The Princess Alexandra Hospital NHS Trust

AGENDA
Public Meeting of the Board of Directors

Date and time: Thursday 1 October 2026 at 09.30 – 13.00
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	19
09:35: Board Story: Kath's Story					
02 Chair and Chief Executive's Reports					
10:00	2.1	Chair's Report	Inform	Trust Chair	21
10:05	2.2	Executive Report including: • Strategic Update	Inform	Chief Executive Chief Strategy Officer	26 33
10:15		*Opportunity for members of the public to ask questions about the board discussions or have a question answered.*			
03 Risk					
10:20	3.1	Corporate Risk Register	Approve	Chief Medical Officer	43
10:30	3.2	Board Assurance Framework 2026-27 *Diligent Resources: BAF 2026-27*	Review/ Approve	Director of Corporate Governance	47
04 Patients					
10:40	4.1	Reports from Quality and Safety Committee on 25.09.26 and revised Terms of Reference • Part I • Part II	Assure	Committee Chairs	53 61 65 (ToR)
10:50	4.2	Maternity Reports: • Maternity Assurance Report • Maternity and Neonatal 10 Point Plan Baseline Assessment	Assure Assure	Interim Chief Nurse/ Director of Midwifery	75 82
11:15	4.3	Trust Response to the Thirlwall Inquiry and Progress on Implementation	Assure	Interim Chief Nurse	84
11:25	4.4	Nursing, Midwifery and Care Staff Levels Diligent Resources: *Appendix 2: Redeployment and trend data*	Assure	Interim Chief Nurse	91

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		Appendix 3: CHPPD *Appendix 4. Nursing Red Flags (NICE 2014), Incident Reports and Trend Data* *Appendix 5: Nursing quality indicators*			
11:35	4.5	Learning from Deaths (Mortality) Report	Assure	Chief Medical Officer	100
		B R E A K 11:40 to 11:50			
05 People					
11:50	5.1	Report from People Committee	Assure	Committee Chair	107
11:55	5.2	Annual Report on Medical Revalidation and Compliance	Assure	Chief Medical Officer	111
06 Pounds and Performance					
12:00	6.1	Report from Performance and Finance Committee	Assure	Chair of Committee	124
12:05	6.2	Finance Update	Assure	Chief Finance & Infrastructure Officer	132
12:15	6.3	Integrated Performance Report (IPR) *Diligent Resources: IPR Full Data Pack (April)*	Discuss	Chief Operating Officer	138
07 Governance					
12:25	7.1	Report from Audit Committee and Revised Terms of Reference	Assure	Chair of Committee	174 178
12:30	7.2	Report from West Essex Health and Care Partnership Board	Assure	Chair of Committee	185
12:35	7.3	Report from Executive Board Meeting	Assure	Chair of Committee	186
12:40		*Opportunity for members of the public to ask questions about the board discussions or have a question answered.*			
08 Closing Administration					
12:45	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
13:00		Close			

Date of next Public Board meeting: 3 December 2026

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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**
Trust Chair	Darshana Bawa	Chief Executive	Thom Lafferty
Non-executive Director and Senior Independent Director (SID)	Oge Austin-Chukwu	Interim Chief Nurse	Jo Ward
Non-executive Director and Vice Chair	Ben Molyneux	Chief Operating Officer	Anna Jebb
Non-executive Director	Colin McCready	Chief Medical Officer	Andrew Kelso
Non-executive Director	David Baines	Chief Finance and Infrastructure Officer	Tom Burton
Non-executive Director	Isabelle Parasram	**Executive Members of the Board (non-voting)**	
Associate Non-executive Director	Ralph Coulbeck	Chief Strategy Officer	Michael Meredith
Associate Non-executive Director	Mark Gammage	Chief People Officer	Catrin Asbrey
		Chief Clinical Transformation Officer	Jim McLeish
		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
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Minutes of the Trust Board Meeting held in Public at Kao Park Board Room
Thursday 4 June 2026 from 09:30 to 13:00

Present:

Darshana Bawa	**Trust Chair TC)**
David Baines	Non-Executive Director (NED-DB)
Tom Burton	Chief Finance & Infrastructure Officer (CFIO)
Anna Jebb	Chief Operating Officer (COO)
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)
Michael Meredith (non-voting)	Chief Strategy Officer (CSO)
Ben Molyneux (non-voting)	Associate Non-Executive Director (ANED-BM)
Jo Ward	Interim Chief Nurse (ICN)

In attendance:

Heather Schultz	Director of Corporate Governance
Marcel Berenblut	Director of Communications & Engagement (DoCE)
Robbie Ayers	Deputy Chief Transformation Officer (DCO)

Staff Story:

Lubna Rafiqi	Consultant Histopathologist
Preethi Gopinath	Consultant Histopathologist/Director of Medical Education

Members of the Public:

Ann Nutt	Chair of Patient Panel
Linda Machakaire	Director of Midwifery
Ganesh Arunachalam	Consultant Physician in Elderly Care (Locum)
Marianne Chadwick	NHS Graduate Management Training Scheme
Mark Taylor	XY Laser Services
Anne Wafula-Strike (non-voting)	Trust Ambassador

Apologies:

Liz Baker	Non-Executive Director (NED-LB)
Jim McLeish (non-voting)	Chief Clinical Transformation Officer (CCTO)
Oge Austin-Chukwu	Non-Executive Director (NED-OA)

Secretariat:

Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed everyone to the meeting. 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 02.04.26 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and no comments on the action log.
Staff Story: Portfolio Pathway (Certificate of Eligibility for Specialist Registration)	

