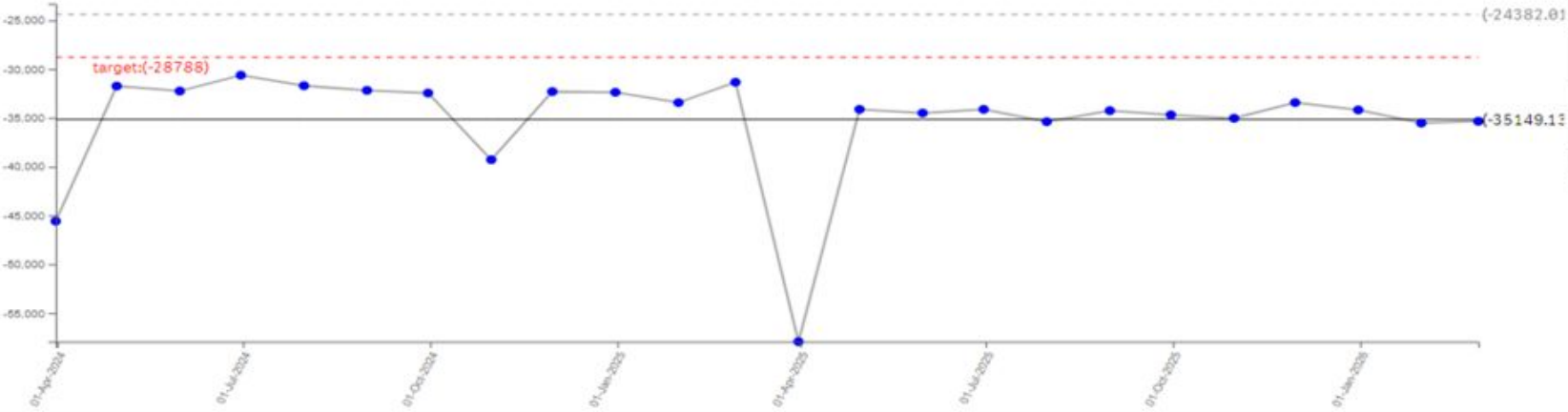
Previous month ...
January-2026

-35,525

Month to date v...
February-2026

-35,336

Target
February-2026
Target is at Trust-wide level



Latest
-35,336
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

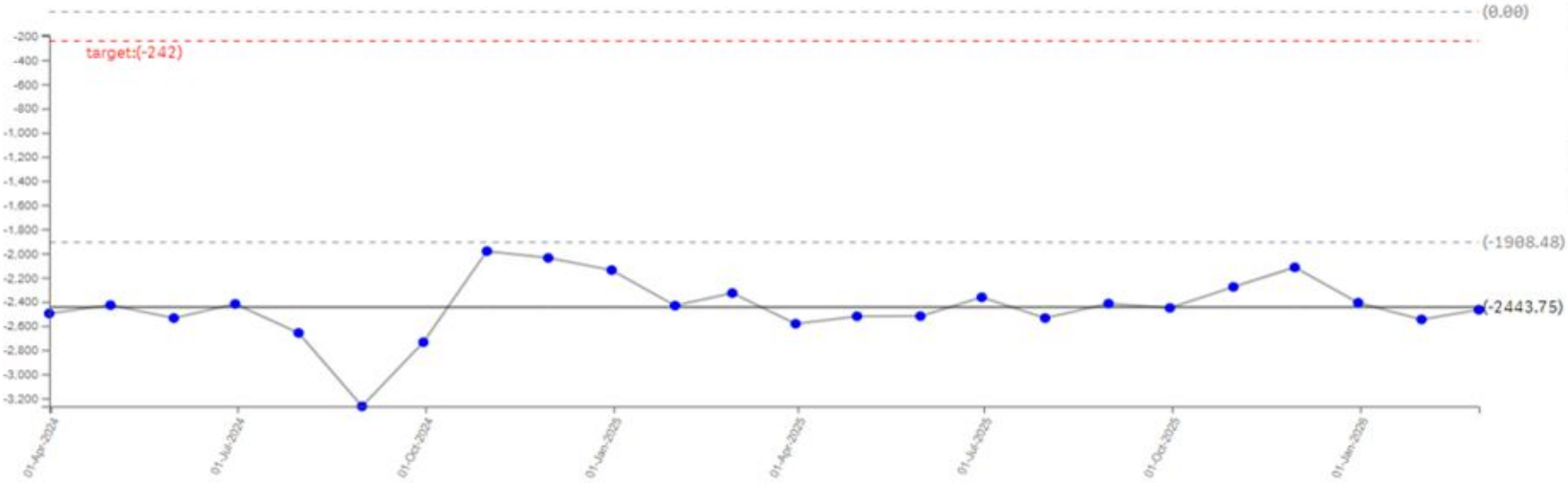
Previous month ...
January-2026

-2,546

Month to date v...
February-2026

-2,466

Target
February-2026
Target is at Trust-wide level



Latest
-2,466
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

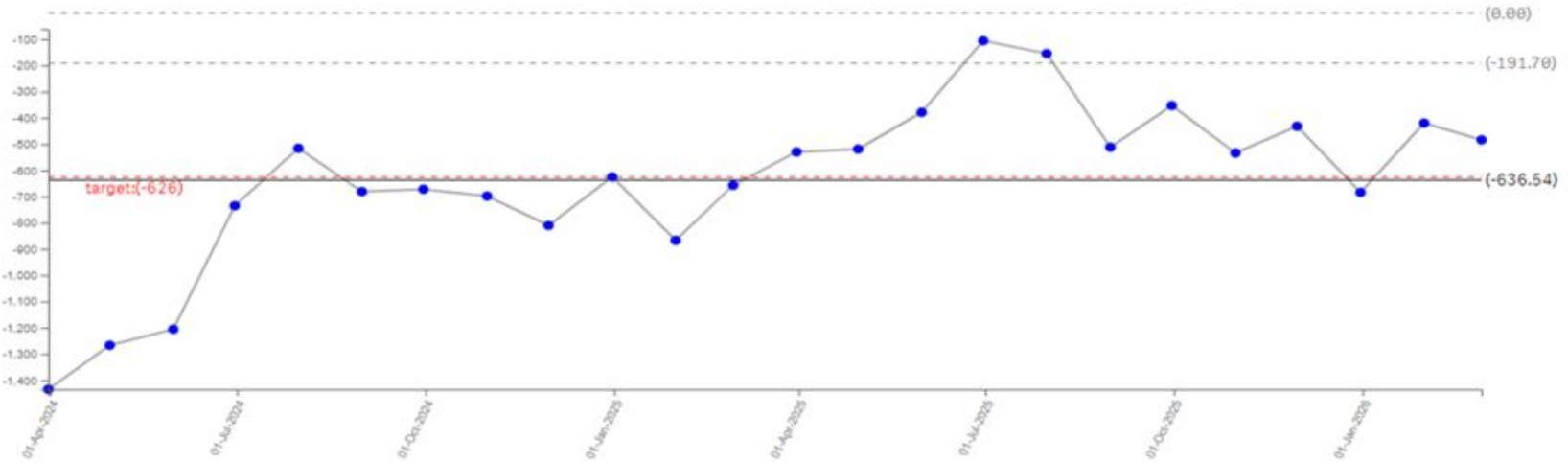
Previous month ...
January-2026

-420

Month to date v...
February-2026

-484

Target
February-2026
Target is at Trust-wide level



Latest
-484
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

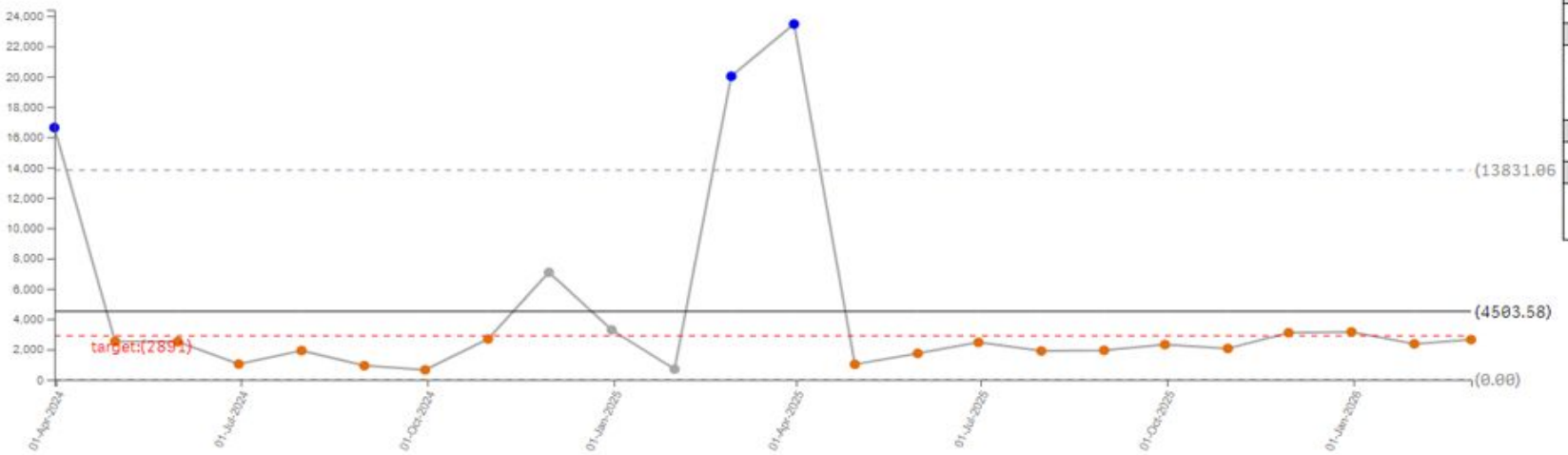
Previous month ...
January-2026

2,361

Month to date v...
February-2026

2,642

Target
February-2026
Target is at Trust-wide level



Latest
2,642
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 ...
January-2026

18,388

Month to date v...
February-2026

20,412

Target
February-2026
Target is at Trust-wide level

Latest
20,412
Variance Type
Common cause variation
Target
28923
Target Achievement
The system may achieve or fail the target subject to random variation

Trust Board (Public) – 2 April 2026

Agenda item:	6.4							
Presented by:	Anna Jebb, Chief Operating Officer							
Prepared by:	Rebecca Gildea, Associate Director of Performance							
Date prepared:	March 2026							
Subject / title:	Access Performance Report							
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**
Key issues:	This report provides a month 11 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. The Board is asked to note sustained pressures across RTT, cancer, urgent care, and diagnostics pathways, alongside key risks linked to reporting readiness and validation activity, all of which may influence delivery trajectories through Q4. Executive Risk and items to note - see Page 1: **Risk / Escalation** • Diagnostic Reporting (DM01) • RTT Performance • Cancer Performance – 62day **Discussion / Note** • Cancer Performance – 28day • UEC Performance • Somerset Deployment							
Recommendatio	The report is provided for information and assurance							

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

Previously considered by:	Operational Board and PAF.26.03.26
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

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Performance Summary - Month 11 (February 26)

Items of risk / escalation:

1. **Diagnostic Reporting (DM01)**
   - February's unvalidated combined Endoscopy position is 53.1%, an improvement on January's 41.7% across all modalities.
   - Some reporting and manual correction issues remain – all expected to be completed before the March 26 submission
2. **RTT Performance**
   - **65-Week Breaches** – February recorded **58 breaches** against a target of **20**, worsening from **38 in January**.
   - **18-Week RTT Target** – February 'live' performance is **57.7%**, slightly below the **58.4% target** (submission 18/03/26).
   - **52-Week RTT Target –** February is tracking **1,229 >52-week breaches**, above the target of **1,000** (submission 18/03/26).
   - The Trust remains committed to eliminating all 65-week waits, delivering 60.6% for 18w % and reducing >52-week waits to 1% by 31 March 2026.
3. **Cancer Performance – 62-Day**
   - February unvalidated performance has worsened to **51.6%** (from 63.2% in January). This is mainly due to delays in key tumour pathways (Breast, Skin, Head & Neck, Lower GI, Upper GI, Lung, Urology), histopathology delays, capacity and workforce challenges.
   - **March's forecast of 75%** needs Urology to achieve 65% and Skin to achieve 75%. Additional capacity and booking resource are in place.

Items to Note

1. **Cancer Performance - 28-Day**
   - February unvalidated performance has increased to **81.5%,** up from 73.4% in January.
   - March is forecast to deliver 80% and is currently on track.
2. **UEC Performance**
   - **4-hour Standard -** February MTD performance improved to 82.8% (January 81.2%) ahead of forecast (74%)
   - **12-hour Standard -** February MTD performance improved to 11% (January 14%) but still behind forecast (7.4%)
   - **Ambulance Handover –** February MTD performance improved to 58.4mins (January 73.1mins) but still behind forecast (44mins)
   - Q4 UEC Sprint actions in place to mitigate and improve performance
3. **Somerset Deployment**
   - Successfully deployed on 02/03/26
   - No adverse impact on performance has been identified.