1.6	This item was introduced by the Chief Medical Officer (CMO) who welcomed two colleagues to the meeting: Dr Preethi Gopinath (Consultant Histopathologist/Director of Medical Education) (PG) and Dr Lubna Rafiqi (Consultant Histopathologist) (LR). He handed over to both colleagues for their Board presentation.
1.7	The presentation showcased the success of the Portfolio Pathway (formerly CESR) as an alternative route to consultant registration and highlighted how it supported workforce development, retention and career progression within the Trust. It explained that the pathway enabled experienced doctors, including international recruits and those without traditional UK training, to demonstrate equivalence to specialist registration through a portfolio of evidence. The Trust's commitment to mentorship, supervision, infrastructure and inclusive career development was emphasised as a key enabler of success.
1.8	The presentation then shared the personal journey of Dr Lubna Rafiqi (LR) who joined the Trust in 2021, and had progressed from Trust Grade Specialty Doctor to Locum Consultant Cellular Pathologist, and successfully obtained specialist registration through the Portfolio Pathway in 2024. Despite significant personal and professional challenges, including balancing family commitments, adapting to UK practice and compiling an extensive evidence portfolio while working full-time, she described how departmental support, mentorship, training opportunities and colleague commitment had enabled her success. The presentation concluded by highlighting the importance of structured support for Portfolio Pathway candidates and Dr Rafiqi's commitment to mentoring others, demonstrating how investment in staff development can strengthen recruitment, retention and the future consultant workforce.
1.9	The Director of Communications & Engagement (DoCE) congratulated PG and LR on their achievements and suggested that the department should promote its strong track record in developing Portfolio Pathway consultants when advertising vacancies. He noted that this was a significant achievement which could help attract high-quality applicants and queried whether similar approaches were being extended to other specialties.
1.10	PG explained that the department had run a Fellowship examination preparation course since 2006, which had helped raise the department's profile and attract candidates. She advised that the department now highlighted its success in supporting Portfolio Pathway candidates within job descriptions, although much of its reputation was gained through word of mouth. She confirmed that the longer-term aim was to expand this approach to other specialties, noting that successful delivery relied upon experienced supervisors with a strong understanding of UK curricula and willing consultants able to take responsibility for supporting and signing off candidates through the GMC process.
1.11	Associate Non-Executive Director Ralph Coulbeck (ANED-RC) congratulated LR on her achievement and recognised the significant personal and professional challenges involved. He asked what changes could be made to improve completion rates, particularly in pathology, where workforce pressures remained significant. LR reflected that securing external placements and attachments could be difficult and was often reliant on personal networks. She noted that she had benefited from strong departmental support and guidance but considered that candidates would find the process much harder without this assistance. She suggested that a more structured framework for Portfolio Pathway doctors would help candidates navigate the process more effectively and reduce uncertainty.
1.12	ANED Ben Molyneux (ANED-BM) also congratulated LR and expressed interest in how the model could be applied more widely across other specialties. He noted that the process required considerable effort from both individuals and departments and asked how support could be better aligned to reduce duplication. In response, PR explained that conventional training programmes benefited from established infrastructure, rotations and clearly defined pathways, whereas Portfolio Pathway support was often developed locally within departments. She noted that the need to release candidates for placements, while maintaining service delivery, could create barriers to progress. PR highlighted the importance of mentoring and departmental commitment and advised that specialties such as Anaesthetics had begun developing regional Portfolio Pathway programmes to address some of these challenges.

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02 Chair and Chief Executive's Reports	
2.1 Chair's Report	
2.1	The TC introduced her report, starting with the recent sad news of the sudden passing of Hattie Llewelyn-Davies, PAHT's former Chair. Hattie's wisdom, kindness and unwavering support had touched many colleagues and she would be very sadly missed by everyone.
2.2	There were no comments from members on the TC's report.
2.3	In concluding the TC commented that the first year of her tenure as Acting Trust Chair had focused very much on maintaining stability through a period of Board member changes. Her focus going forward would move to external partnerships to support key aspects of the hospital's new strategy.
2.2 CEO's Report	
2.4	The CEO also paid tribute to Hattie Llewelyn-Davies, echoing the Chair's comments and recalling her pivotal role in informing him of his appointment to PAHT. He reflected on her continued support, wise counsel, encouragement and constructive challenge, noting that she had enabled him to perform at his best. She was a highly intelligent, capable and exceptional individual.
2.5	In terms of 'Patients' the CEO reported that draft CQC reports for Well-Led and Medicine were awaited, with draft reports for Urgent and Emergency Care and Surgery already received but final reports not yet issued. He advised that the finalisation of the Inpatient Survey results was also pending and expected within the coming months. He noted modest improvements across the organisation, with further data to follow.
2.6	Under 'People' the CEO formally welcomed Darshana Bawa to her first public Board meeting following her substantive appointment as Trust Chair and noted the strength of their developing partnership. He advised that Giovanna Leeks, Chief People Officer (CPO), would be leaving after three years to take up a role at the Whittington, acknowledging her contribution and noting the opportunity to learn from that organisation. He also reported that International Nurses Day and International Midwives Day had been celebrated, with both events well received and supported at national and regional level.
2.7	Under 'Place' the CEO provided an update on the development of Neighbourhood Health Centre proposals across Harlow, Uttlesford, Epping Forest and East Hertfordshire. He reported that engagement had taken place with regulators, commissioners and providers during May, and that the proposals aimed to improve access to joined-up care closer to home, supporting wider transformation including the New Hospital Programme. He outlined locality-specific proposals, including the development of St Margaret's Hospital as a community hub in Epping Forest, a town-centre Neighbourhood Health Centre in Harlow, and enhanced provision at Saffron Walden Community Hospital in Uttlesford.
2.8	The CEO continued informing members that three new facilities had opened in the past month, including the Community Diagnostic Centre (CDC) at Epping and a new town centre phlebotomy service, both of which had received positive feedback. He advised that the new Paediatric Emergency Department had also opened, with occupancy planned for the following week, noting the positive impact of these developments on patient experience and staff morale.
2.9	Ann Nutt, Chair of the Patient Panel (CoPP) congratulated the CEO on the new phlebotomy service and welcomed the positive feedback received. She also reported having recently visited the new CDC and engaging with colleagues from EPUT, commending the work undertaken.
2.10	The CEO reported that he had recently hosted the Chief Executive of the NHS Alliance, with attendance from system partners including EPUT and primary care leaders. He noted that the visit had provided an opportunity to present the Trust's ambitions, particularly in relation to neighbourhood health, and that there was a clear understanding of the intention to deliver care aligned to local population needs.
Questions from the Public	

2.11	There were no questions from the public.
03 Risk	
3.1 Corporate Risk Register (CRR)	
3.1	The CMO presented his report and updated that the overall position remained static for the month, with no risks scoring 20 on the corporate risk register and no new significant risks above 15. He advised that within departmental risk registers there had been two risks previously scoring 20, now reduced to one. He outlined that the remaining high-scoring risk related to obstetrics and gynaecology consultant staffing, with concerns regarding capacity to undertake specific duties. He noted that this was being actively managed with the department and could be escalated to the corporate risk register if the risk level remained elevated. He further advised that the second risk, relating to a data and work-list issue, had reduced in score.
3.2	Non-Executive Director David Baines (NED-DB) sought clarification on the process for reconciling differences where departments were not assured and the Risk Management Group (RMG) did not agree with risk scoring. The CMO responded that this situation had not yet arisen, noting that discretion remained with departments to bring risks to the RMG. He added that where there was concern regarding lack of progress, departments would be invited to present the risk for discussion.
3.3	NED-DB noted the improvement reflected in the report and welcomed that there had been no new high-scoring risks since the previous paper.
3.2 Board Assurance Framework 26/27	
3.4	The Director of Corporate Governance (DCG) presented the Board Assurance Framework (BAF) update, advising that two new risks were being submitted for approval, both of which had been discussed at the Performance and Finance Committee (PAF) with the Chief Medical Officer as Executive Lead. She confirmed that the two risks related to climate change and the NHS Net Zero Strategy, and that both had been endorsed by PAF. She further reported that a third risk relating to the 2025/26 financial position was recommended for closure, as the Trust had achieved its plan for the year and would be replaced by a new risk for the current year; this recommendation had also been supported by PAF. A further risk relating to system pressures was presented for routine review, with no change proposed to its current scoring. It was noted that all risks had been reviewed by the relevant Committees during the month.
3.5	Associate NED Ralph Coulbeck (ANED-RC) welcomed the alignment of risks with the new Rise Strategy and sought assurance that the two new risks were sufficiently distinct to warrant separate inclusion on the BAF. The CMO acknowledged that both risks addressed different aspects and could reasonably be considered either separately or as a single combined risk. He advised that, on balance, the recommendation had been to retain them as two distinct risks but agreed to keep this under review.
3.6	ANED-RC further queried the target risk score of 8 for the estates risk, questioning whether this represented a realistic and achievable position within an appropriate timeframe. The Chief Finance and Infrastructure Officer (CFIO) acknowledged the challenge and advised that delivery of the New Hospital Programme was key to reducing the risk. He noted that mitigation actions were in place across priority areas and emphasised that the aspiration remained to reduce the risk as far as practicable.
3.7	NED Colin McCready (NED-CM) supported the CMO's position to retain the two new risks as separate items, noting that future changes to national net zero targets could impact each risk differently and therefore justified their distinction.
3.8	In line with the recommendation, the Board: - Approved the inclusion of the 2 new risks. - Approved the closure of the Finance risk for 2025/26. - Noted that the system pressures risk score had not changed and risk scores for the other risks had also not changed.

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04 Patients	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	Quality & Safety Committee Part I ANED-BM reported on the Committee discussion in the absence of NED Oge Austin Chukwu (NED-OA). It was noted that the new Integrated Performance Report (IPR) had been reviewed in detail, including the associated metrics, with some areas identified as requiring further refinement, particularly those relating to maternity indicators.
4.2	The Committee had received an update on the Handover 45 initiative and noted the significant level of work underway to strengthen processes and support patient safety. Mortality figures were also reviewed, and it was observed that ongoing coding issues continued to impact and elevate the reported data.
4.3	A thematic review of Prevention of Future Deaths was considered, with discussion extending beyond the Trust to include wider system learning. The importance of effectively disseminating education and training was highlighted to maximise impact and ensure that learning was embedded across the organisation.
4.4	Quality & Safety Committee Part II (Maternity) ANED-BM reported on the discussion at QSCII, noting positive performance in relation to booking before 10 weeks. It was highlighted that triage rates remained below target, and a deep dive had been scheduled for the autumn. Staffing challenges within maternity services were also noted, alongside a shortage of the drug used to induce labour. A broader discussion took place regarding patient experience of induction of labour, particularly during periods of high demand, and it was confirmed that a further deep dive would also be undertaken in this area to ensure safety and experience were maintained. It was further noted that maternity staffing levels remained below optimal establishment. Mortality data was reviewed, with headline figures appearing above the national average; however, when adjusted for other factors, performance returned closer to baseline, and it was agreed that this required further understanding.
4.5	The CEO highlighted the focus on pressure ulcers within QSCI, noting that while considerable work had been undertaken to reduce prevalence, the number of reported incidents had remained static.
4.6	The Interim Chief Nurse (ICN) advised that pressure ulcer rates remained at an unacceptable level but reported early signs of improvement in recent months, with reductions in harm levels observed. Targeted work had been undertaken in key pressure areas, including Tye Green Ward and ITU, resulting in a sustained reduction in harm severity. It was noted that, following the internal audit undertaken by BDO , a revised approach had been implemented by the Practice Development Team, working alongside nursing teams and Tissue Viability Nurses to support earlier intervention. This was complemented by the introduction of the Fundamentals of Care programme in February and increased senior leadership visibility. It was reported that further improvements were anticipated through the development of the nursing and quality dashboard, and that there had been a notable shift in ward-level practice, with an increased emphasis on accountability.
4.7	NED-CM sought assurance that the limited assurance findings from the Tissue Viability Nurse audit were being addressed. The ICN confirmed that actions had been completed and that evidence of impact was now being monitored.
4.8	The CEO clarified the interpretation of assurance ratings within Committee reports, noting that 'assured' reflected confidence in the approach rather than full resolution of risk, and highlighted the need for greater consistency in the application of assurance terminology, particularly in relation to audit reports. NED-DB noted the nuance associated with multiple risk areas considered at PAF. The CEO reiterated the need for a consistent approach across reporting.
ACTION **TB1.04.06.26/04**	**Review and ensure consistency in the definition and application of assurance terminology across reports, including alignment with audit reporting.** **Lead: Director of Corporate Governance/Committee Chairs**