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		December		January	
		Target	Actual	Target	Actual	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%	77%	77.4%	77%	73.4%
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%	96.5%	96.0%	96.5%	96.7%
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%	74.2%	67.5%	74.2%	63.2%

RTT Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance																			
		April		May		June		July		August		September		October		November		December		January	
		Target	Actual	Target	Actual	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%	57.00%	56.30%	57.70%	56.00%
RTT 65 + week waiters	0	0	5	0	3	0	12	0	27	0	46	0	39	0	39	0	24	0	24	0	39
RTT >52week Standard	498	2748	2403	2494	2175	2278	2265	2066	2402	2300	2449	2200	2157	1800	1947	1350	1931	1,081	1,650	1	1,659
	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%	2.10%	4.1%	1.80%	4.1%
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%	61.60%	51.40%	63.40%	52.70%
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	0	203	0	211
		8%	9.70%	7%	12.30%	6%	11.70%	5%	9.10%	4%	8.20%	3%	9%	2%	9.2%	1%	9.9%	0%	12.3%	0%	12.7%
Reduction in ASIs	0		12074		10071		9197		8683		8591		8157		8669		8858		8938		8459

Diagnostic Standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance																					
		April		May		June		July		August		September		October		October		November		December		January	
		Target	Actual	Target	Actual	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%	95%	85.36%	95%	80.40%
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%	95%	79.21%	95%	85.58%
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%	75%	74.52%	75%	71.16%
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%	95%	33.13%	95%	34.36%
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%	93%	38.96%	93%	37.68%
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%	94%	33.33%	94%	37.09%
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%	87%	86.09%	87%	85.09%
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%	15%	12.77%	15%	14.77%
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%	TBC	71.88%	TBC	57.69%

Urgent Care standards

Operating Plan Performance Measure	% Target by March 26	Month End Performance																			
		April		May		June		July		August		September		October		November		December		January		February	
		Target	Actual	Target	Actual	Target	Actual	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%	71%	79%	72%	81.2%	74%	82.8%
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%	9%	9%	9%	14%	7.5%	11%
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	41 mins	39.41 mins	43mins	73.19 mins	44mins	58.4mins

Appendix 2 – Non-Elective and Elective Benchmarking

A. 4 Hour

System	Trust level performance	Performance in March last year	March to date	Comparison to last ye	Plan	Comparison to plan	Required to achieve plan for remainder o month	Average over last 7 day	Thu 05 Mar	Wed 04 Mar	Tue 03 Mar	Mon 02 Mar	Sun 01 Mar	Sat 28 Feb	Fri 27 Feb
BLMK	Bedfordshire Hospitals NHS Foundation Trust	72.0%	77.5%	5.5%	78.1%	-0.5%	78.2%	77.3%	76.8%	74.2%	73.1%	78.9%	85.1%	77.5%	76.0%
BLMK	Milton Keynes University Hospital NHS Foundation Trus	74.7%	71.7%	-3.0%	74.3%	-2.6%	74.9%	72.0%	63.3%	62.4%	72.8%	78.6%	81.5%	75.2%	70.5%
C&P	Cambridge University Hospitals NHS Foundation Trust	70.9%	66.3%	-4.6%	78.3%	-12.0%	80.6%	66.1%	73.3%	73.7%	62.8%	57.7%	65.2%	69.8%	61.8%
C&P	North West Anglia NHS Foundation Trust	64.5%	75.3%	10.9%	78.0%	-2.7%	78.5%	73.8%	73.5%	69.4%	78.3%	78.7%	77.1%	68.8%	70.8%
HWE	East and North Hertfordshire NHS Trust	74.0%	76.0%	2.0%	78.3%	-2.3%	78.8%	74.5%	76.8%	79.4%	75.8%	75.1%	73.1%	65.9%	74.8%
HWE	The Princess Alexandra Hospital NHS Trust	66.4%	78.1%	11.6%	78.0%	0.1%	78.0%	78.3%	74.9%	75.2%	79.5%	80.0%	80.1%	79.3%	78.3%
HWE	West Hertfordshire Teaching Hospitals NHS Trust	81.9%	88.0%	6.2%	85.0%	3.0%	84.4%	86.7%	95.0%	92.9%	90.2%	81.9%	80.9%	80.8%	84.9%
MSE	Mid and South Essex NHS Foundation Trust	68.3%	68.3%	0.0%	78.0%	-9.7%	79.9%	68.9%	68.3%	67.9%	65.6%	71.2%	68.3%	69.9%	71.3%
N&W	James Paget University Hospitals NHS Foundation Trust	63.0%	72.1%	9.1%	78.0%	-5.9%	79.1%	72.7%	74.4%	72.1%	64.6%	68.5%	82.4%	76.3%	72.5%
N&W	Norfolk and Norwich University Hospitals NHS Foundatio	81.7%	81.4%	-0.3%	80.9%	0.5%	80.8%	81.5%	79.5%	81.0%	77.6%	83.0%	85.5%	84.6%	78.8%
N&W	The Queen Elizabeth Hospital, King's Lynn, NHS Found	58.8%	69.1%	10.4%	78.2%	-9.1%	79.9%	67.3%	70.7%	73.7%	71.5%	67.4%	60.8%	59.8%	64.3%
SNEE	East Suffolk and North Essex NHS Foundation Trust	76.4%	76.7%	0.3%	78.4%	-1.6%	78.7%	76.5%	74.6%	75.9%	76.6%	79.7%	76.6%	77.0%	74.9%
SNEE	West Suffolk NHS Foundation Trust	88.4%	72.5%	-15.9%	78.0%	-5.4%	79.0%	69.6%	71.3%	69.1%	70.6%	72.4%	80.2%	60.6%	63.9%
	Region	72.7%	74.9%	2.2%	79.3%	-4.4%	80.1%	74.5%	74.7%	74.3%	73.5%	75.4%	76.7%	73.6%	73.1%