4.9	NED-RC expressed interest in the Waiting Well programme and its potential to improve patient experience. The ICN undertook to share further information following the meeting.
ACTION **TB1.04.06.26/05**	**Circulate further details on the Waiting Well programme to Associate NED Ralph Coulbeck.** **Lead: Interim Chief Nurse**
4.10	The TC sought assurance regarding the management of Never Events and the mechanisms for ensuring learning was captured and reported to QSC. The ICN confirmed that these were reported through the Patient Safety Report to QSC, with learning disseminated and actions tracked through Datix.
4.11	In response to a query regarding the implications of the Infected Blood Inquiry and the need for a systemic approach, the ICN agreed to take this away for further consideration. However the CMO then added that national guidance from NHS England was awaited regarding recommendations and confirmed he would follow this up as it was an area he had worked on previously.
ACTION **TB1.04.06.26/06**	**Seek clarity from NHS England on the Infected Blood Inquiry recommendations and their application.** **Lead: Chief Medical Officer**
4.2 Maternity Reports: Maternity Patient Safety Incidents Update/Maternity Assurance Report	
4.12	Maternity Patient Safety Incidents Update The Director of Midwifery (DoM) reported that there had been no new incidents in April or May. She advised that the maternal death incident had now been closed and would be referred to the Coroner in July. She outlined that significant improvement work had been undertaken in response to the incident earlier in the year. This included developments in Emergency Department pathways and the embedding of the maternity early warning system (MEWS) in clinical areas outside of Maternity. She noted positively the progress made through Alex Health, which was ready to launch a tracker to support monitoring of MEWS compliance for women.
4.13	The DoM further highlighted improvements relating to informed decision-making, ensuring that women were provided with appropriate information to support choices regarding further screening or testing, particularly in relation to venous thromboembolism (VTE), which had been a factor in the case. She confirmed that the outcome of the Coroner's review would be reported back at a later date.
4.14	Maternity Assurance Report The DoM provided an update on PALS and complaints, advising that additional resource had been deployed to reduce the backlog and align closure rates with incoming volumes. She reported that a new post would commence in early July, with a focus on improving patient experience in real time, ensuring that concerns were addressed promptly during a patient's care rather than post-discharge. She highlighted that this work was being supported by a broader cultural focus on improving engagement and responsiveness to patient feedback.
4.15	ANED-RC queried the status of four high risks, noting that two had improved and two were pending approval, and sought clarification on whether these were new risks. The DoM confirmed that one related to caesarean section capacity, which remained a challenge across the sector, and advised that this was being progressed by a senior colleague with consideration of mutual aid arrangements with Mid and South Essex. The second risk was also noted as being in development. The CMO added that both risks had been reviewed by the Risk Management Group and Executive Board, and that further work had been undertaken to refine the risk scoring to better reflect the impact on women's experience.
4.16	NED-DB sought assurance regarding the adequacy of resource to address the complaints backlog. The DoM confirmed that a dedicated post had been created to support patient experience and described plans to reinstate the "Professional Midwife Advocate of the Day" role, enabling engagement with women on the wards to identify and address issues at an early stage.

4.17	NED-DB asked how long it would take for improvements to be realised. The DoM advised that early signs of improvement were emerging, noting that the approach was multi-faceted and that progress would be reflected through patient survey results over time.
4.18	The CPO reported that cultural and benchmarking work had been undertaken within maternity services, with additional support being provided. She noted that language and cultural barriers had been identified as areas requiring further attention and acknowledged that improvements would take time to embed.
4.19	The Deputy Chief Transformation Officer (D-CTO) shared positive feedback received from a Royal College of Nursing colleague, who had relayed thanks from a patient in recognition of the Trust's response to a complaint and the changes implemented as a result. It was suggested that this example could be developed into a patient story.
4.20	The ICN highlighted that International Day of the Midwife had showcased positive work across the service. Proactive improvements would help address some of the concerns raised and this had been recognised externally.
4.21	The TC acknowledged the positive work undertaken to improve culture within maternity services and commended the leadership shown in driving these changes.
4.3 Nursing Midwifery and Care Staff Levels	
4.22	The Interim Chief Nurse (ICN) reported that an overall fill rate of approximately 80% had been maintained across the majority of shifts. It was noted that concerns previously raised regarding responses to red flag indicators had been addressed, with matrons now supporting the closure of these in real time. The ICN advised that the mid-year establishment review would be presented to the People Committee in June. Work was also underway to better understand shifts exceeding a 120% fill rate, with a revised approach to demonstrating demand being developed; a supporting table was expected to be included in a future report.
4.23	It was further reported that triangulation between fill rates and quality indicators was being strengthened, with early indications suggesting that targeted workforce interventions were beginning to influence quality metrics, which would be reflected in subsequent reporting.
4.24	ANED-BM queried the position in relation to mental health nursing, noting the reliance on bank and agency staff in the absence of substantive posts and asking whether there was a case to incorporate these roles into the establishment. The ICN acknowledged the recruitment challenges but advised that two trained nurses had recently been recruited to the acute assessment area. It was also noted that, as part of the full-year establishment review, efforts had been made to recruit additional care support workers to meet enhanced care needs, alongside consideration of adjustments to wards with higher acuity.
4.25	In response to a further query from ANED-BM as to whether enhanced care requirements were reflected in fill rates above 100%, the ICN confirmed that future reports would incorporate enhanced care needs, which may result in reported fill rates appearing lower. The TC queried the staffing position on Jon Snow Ward, and the ICN explained that lower staffing numbers reflected reduced bed occupancy, as patients did not typically remain on the ward for extended periods.
4.4 Learning from Deaths (Mortality) Update	
4.26	The CMO presented the report, advising that it had been reviewed through the Strategic Learning from Deaths Group (SLfDG) and demonstrated an improving position across in-month and 12-month rolling trends for Standardised Mortality Ratio (SMR) and Hospital Standardised Mortality Ratio (HSMR), with the Summary Hospital-level Mortality Indicator (SHMI) remaining within the normal range. He noted that trends identified through mortality reviews had been included. It was acknowledged that the report did not reference the backlog of Structured Judgement Reviews (SJRs); however, this was being actively managed by the Deputy Medical Directors and monitored through Divisional Review Meetings and the SLfDG. The CMO further advised that updated data from Telstra, following coding backlog correction work, indicated that 12-month rolling trends were now within the expected range, including weekend data, with further updates to be presented at the next meeting.

4.27	The Chief Strategy Officer (CSO) reflected on previous issues relating to coding accuracy, which had skewed mortality data, and sought assurance that reliance on data quality explanations would not obscure underlying care issues. The CMO confirmed that improvements to the coding function were being progressed by the relevant team, with external support from Telstra and Dr Foster providing detailed analysis to identify drivers and test improvement actions.
4.28	ANED-RC queried the position as 'improving', noting that trends had previously been described as stable, and sought assurance regarding the validation of assumptions that data quality issues had driven performance outside the expected range. The CMO clarified that improvements had been observed over the preceding three to four months across key indicators, while emphasising the importance of maintaining focus on both data quality and care delivery. He advised that hypotheses were tested through implemented actions, with subsequent improvements providing validation.
4.29	ANED-BM noted that additional manual triangulation was undertaken to provide further assurance regarding the data. ANED-RC reiterated the importance of caution in describing improvement where performance remained within the same overall range and sought clarity on the pathway to resolving data quality issues.
4.30	The Chief Operating Officer (COO) advised that the Data Quality Group, which she co-chaired, provided oversight of coding improvements and wider data quality matters, with regular monthly monitoring in place. She further referenced wider discussions on mortality data, including consideration of raw deaths and review processes, to support validation of assumptions.
4.31	The TC sought clarification regarding the updated data from Telstra, and the CMO confirmed that while the most recent report reflected improvement, the impact of coding corrections would be more fully reflected in the next reporting cycle.
Break 1054 to 1104	
05 People	
5.1 Report from People Committee (PC)	
5.1	The TC noted the overall positive performance against KPIs. It was highlighted that vacancy rates remained high; however, this was attributed to an increase in funded establishment alongside a temporary embargo on recruitment, rather than an increase in staff turnover. The CPO added that there had been a national shift towards holding vacancies, and advised that the Trust may need to operate above its internal KPI of 9%, with up to 12% considered sustainable to provide assurance.
5.2	The TC further reported that the use of temporary workforce had remained stable and was not increasing, providing assurance in this area. Updates were also received on Equality, Diversity and Inclusion, and assurance was taken from the Guardian of Safer Working report. It was noted that recruitment to the Guardian of Safer Working post was required, and the CMO confirmed that interviews were scheduled for the end of June.
5.3	The TC highlighted good engagement with the Improving Resident Doctors' Lives 10-point plan but noted that only limited assurance had been received from the Medical Workforce Group. The CMO advised that while constructive discussions were now taking place, he remained concerned about the robustness of the data and the strength of divisional plans. He confirmed that further work was required, in collaboration with the CPO and COO to strengthen data quality and provide clearer assurance. In response to a request for a timeframe, the CMO advised that a plan would be brought back to the next Board meeting.
ACTION **TB1.04.06.26/07**	**Present a plan to improve assurance on medical workforce data and delivery at the next Board meeting.** **Lead: Chief Medical Officer supported by Chief People Officer/Chief Operating Officer**
5.4	The COO advised that external support from Moorhouse had been engaged to review job planning and support data development, with outputs to be brought back to the Board.

5.5	ANED-BM sought clarification on the scope of the work, and the CMO confirmed that the initial focus was on consultants and SAS doctors, with further work planned to develop a comprehensive medical workforce strategy.
5.6	The TC noted the update on the corporate consultations, including its impact on staff fatigue and morale, and the importance of ensuring appropriate health and wellbeing support. The CEO acknowledged that while restructures could impact morale, they were sometimes necessary, citing positive outcomes from previous clinical restructuring. The TC requested that a further update be brought back to the Board to understand how the impact of the restructure had manifested. The COO agreed to bring together relevant information, including outputs from the after-action review.
ACTION **TB1.04.06.26/08**	**Present a report to the Board on the impact and learnings of the divisional restructure, on both workforce and operations.** **Lead: Chief People Officer/Chief Operating Officer**
5.2 Annual Report on Equality, Diversity and Inclusion	
5.7	The CPO presented her paper which provided a retrospective overview of activity in relation to the Equality, Diversity and Inclusion (EDI) agenda. The CPO highlighted that the Trust served a diverse population with a workforce of approximately 4,000 staff, and that governance arrangements had been strengthened over the past year through the EDI Steering Group, supported by WRES, WDES, and pay gap reporting. Progress had been made against key priorities, including inclusive recruitment, cultural benchmarking, and the planned reinforcement of staff networks, with recruitment underway for network chairs. The Staff Survey findings underscored the importance of engagement, while also identifying ongoing challenges in relation to wellbeing, staff experience, stress, and burnout. Key areas for further development included expanding development opportunities, addressing violence and aggression, and improving sexual safety. Looking ahead, the CPO advised that the focus would be on embedding equality and equity into business as usual, supported by a restructure within the People team and additional capability in workforce data.
5.8	NED-DB queried the rating of ‘green’ against the objective relating to staff feeling able to speak up and protections relating to characteristics, noting that this appeared inconsistent with feedback suggesting staff did not always feel able to raise concerns. The CPO acknowledged the point and clarified that the rating reflected delivery against the previous year’s action plan, particularly improvements in data and visibility. It was confirmed that further work in this area formed part of the current year’s priorities. NED-DB observed that this still felt at odds with the lived experience, and the CPO reiterated that progress to date had been achieved against plan, with ongoing work planned.
5.9	ANED-BM raised the importance of inclusivity across all staff groups, particularly in the context of Pride month, and suggested that further consideration be given to characteristics such as age and gender, including whether there should be representation or networks for men alongside women. The CPO confirmed that this had been discussed with the senior team and acknowledged that previous focus had been primarily on race, disability, and to a lesser extent LGBT+, with other protected characteristics requiring greater attention. It was noted that the incoming Head of EDI would take a broader, more inclusive approach to ensure no groups were overlooked. The TC noted that there was no barrier to establishing additional groups; however, the CPO highlighted the practical challenge of first establishing leadership within existing networks before expanding further commitments.
5.10	The CFIO emphasised the importance of maintaining alignment with the community, noting that broader societal influences and differing perspectives across system partners could present challenges. It was recognised that, as the Trust moved towards greater integration, it may not always be aligned with partner organisations, but must continue to support its EDI commitments. Members agreed on the importance of a unified approach with system partners, whilst maintaining a clear focus on the needs of the Trust’s workforce and local population. ANED-BM reiterated that EDI must be visibly inclusive of all staff to prevent division and reinforce that it applied to everyone.