B. 12 Hour

System	Trust level performance	Performance in March last year	March to date	Comparison to last year	Plan	Comparison to plan	Required to achieve plan for remainder of month	Average over last 7 days	Wed 04 Mar	Tue 03 Mar	Mon 02 Mar	Sun 01 Mar	Sat 28 Feb	Fri 27 Feb	Thu 26 Feb
BLMK	Bedfordshire Hospitals NHS Foundation Trust	6.1%	4.8%	-1.3%	3.0%	1.8%	2.7%	4.4%	2.6%	7.0%	5.6%	3.9%	2.8%	4.5%	4.1%
BLMK	Milton Keynes University Hospital NHS Foundation Trust	6.9%	6.4%	-0.5%	5.0%	1.4%	4.8%	4.7%	0.0%	6.4%	7.3%	5.9%	2.9%	3.9%	1.8%
C&P	Cambridge University Hospitals NHS Foundation Trust	10.1%	12.5%	2.4%	5.0%	7.5%	3.9%	13.2%	12.7%	11.9%	15.4%	9.8%	13.8%	16.8%	12.1%
C&P	North West Anglia NHS Foundation Trust	11.7%	10.8%	-0.9%	9.5%	1.4%	9.3%	11.7%	13.6%	11.6%	9.7%	7.9%	10.4%	14.1%	14.0%
HWE	East and North Hertfordshire Teaching NHS Trust	11.8%	11.3%	-0.5%	5.0%	6.3%	4.1%	11.2%	14.0%	13.3%	8.1%	9.8%	7.7%	5.8%	17.8%
HWE	The Princess Alexandra Hospital NHS Trust	7.4%	11.6%	4.2%	6.5%	5.1%	5.7%	10.6%	9.7%	20.7%	9.7%	6.1%	9.9%	6.0%	11.4%
HWE	West Hertfordshire Teaching Hospitals NHS Trust	8.5%	6.5%	-2.0%	6.4%	0.1%	6.4%	8.8%	4.0%	5.3%	6.3%	11.3%	13.4%	12.2%	10.1%
MSE	Mid and South Essex NHS Foundation Trust	9.4%	13.7%	4.3%	9.8%	3.9%	9.2%	14.7%	15.8%	14.6%	12.2%	12.5%	13.7%	15.6%	18.0%
N&W	James Paget University Hospitals NHS Foundation Trust	10.5%	9.5%	-1.0%	6.9%	2.6%	6.5%	9.7%	8.4%	8.6%	15.1%	4.8%	11.3%	9.1%	9.9%
N&W	Norfolk and Norwich University Hospitals NHS Foundation Trust	5.7%	8.9%	3.2%	4.0%	4.9%	3.3%	7.7%	9.5%	10.8%	8.8%	4.1%	5.9%	7.7%	7.0%
N&W	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	15.5%	12.0%	-3.5%	7.8%	4.3%	7.1%	12.9%	15.9%	9.2%	12.0%	12.1%	11.6%	15.8%	14.4%
SNEE	East Suffolk and North Essex NHS Foundation Trust	13.2%	12.5%	-0.8%	5.3%	7.2%	4.2%	12.9%	10.7%	13.2%	13.0%	13.1%	14.2%	14.7%	11.2%
SNEE	West Suffolk NHS Foundation Trust	2.2%	11.2%	9.0%	2.8%	8.4%	1.6%	11.4%	11.8%	13.7%	9.8%	8.6%	7.3%	13.9%	13.8%
	Region	9.1%	10.5%	1.3%	6.4%	4.1%	5.8%	10.7%	11.1%	11.5%	10.3%	8.8%	9.8%	11.2%	11.8%

C. Cancer – 62day

	Sep-25	Oct-25	Nov-25			
	% in target (Total)	% in target (Total)	Cases	Breaches	% in target (Total)	Change from last month
EAST AND NORTH HERTFORDSHIRE NHS TRUST	83.3%	85.7%	426	56	86.9%	1.2%
WEST SUFFOLK NHS FOUNDATION TRUST	84.9%	81.7%	265	36	86.4%	4.7%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	75.3%	75.7%	325	56	82.8%	7.0%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	67.5%	75.1%	482	114	76.3%	1.2%
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	40.5%	61.0%	25	6	76.0%	15.0%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	70.4%	68.3%	559	145	74.1%	5.7%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	71.2%	70.4%	543	164	69.8%	-0.6%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	72.0%	65.9%	254	77	69.7%	3.7%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	56.6%	63.8%	651	224	65.6%	1.8%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	61.9%	67.4%	269	94	65.1%	-2.3%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	70.7%	58.7%	686	250	63.6%	4.9%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	63.0%	53.3%	255	107	58.0%	4.7%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	52.1%	60.3%	219	98	55.3%	-5.0%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	47.3%	47.1%	1035	486	53.0%	6.0%
Total	65.4%	65.1%	5994	1913	68.1%	3.0%

RAG rating used

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

D. 28 Day FDS

	Sep-25	Oct-25	Nov-25			
	% in target (Total)	% in target (Total)	Cases	Breaches	% in target (Total)	Change since last month
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	69.5%	81.9%	2,627	392	85.1%	3.2%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	75.8%	84.0%	2,334	380	83.7%	-0.3%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	82.1%	85.0%	1,610	274	83.0%	-2.1%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	73.7%	81.8%	3,173	584	81.6%	-0.3%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	76.5%	73.6%	1,154	261	77.4%	3.7%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	76.3%	77.6%	1,586	360	77.3%	-0.3%
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	73.9%	76.5%	2,659	636	76.1%	-0.4%
WEST SUFFOLK NHS FOUNDATION TRUST	74.1%	74.6%	1,372	366	73.3%	-1.3%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	77.0%	77.0%	1,770	483	72.7%	-4.3%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	69.6%	67.7%	1,450	401	72.3%	4.6%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	71.2%	77.3%	1,421	436	69.3%	-8.0%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	70.5%	66.2%	4,705	1,632	65.3%	-0.9%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	60.5%	61.3%	6,723	2,374	64.7%	3.4%
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	0.0%		1	1	0.0%	
Total	70.9%	74.1%	32,585	8,580	73.7%	-0.4%

RAG rating used

Green: ≥80%
Amber: 75-80%
Red: <77%

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

E. Elective – Waiting for First Attendance

		w-e 28 Dec 25	w-e 04 Jan 26	w-e 11 Jan 26	w-e 18 Jan 26	w-e 25 Jan 26	w-e 01 Feb 26	
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	Distance from Mar-26 target*
Y61	EAST OF ENGLAND	60.8%	60.5%	60.7%	61.4%	62.0%	62.5%	-4.5%
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED (	63.4%	63.2%	63.9%	64.2%	64.6%	64.3%	-2.7%
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE	62.9%	62.5%	63.0%	63.5%	63.9%	64.9%	-2.1%
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOAR	65.1%	64.6%	64.8%	64.9%	65.7%	66.1%	-0.9%
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	49.9%	49.5%	49.5%	49.7%	50.0%	50.8%	-16.2%
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	59.8%	59.5%	59.5%	61.6%	62.7%	63.3%	-3.7%
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARI	72.0%	71.8%	72.1%	72.7%	73.4%	73.6%	3.0%
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	63.6%	63.4%	64.2%	64.4%	64.8%	64.6%	-2.4%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	63.4%	62.8%	63.6%	64.2%	65.0%	65.8%	-2.8%
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	71.3%	71.3%	71.5%	71.3%	72.2%	72.6%	1.9%
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	70.7%	70.7%	71.4%	72.1%	73.0%	73.3%	5.1%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	57.9%	57.4%	57.8%	57.6%	57.4%	58.2%	-11.3%
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	49.9%	49.5%	49.5%	49.7%	50.0%	50.8%	-16.2%
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUS	62.9%	62.8%	63.1%	63.5%	64.0%	63.6%	-3.4%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDA	62.0%	62.1%	62.0%	66.5%	68.9%	69.6%	2.6%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	61.6%	61.4%	61.6%	62.0%	62.3%	63.5%	-3.5%
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	92.9%	92.4%	92.7%	93.2%	92.8%	93.5%	11.2%
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	52.1%	51.4%	51.5%	52.4%	52.9%	52.7%	-14.3%
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATIC	56.7%	55.9%	55.5%	55.8%	56.0%	56.2%	-10.8%
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	70.0%	68.9%	68.9%	68.5%	69.4%	70.1%	-3.3%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	75.4%	74.7%	74.1%	74.3%	74.5%	74.2%	-4.7%

F. Elective – Total Waiting trend

				Total Incomplete Pathways									
Org code	Org Name			w-e 28 Dec 25	w-e 04 Jan 26	w-e 11 Jan 26	w-e 18 Jan 26	w-e 25 Jan 26	w-e 01 Feb 26	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			853,059	851,060	849,109	842,202	837,815	835,098	-2,717	-3,991	1,274
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CA			120,888	120,631	120,471	120,877	120,699	120,951	252	80	172
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE B			150,941	150,470	150,068	149,576	148,985	148,555	-430	-479	49
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD			143,207	142,848	142,087	141,567	140,892	140,037	-855	-703	-152
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD			179,257	178,654	178,326	178,271	176,958	176,499	-459	-539	80
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD			135,488	135,304	135,121	129,327	128,437	127,856	-581	-1,862	1,281
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD			123,278	123,153	123,036	122,584	121,844	121,200	-644	-488	-156
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST			85,828	85,547	85,387	85,275	85,275	85,904	629	89	540
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST			65,387	65,252	65,235	64,984	64,703	64,424	-279	-207	-72
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST			53,579	53,524	53,376	53,399	53,098	53,223	125	-75	200
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST			90,678	90,631	90,514	90,342	89,547	89,142	-405	-372	-33
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST			33,781	33,765	33,638	33,358	33,269	33,345	76	-105	181
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST			179,257	178,654	178,326	178,271	176,958	176,499	-459	-539	80
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST			35,060	35,084	35,084	35,602	35,424	35,047	-377	-9	-368
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATIC			75,618	75,468	75,222	69,507	68,683	68,373	-310	-1,774	1,464
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST			80,031	79,674	79,358	79,144	78,964	78,800	-164	-219	55
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST			5,523	5,544	5,475	5,448	5,318	5,331	13	-53	66
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST			41,691	41,759	40,956	40,430	40,019	40,182	163	-394	557
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATIOI			26,089	26,071	26,261	26,462	26,485	26,138	-347	17	-364
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST			47,937	47,565	47,755	47,738	47,775	46,632	-1,143	-233	-910
RGR	WEST SUFFOLK NHS FOUNDATION TRUST			32,600	32,522	32,522	32,242	32,297	32,058	-239	-116	-123