5.11	Discussion then turned to employee relations data. ANED-RC noted the positive position regarding long-term ill health cases but queried the year-on-year increase in grievance cases and whether this reflected improved data collection. The CPO confirmed that there had been an increase in concerns being raised, which was viewed as a positive indication of improved psychological safety and empowerment. It was noted that many grievances related to historical issues rather than current concerns, which contributed to a significant increase in workload and presented challenges in relation to timeliness of resolution.
5.12	The Board then discussed workforce data in relation to ethnicity. It was noted that the overall workforce composition broadly reflected expectations, with a near 48/52 split, although it was acknowledged that the relatively small numbers in some areas could result in cultural tensions. The CPO highlighted the role of Freedom to Speak Up Guardians and ambassadors from diverse backgrounds in supporting staff, alongside broader representation across age, gender, seniority, and profession. The Interim Chief Nurse (ICN) added that professional advocates were also in place within nursing, midwifery, and AHP groups to provide additional support.
5.13	In conclusion, the Board took assurance from the report and noted that there had been demonstrable improvement across the EDI agenda, whilst recognising that further work remained to address ongoing challenges and embed progress.
5.3 People Priorities and Actions 26/27	
5.14	The CPO presented the People Priorities Action Plan for the next 12 months, which had been developed to align with the Trust's Rise Strategy and bring together feedback from the Staff Survey, Pulse Surveys, cultural benchmarking and other workforce intelligence. The plan focused on the issues having the greatest impact on staff experience and organisational culture, including confidence in raising concerns, staff recognition, violence and aggression, wellbeing, burnout, leadership visibility and the embedding of equality initiatives. Members noted that the priorities would be delivered across the organisation with clear divisional accountability and alignment to the Trust's wider strategic objectives.
5.15	The Board discussed the significance of violence and aggression towards staff and received assurance regarding the range of initiatives in place to support staff, including de-escalation training, body-worn cameras, red and yellow card processes and Executive oversight. Members also sought assurance that the wider People Strategy would continue to be delivered alongside the identified priority actions. The CPO confirmed that the proposed People team restructure would provide the capacity required to support both immediate priorities and longer-term objectives. The Board was assured that the priorities reflected staff feedback, were deliverable, and would support meaningful improvements in staff experience and organisational culture.
06 Performance/Pounds/Places	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	NED-DB informed members that PAF had reviewed the Estates and Facilities Annual Report and noted significant progress during the year, particularly in relation to fire safety, although the overall estates risk position remained largely unchanged. The Committee had also considered the Trust's financial position, noting that mitigating actions had been taken to manage emerging pressures. However, risks remained around unfunded sprint costs, ERF funding and delivery of the Productivity and Quality Programme, with a proportion of the savings target still to be secured.
6.2	PAF had also received updates on the BDO patient flow review, where improvement plans were in place to address recommendations, and on data quality, where assurance was provided that identified issues were being addressed through a clear improvement plan and timetable. Members also reviewed progress with Alex Health, acknowledging continuing adoption and performance challenges following implementation despite extensive training. Assurance was also taken from the Business Case Review Group that robust arrangements were now in place for the prioritisation of business cases.