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	3074	2537	2000	1463	926	380
	Cohort actual	8374	7862	7508	7220	6939	6425	5825	5227	4759	4281	3611	3118	2448	1959			
	Cohort variance					145	181	131	83	165	237	117	44	89	41			
	52+ breach plan/trajectory	1081	1044	1007	970	933	896	859	822	785	748	711	1496	1269	1045	818	596	380
	52+ actual	2022	2002	1819	1801	1891	1879	1764	1761	1768	1778	1650	1611	1398	1266			
	Actual variance	941	958	812	831	958	983	905	939	983	1030	939	115	129	221			
	52+ % Trajectory												3.75%	3.20%	2.65%	2.10%	1.55%	1.00%
	52+ % actual					4.50%	4.55%	4.55%	4.39%	4.37%	4.37%	4.11%	4.03%	3.56%	3.26%			
	Predicted WL size												39902	39669	39436	38958	38480	38000
	Actual WL size											40135	39962	39268	38889			
T&O	Cohort plan/trajectory					1406	1296	1186	1076	966	856	746	636	526	416	306	196	80
	Cohort actual	1743	1639	1538	1474	1432	1366	1233	1078	989	893	717	574	433	323			
	Cohort variance					26	70	47	2	23	37	29	62	93	93			
	AFB Cohort plan / trajectory								15	14	5	0	0	0	0	0	0	0
	AFB Cohort actual					14	26	16	15	14	16	15	10	8	5			
	AFB Cohort variance								0	0	11	15	10	8	5			
	52+ breach plan/trajectory	204	198	192	186	180	174	168	162	156	150	144	138	132	126	120	114	80
	52+ actual	530	537	480	455	451	475	406	392	384	375	323	303	281	242			
	Actual variance	326	339	288	269	271	301	238	230	228	225	179	165	149	116			
ENT	Cohort plan/trajectory					1082	1002	922	842	762	682	602	522	442	362	282	202	80
	Cohort actual	835	908	1113	1094	1098	1055	984	933	868	820	750	693	494	378			
	Cohort variance					16	53	62	91	106	138	148	171	52	16			
	AFB Cohort plan / trajectory								23	15	7	0	0	0	0	0	0	0
	AFB Cohort actual					74	61	24	23	17	11	9	33	17	3			
	AFB Cohort variance								0	2	4	9	33	17	3			
	52+ breach plan/trajectory	195	189	183	177	171	165	159	153	147	141	135	129	123	117	111	105	80
	52+ actual	267	295	296	306	322	337	318	343	341	359	361	364	256	230			
	Actual variance	72	106	113	129	151	172	159	190	194	218	226	235	133	113			
Gynaecology	Cohort plan/trajectory					419	394	369	344	319	294	269	244	219	194	169	144	80
	Cohort actual	442	411	413	421	431	381	340	296	318	301	348	373	334	323			
	Cohort variance					12	13	29	48	1	7	79	129	115	129			
	AFB Cohort plan / trajectory								386	286	186	60	0	0	0	0	0	0
	AFB Cohort actual					403	426	416	386	243	240	221	115	83	23			
	AFB Cohort variance								0	43	54	161	115	83	23			
	52+ breach plan/trajectory	206	199	192	185	178	171	164	157	150	143	136	129	122	115	108	101	80
	52+ actual	166	162	140	155	156	153	135	136	202	197	238	254	242	239			
	Actual variance	40	37	52	30	22	18	29	21	52	54	102	125	120	124			
Cardiology	Cohort plan/trajectory					752	692	632	572	512	452	392	332	272	212	152	92	45
	Cohort actual	1152	985	886	826	770	675	607	525	479	372	261	179	161	124			
	Cohort variance					18	17	25	47	33	80	131	153	111	88			
	AFB Cohort plan / trajectory								9	6	0	0	0	0	0	0	0	0
	AFB Cohort actual					20	21	13	9	6	8	9	13	11	0			
	AFB Cohort variance								0	0	8	9	13	11	0			
	52+ breach plan/trajectory	119	115	111	107	103	99	95	91	87	83	79	75	71	67	63	59	52
	52+ actual	140	103	74	74	84	88	86	69	69	75	72	78	77	67			
	Actual variance	21	12	37	33	19	11	9	22	18	8	7	3	6	0			
General Surgery	Cohort plan/trajectory					364	344	324	304	284	264	244	224	204	184	164	144	50
	Cohort actual	469	447	393	382	370	335	292	265	240	221	200	172	132	108			
	Cohort variance					6	9	32	39	44	43	44	52	72	76			
	AFB Cohort plan / trajectory								3	3	0	0	0	0	0	0	0	0
	AFB Cohort actual					6	5	4	3	3	2	2	1	1	0			
	AFB Cohort variance								0	0	2	2	1	1	0			
	52+ breach plan/trajectory	202	195	188	181	174	167	160	153	146	139	132	125	118	111	104	99	50
	52+ actual	144	140	115	118	114	112	115	114	109	104	100	95	80	78			
	Actual variance	58	55	73	63	60	55	45	39	37	35	32	30	38	33			

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
Urology	Cohort variance					4	13	7	1	4	17	9	23	42	27			
	AFB Cohort plan / trajectory								3	3	0	0	0	0	0	0	0	0
	AFB Cohort actual					4	1	4	3	3	3	2	1	1	0			
	AFB Cohort variance								0	0	3	2	1	1	0			
	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	104	98	99	93	97	56	34	17	17			
	Actual variance	87	81	71	66	78	79	75	78	74	80	41	21	6	8			
Gastroenterology	Cohort plan/trajectory					261	244	227	210	193	176	159	142	125	108	91	74	45
	Cohort actual	383	357	322	279	274	253	225	177	165	147	131	118	96	82			
	Cohort variance					13	9	2	33	28	29	28	118	29	26			
	AFB Cohort plan / trajectory								1	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					0	0	1	1	0	0	0	0	2	0			
	AFB Cohort variance								0	0	0	0	0	2	0			
	52+ breach plan/trajectory	104	101	98	95	92	89	86	83	80	77	74	71	68	67	62	59	45
	52+ actual	57	57	53	46	45	46	44	37	40	40	35	40	39	51			
	Actual variance	47	44	45	49	47	43	42	46	40	37	39	31	29	16			
Dermatology	Cohort plan/trajectory					39	36	33	30	27	24	21	18	15	12	9	6	0
	Cohort actual	73	56	45	42	39	34	30	24	21	20	19	11	10	9			
	Cohort variance					0	2	3	6	6	4	2	7	5	3			
	AFB Cohort plan / trajectory								1	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					1	0	0	1	0	0	0	0	0	0			
	AFB Cohort variance								0	0	0	0	0	0	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	8	5	8	10	12	12	8	8	8			
	Actual variance	7	6	5	3	3	3	5	1	2	5	6	3	4	5			
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	427	401	363	302	284	257	234	194	154			
	Cohort variance					10	1	15	17	4	18	31	48	48	48			
	AFB Cohort plan / trajectory								15	7	0	0	0	0	0	0	0	0
	AFB Cohort actual					27	22	18	15	1	0	0	0	0	0			
	AFB Cohort variance								0	6	0	0	0	0	0			
	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	155	149	144	116	115	112	119	112	91			
	Actual variance	176	189	189	172	166	155	149	144	116	115	112	119	112	91			
Rheumatology	Cohort plan/trajectory					374	344	314	284	254	224	194	164	134	104	74	44	0
	Cohort actual	457	432	407	395	375	353	327	304	288	247	186	145	112	83			
	Cohort variance					1	9	13	20	34	23	8	19	22	21			
	AFB Cohort plan / trajectory								1	1	0	0	0	0	0	0	0	0
	AFB Cohort actual					0	0	0	1	1	1	0	1	2	0			
	AFB Cohort variance								0	0	1	0	1	2	0			
	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	99	96	97	95	92	72	66	62	54			
	Actual variance	89	98	88	90	166	99	96	97	95	92	72	66	62	54			
Neurology	Cohort plan/trajectory					297	272	247	222	197	172	147	122	97	72	47	22	0
	Cohort actual	366	342	314	314	299	290	276	269	226	168	97	81	57	46			
	Cohort variance					2	18	29	47	29	4	50	41	40	26			
	AFB Cohort plan / trajectory								4	2	0	0	0	0	0	0	0	0
	AFB Cohort actual					5	4	4	4	0	1	2	3	12	0			
	AFB Cohort variance								0	2	1	2	3	12	0			
	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	6	11	15	20	24	16	16	11	10			
	Actual variance	14	9	2	4	4	6	11	15	20	24	16	16	11	10			

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
	Actual variance	-14	-9	-1	-4	-4	-8	-12	-23	-20	-14	-10	-10	-11	-10			
Endocrinology	Cohort plan/trajectory					280	255	230	205	180	155	130	105	80	55	30	5	0
	Cohort actual	358	342	317	313	283	269	256	238	219	194	144	106	83	41			
	Cohort variance					-3	-14	-26	-33	-39	-39	-14	-1	-3	-14			
	AFB Cohort plan / trajectory								2	1	0	0	0	0	0	0	0	0
	AFB Cohort actual					3	1	1	2	1	1	0	1	1	0			
	AFB Cohort variance								0	0	-1	0	-1	-1	0			
	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	95	100	98	96	86	57	36	23	13			
	Actual variance	-106	-95	-93	-98	-85	-95	-100	-98	-96	-86	-57	-36	-23	-13			
Ophthalmology	Cohort plan/trajectory					208	191	174	157	140	123	106	89	72	55	38	21	0
	Cohort actual	314	297	261	239	210	194	160	154	133	130	111	97	80	73			
	Cohort variance					-2	-3	14	3	7	7	5	8	8	18			
	AFB Cohort plan / trajectory								1	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					37	23	4	1	0	0	0	1	0	0			
	AFB Cohort variance								0	0	0	0	-1	0	0			
	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	43	42	48	48	53	53	54	52	50			
	Actual variance	-59	-65	-60	-53	-44	-43	-42	-48	-48	-53	-53	-54	-52	-50			
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	159	141	126	98	99	91	82	75	59			
	Cohort variance					-3	-5	-1	0	14	-1	7	12	19	17			
	AFB Cohort plan / trajectory								5	2	0	0	0	0	0	0	0	0
	AFB Cohort actual					5	3	4	5	2	2	2	2	2	1			
	AFB Cohort variance								0	0	-2	2	2	-2	-1			
	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	60	62	61	57	61	61	57	57	46			
	Actual variance	-71	-67	-57	-59	-57	-60	-62	-61	-57	-61	-61	-57	-57	-46			
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	122	92	62	47	42	28	26	18	14			
	Cohort variance					-34	-3	21	39	42	35	37	27	23	15			
	AFB Cohort plan / trajectory								1	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					2	0	0	1	0	0	0	0	0	0			
	AFB Cohort variance								0	0	0	0	0	0	0			
	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	21	14	13	10	11	10	11	6	5			
	Actual variance	-18	-12	-12	-15	-16	-21	-14	-13	-10	-11	-10	-11	-6	-5			
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	86	76	72	59	56	53	52	46	38			
	Cohort variance					0	-4	-1	-4	2	2	6	12	13	12			
	AFB Cohort plan / trajectory								0	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					2	1	0	0	0	0	1	1	1	0			
	AFB Cohort variance								0	0	0	1	1	-1	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	27	25	27	22	22	23	26	25	20			
	Actual variance	-31	-28	-24	-25	-25	-27	-25	-27	-22	-22	-23	-26	-25	-20			
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	87	82	80	74	72	60	60	58	53			
	Cohort variance					0	-5	-7	-12	-13	-18	-13	-20	-25	-27			
	AFB Cohort plan / trajectory								0	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					4	4	2	0	0	0	0	0	0	0			
	AFB Cohort variance								0	0	0	0	0	0	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	34	46	47	45	44	38	40	41	36			
	Actual variance	-10	-10	-14	-14	-24	-34	-46	-47	-45	-44	-38	-40	-41	-36			

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
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	43	43	36	32	29	26	25	20	16			
	Cohort variance					0	1	3	0	0	-1	2	-5	-4	-4			
	AFB Cohort plan / trajectory								0	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					0	0	0	0	0	0	0	0	0	0			
	AFB Cohort variance								0	0	0	0	0	0	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	12	9	10	8	9	8	8	8	7			
	Actual variance	10	10	8	9	15	12	9	10	8	9	8	8	8	7			
Diabetes	Cohort plan/trajectory					13	12	11	10	9	8	7	6	5	4	3	2	0
	Cohort actual	14	14	14	14	13	11	10	9	8	5	3	0	0	0			
	Cohort variance					0	1	1	1	1	3	4	6	5	4			
	AFB Cohort plan / trajectory								0	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					0	0	0	0	0	0	0	0	0	0			
	AFB Cohort variance								0	0	0	0	0	0	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	1	1	1	1	0	1	0	0	0			
	Actual variance	1	1	1	1	1	1	1	1	1	0	1	0	0	0			
Paediatrics	Cohort plan/trajectory					12	11	10	9	8	7	6	5	4	3	2	1	0
	Cohort actual	23	21	13	13	12	12	8	7	4	4	3	3	2	2			
	Cohort variance					0	-1	2	2	4	3	3	2	2	1			
	AFB Cohort plan / trajectory								0	0	0	0	0	0	0	0	0	0
	AFB Cohort actual					0	0	0	0	0	0	0	0	0	0			
	AFB Cohort variance								0	0	0	0	0	0	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	3	2	2	2	2	2	2	1	2			
	Actual variance	2	1	2	2	2	3	2	2	2	2	2	2	1	2			

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2nd April 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:	**19th March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 National Neighbourhood Health Implementation Programme (NNHIP) update	Y	Y Ongoing	N	The Board was asked to note the assessment against the national quarter 4 priorities and the maturity matrix that illustrates the level of achievement in the programme. The Neighbourhood plans have been assessed and aligned to the PAHT RISE Strategy. There is a risk that the business intelligence team support and access to population health modelling tools may not be available after the transition into Essex ICB on 1/4/26 and in October when the data platform changes. There is also a risk that the ICB transition and staff restructure will delay the ongoing work of neighbourhood development. The Local Government Reform geographies have not yet been announced and therefore the future neighbourhood footprints, and staffing, are unknown.

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2nd April 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:	**19th March 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 NNHIP Development session feedback and development of the multi-neighbourhood provider contract	Y	Y	N	Feedback from the WE HCP Board development session was reported to the Board, highlighting that the key elements of the future neighbourhood model remain consistent regardless of the local government re-organisation, with 5 areas to work on over the next 6 months. The aims from the NNHIP Development session, the NNHIP Maturity Framework plans and the WE Neighbourhood Transformation Plan (NTP) are clear & in alignment. Together these directions create the next phase of the WE HCP development, along with the enhancement of neighbourhood working. The development of two neighbourhood services to pilot the multi-neighbourhood provider contract will be an important part of delivering the NTP, End of Life Integrated Pathway and expansion of Integrated Neighbourhood Team patient cohorts.