6.3	Overall, the Board was assured that appropriate actions were in place to manage key operational, financial and performance risks.
6.2 Finance Update	
6.4	The CFIO provided an update on the Trust's financial and operational position, noting that the Trust was being recognised nationally and regionally for its performance improvement and effective use of sprint funding. Members heard that a financial stocktake would be undertaken and linked closely to the Productivity and Quality Programme to ensure an appropriate balance between investment, savings delivery and operational performance within a challenging financial environment. The financial stocktake would be presented to PAF.
6.5	The Board discussed ongoing financial risks, including the delivery of planned productivity savings and uncertainty regarding future sprint funding. Assurance was provided that a significant proportion of the remaining savings requirement was reflected within non-pay forecasts and that the stocktake would test delivery assumptions. Whilst no confirmation had been received regarding additional sprint funding, the Trust's strong track record placed it in a favourable position should further funding become available. Members noted the challenges associated with planning amid uncertain funding arrangements and acknowledged the associated risks and dependencies.
6.3 Integrated Performance Report (IPR)	
6.6	The COO presented the Integrated Performance Report, highlighting that RTT, four-hour performance, the staff survey and inpatient survey remained rated amber within the National Oversight Framework, while cancer performance and patient experience continued to be areas of concern. Members noted a number of positive performance indicators, including improvements in RTT variation, ambulance handovers, infection prevention and control measures, the outpatient follow-up ratio, bank spend, staff turnover and mandatory training compliance. The Board also noted the significant reduction in 52-week waits and received assurance that the year-end target remained achievable.
6.7	Members particularly welcomed the introduction of health inequalities metrics within the report, which identified variations in waiting times by gender, ethnicity and deprivation, with deprivation showing the greatest disparity. The Board commended the continued development of the IPR and agreed that further specialty-level analysis and patient engagement work would help better understand the causes of inequalities and support targeted improvement actions. Overall, assurance was received that performance remained stable in a number of key areas, while focused work continued to address remaining challenges, particularly cancer performance, patient experience and health inequalities.
6.4 The Terrorism (Protection of Premises) Act 2025 (Martyn's Law)	
6.8	This item was presented by the COO and was an update on the requirements of the Terrorism (Protection of Premises) Act. Members noted that the legislation had come into effect in April 2025, with compliance required by May 2027 with a one-year grace period to May 2028. It was reported that counter-terrorism preparedness had moved from good practice to a statutory compliance requirement. As a large acute organisation, the Trust would be required to demonstrate appropriate plans, training and awareness arrangements.
6.9	Members were advised that many of the requirements aligned with existing EPRR responsibilities, although there would be a greater emphasis on agility, site lockdown procedures, estate plans and security risk assessments. An action plan would be developed, regular progress updates would be provided through PAF, and on-call teams had already been briefed.
6.10	In response to a question from NED-CM regarding the financial implications of compliance, the Board was advised that a formal gap analysis had not yet been completed. It was anticipated that any significant costs would be associated with capital measures required to improve the safety and security of the estate, and it was noted that these considerations should be reflected within planning for the new hospital development.

07 STRATEGY/GOVERNANCE	
7.1 Rise Strategy	
7.1	The CSO presented this item which set out the organisation's approach to responding to future healthcare challenges both locally and across the wider system. Members noted the three strategic themes of Hope, Communities and Standards, which focused respectively on supporting people, redesigning models of care to meet population needs through partnership working, and improving the quality and consistency of services. It was acknowledged that delivery would take place over time, ranging from immediate recovery actions through to longer-term ambitions over the next one to five years. It was noted that the strategy had been formally launched that week and that work with clinical specialties was already well advanced. Members also noted the availability of full, summary and easy-read versions of the strategy and thanked the Communications Team for their support with this.
7.2	The DoCE then provided an update on the communications and engagement programme supporting the strategy. It was reported that the communications launch plan had now been implemented, with changes made to the Trust website, intranet and staff communications channels. Following staff feedback that internal communications were repetitive, overly focused on digital methods and difficult to access for frontline staff, a new weekly electronic newsletter had been introduced alongside a leadership cascade process. Members noted that the CEO had launched the new cascade approach, which combined verbal updates with supporting written communications to improve engagement and message consistency across the organisation.
7.3	The Board also noted that the *Rise Strategy* had been launched through social media and would be supported by regular video updates from Executive and Non-Executive Directors, thematic monthly features and wider staff engagement activity. It was reported that the strategy would be embedded through staff meetings and leadership forums to support delivery and engagement across the organisation.
7.2 Draft Quality Account 25/26	
7.4	This item was presented by the ICN who highlighted this was a statutory document providing an assessment of the quality of services delivered during the previous year, together with quality objectives for the year ahead. Members were invited to provide comments on the draft, with final feedback requested by the following week to enable publication by the statutory deadline of 30 June. The Board then also considered and approved the request to delegate final sign-off of the Quality Account to the Quality and Safety Committee to ensure that the publication deadline could be met.
7.5	Members thanked the team for the significant work undertaken in preparing the document. During discussion of the proposed priorities for the coming year, concern was raised by NED-DB that cancer 62-day performance had not been included given the potential risks and harms associated with poor performance. The ICN agreed to review this.
ACTION **TB1.04.06.26/09**	**Review the inclusion of cancer 62-day performance within the priorities.** **Lead: Interim Chief Nurse**
7.6	Members then discussed the need for a clearer objective relating to the reduction of long waiters. It was suggested that the elimination of long waits should be made more explicit within the document. The ICN agreed to consider this.
ACTION **TB1.04.06.26/10**	**Consider having a clearer objective relating to the reduction of long waiters and bring a revised position back through the Quality and Safety Committee, noting that complete elimination may not be achievable.** **Lead: Interim Chief Nurse**
7.7	The D-CTO then provided assurance that the quality improvement transformation programme was aligned with the Trust's Rise Strategy and wider transformation priorities, including outpatient and theatre improvement programmes. The Board noted that this work would support delivery of both the Quality Account objectives and the strategic priorities of the organisation.
7.3 Information Governance Data Security Protection Toolkit 25/26	