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BOARD OF DIRECTORS:	**Trust Board (Public) – 2nd April 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:	**19th March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Community Assessment & treatment Unit (CATU) evaluation	Y	Y	Y	The Community Assessment & Treatment Unit (CATU), on Poplar Ward at St Margaret's Hospital, is a short-stay community alternative to ED and acute admission for frail adults. This pilot was funded for four months over winter and early outcomes show: • High patient satisfaction • Low & appropriate clinical escalation rates • Effective ambulance diversion from acute care • 260 patients through the service (Dec – Feb) with average length of stay 4.2 days. • Close liaison with PAH's OPAL unit The evaluation proposed an extension to 31/3/2027 to enable a robust system evaluation of the model.
2.3 Essex ICB Structure	Y	Y	Y	The staffing structure in the Essex ICB has been published and recruitment is underway with the senior post holders in place and ongoing interviews into April.

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NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2nd April 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:	**19th March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 Neighbourhood Transformation Plan: proposed outcome metrics	N	Y	Y	A set of 11 over-arching outcome measures were considered by the Board. The Board asked for the metrics to be considered by a small working group and brought back to the May meeting. Discussions with partners will take place in the next month to clarify the leads and partner capacity for the projects. A refreshed governance structure has been proposed for Board consideration which reduces the number of meetings and aligns them to the NTP priorities. There will be a requirement for additional partner support, both clinical & transformational, to deliver the projects over the coming year.
2.5 PAHT RISE Strategy	Y	N	N	The PAHT RISE Strategy was presented to the Board and it was noted that it is in development and due to be launched in the Spring of 2026. The content of RISE has been drafted through recent engagement with several specialities and specialty strategy & engagement sessions are due to continue until the end of April 2026.

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NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2nd April 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:	**19th March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.8 Locality Highlight Report	Y	N	N	Epping – highlights included the opening of the Community Diagnostic Centre, the inclusion of primary care in the Whipps Cross Centre of Excellence development and potential for estate developments. Harlow – discussed the evaluation of the enhanced proactive care pilot in Harlow North & South, development of frailty super MDTs after the initial pilot with PAH. Stort Valley – discussed the continuing frailty work with PAH consultants on an ad hoc basis, working with Isobel Hospice and the practice is part of the National Patient Safety Pilot in primary care. Uttlesford – no report

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS:	**Trust Board (Public) – 2nd April 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:	**19th March 2026**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.1 WE HCP Commissioning Assurance Report	Y	N	Y	There were no escalations to the Board from the groups other than four business cases which had been recommended for agreement to the Essex & HWE governance process: • Falls Car – recommended the continuation of the Falls Car, saves £718k admissions for a cost of £284k, funded by ageing well funds which are baselined in 26/27. • Hospital Discharge Support Service – WECAN and UCAN commissioned service through Better Care Fund (BCF) – recommended for continuation. • Alzheimer's business case – uses funds from the Mental Health Investment Standard, recommended the increase in staffing to enable 15-20 more people to use the service each month. • 'While you are waiting' project, requested additional £15k to extend late start into the whole of 26/27. BCF funded for social prescribing services to assist patients on elective waiting lists.
Any other business	N/A	Y	N	Rainbow Services reported the successful re-commissioning of the discharge support service for west Essex. It was proposed to include a patient or staff story at future meetings. Members agreed that this would be an effective method of focussing the work of the Board.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board – 2nd April 2026**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**Executive Board (EB)**			
REPORT FROM:	**Committee Chair – Thom Lafferty**			
DATE OF COMMITTEE MEETING:	**17th March 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Strategy Update: RISE and Strategic Objectives	Y	Y	N	EB noted the update on RISE, together with detail of how success will be measured and the setting of milestones. EB considered the strategic objectives and recommended them to the Board for approval.
National Neighbourhood Implementation Programme	Y	Y	N	EB noted the update on NNIP and the end of the 6-month national programme on the 31st March 26. The following risks were highlighted: • Support for the DELPPHI Population Health Management Platform is unknown from 1st April (as existing staff will be aligned to Central East). • ICB staff reductions/changes from 1st April. Specifically, Deputy Director for Transformation moving to a County wide Commissioning role and HWE ICB Clinical leadership ending 31st March. • Potentially different geographies as a result of Local Government Reform.
Staff Survey	Y	Y	N	The paper submitted to EB outlined the 5 recommended priorities developed in response to the staff survey results. EB supported the 5 recommended priorities

Business Cases CDC Isilon upgrade and licenses business case Core Network Replacement Business Case Temporary Agency Validation and Booking Resource to Address Alex Health Worklist Backlog	Y	Y	N	EB approved the business case and recommended it to PAF and Trust Board EB approved the business case and recommended it to PAF and Trust Board EB approved the business case
Performance: Access Report and IPR Cancer Improvement Plan Update	Y	Y	N	EB noted the Access Report for M11 and the IPR Work to improve pathways for the tertiary referral process has commenced. Options are being explored with neighbouring trust for tertiary capacity. Consultant capacity in Urology is emerging as an issue - the division has a plan in place to make improvements in this respect. Urology performance remains challenging and is impacting on the Trust overall cancer performance.
2026/2027 CDC Bids	Y	Y	N	EB approved the CDC bids.

Finance & Planning Update	Y	Y	N	EB noted the report M11 financial delivery which is on plan. The Trust is on plan to spend the annual capital allocation. Planning – the final plan was submitted in February with a £15m deficit. Further discussions with NHSE were underway.
Corporate Risk Register	Y	N	N	EB noted the Corporate Risk Register
Risk Management Group report	Y	Y	N	EB considered the following risks: Risk ID 844 current score 4 x 4 = 16 relating to infestation of drain flies in maternity theatres – **Approved** for inclusion in the Trust wide risk register Risk ID 876 current score 4 x 5 = 20 relates to mortality rates. EB requested further review of the risk score before providing approval for inclusion on the corporate risk register
Coding Team: R & R Payment	Y	N	N	EB supported the proposal to implement a 20% Recruitment and Retention payment for substantive Clinical Coders at Band 5 and Band 6 only. The payment will: • apply to vacant and newly appointed posts at these bands • be reviewed after 12 months • be conditional on continued employment in post.