7.8	This item was presented by the Director of Corporate Governance (DCG). It was noted that the Trust had now evidenced all mandatory outcomes within its CAF (Cyber Assessment Framework) profile and would publish its 25/26 DSPT return as 'Standards Met'. This would take place on or before 30.06.2026.
7.4 Report from Audit Committee 01.06.26	
7.9	This item was presented by NED-CM and the following key highlights were noted: • No issues noted in terms of the current external audit which was progressing to plan. • Draft annual report and governance disclosures had been reviewed and final drafting issues addressed/being addressed. • Delivery of the 2025/26 internal audit plan was substantially complete, with the access policy audit to conclude within the next audit cycle. Limited assurance opinions were reported for the KFS: Fixed Asset Register and Tissue Viability audits, with management actions now in place. • Improved closure rates for internal audit recommendations were noted, including closure of all 2023/24 actions, with one overdue recommendation remaining. Revised due dates had been agreed where appropriate. • The Head of Internal Audit had issued an annual opinion of 'improvements required' for 2025/26, reflecting the number of limited assurance reviews in high-risk areas under the revised internal audit standards. • A proactive expenses review had identified gaps in compliance with supporting evidence requirements, indicating a need for further strengthening of controls and accountability. • Medical annual leave policy noted as robust, but inconsistent local application and system limitations had resulted in control weaknesses. There would be a further update on progress in six months' time. • Audit Committee had supported a proposal to strengthen the clinical effectiveness review process through a revised meeting structure, more standardised metrics, and greater focus on timely, outcome-based reporting.
7.10	In conclusion the TC highlighted the importance of any improvement actions associated with the Internal Audit Progress Report being followed through with the Chairs of other Board Committees to ensure everyone was sighted.
7.5 Report from West Essex Health & Care Partnership Board 21.05.26	
7.11	The CEO highlighted two key areas from the recent system meeting. Firstly, a patient story had been shared for the first time, which had been particularly powerful. The case had involved an individual with complex care needs and demonstrated how the system had failed due to the involvement of multiple organisations and the fragmented nature of care delivery. The meeting had focused on identifying ways to improve integration and coordination of services going forward.
7.12	Secondly, the CEO raised concerns regarding the ongoing "East Herts conundrum" and the variation in services received by Essex and Hertfordshire patients as a result of differing commissioning arrangements. He noted that this was a longstanding issue which had been exacerbated by changes to ICB boundaries. Challenges had also arisen in relation to neighbourhood health centre developments, as Herts & Essex Hospital fell within Hertfordshire, preventing Essex partners from bidding for opportunities and prompting further discussions at system level.
7.13	In response to a question from ANED-RC the CEO confirmed that the issue pre-dated the boundary changes but had become more pronounced since the ICB reorganisation. NED-DB sought clarification on whether patients were treated differently in practice. The COO explained that the impact was most evident when patients were discharged to community services, where significant variation existed. She noted examples relating to ambulance conveyance arrangements, community triage services and rheumatology provision, and advised that local negotiations with commissioners had been required to mitigate some of these issues, with the Trust contributing funding in certain circumstances.

7.14	The CSO added that maternity services provided a further example of the challenges created by differing arrangements, noting that women were currently discharged into two separate services, which created additional risks and complexity, particularly for mothers requiring enhanced support or safeguarding oversight.
7.6 Report from Executive Board 19.05.26	
7.15	This item was presented by the CEO and was for noting. Members had no comments.
Questions from the Public	
7.16	The Chair of the Patient Panel (CoPP) reiterated the importance of engaging with local residents when explaining and making decisions relating to the East Herts commissioning issues. She also welcomed the new Paediatric Emergency Department and thanked staff for the improvements made. She then raised a longstanding recommendation from the Patient Panel's wheelchair audit regarding the provision of juvenile wheelchairs, noting the health and safety risks associated with children using adult wheelchairs. In addition, she requested that disability assessments be incorporated into Place Assessments on a periodic basis, highlighting accessibility concerns such as alarm cords in shower rooms and the need to consider visual, hearing and other disabilities alongside physical impairments.
7.17	The CFIO advised that significant investment had been made in wheelchairs over the previous year; however, the absence of suitable docking stations had delayed implementation. He reported that the issue was being addressed and expected to progress during the summer.
7.18	The CPO informed members that the Disability Network had undertaken a walkaround focused on neurodiversity and supported extending this work to consider a broader range of disabilities. She noted that the Network was working with the organisation's Associate Director of Patient Engagement & Experience (AD-PE&E) to implement improvements for both staff and patients. The ICN agreed to work with the AD-PE&E to explore how disability considerations could be incorporated into the Place Assessment process.
ACTION **TB1.04.06.26/11**	**Include disability considerations/assessments within Place Assessments.** **Lead: Interim Chief Nurse/Associate Director of Patient Experience & Engagement**
7.19	Anne Wafula-Strike then sought assurance regarding preparedness for terrorist incidents and asked whether staff could be prepared without causing unnecessary alarm. The COO acknowledged the concern and advised that discussions were underway regarding emergency communication arrangements, including the potential introduction of a site-wide tannoy system.
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	It was agreed the issue of juvenile wheelchairs was a risk.
8.5 Any Other Business (AOB)	
8.6 Reflections on Meeting	
8.5	Members reflected that the meeting had included a good range of discussions, with a continued focus on keeping patients at the centre of decision-making and supporting staff health and wellbeing.
8.6	The CEO noted that the majority of items considered had already been discussed at Board Committees and Executive Board, resulting in some matters being reviewed by Executive colleagues for a third time. Whilst he was not suggesting changes to the overall Board structure, he felt that Board discussions were often heavily operational in nature and would

	benefit from a greater strategic focus. He emphasised the importance of ensuring maximum value from the time invested by Board members and senior leaders.
8.7	The DoCE welcomed the staff story presented during the meeting, noting that it had showcased excellent work taking place across the Trust that was not always visible. He considered it a valuable contribution to the Board's discussions.
8.8	The TC acknowledged the CEO's observations regarding duplication across Board and Committee agendas but noted that not all Board members attended every committee. She suggested that there may be opportunities to review how the Board agenda was structured to ensure the most effective use of meeting time.
8.9	The COO suggested that Board cover sheets could include a summary of key points previously discussed at committee level to help provide context and reduce unnecessary repetition where possible, whilst recognising that some duplication was unavoidable. Members also reflected that topics such as the Quality Impact Assessments and Neighbourhood Health Centres may have been suitable for discussion in public session rather than private session.
8.10	The meeting closed at 12:33.

Signed as a correct record of the meeting:	
Date:	01.10.26
Signature:	
Name:	Darshana Bawa
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 01.10.26

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.04.06.26/04	Assurance Terminology	Review and ensure consistency in the definition and application of assurance terminology across reports, including alignment with audit reporting.	DCG/ Committee Chairs	TB1.01.10.26	Reporting template updated to enable the committees to report the level of assurance as full/partial/limited.	Closed
TB1.04.06.26/05	Waiting Well Programme	Circulate further details on the Waiting Well programme to Associate NED Ralph Coulbeck.	I-CN	TB1.01.10.26	Actioned.	Closed
TB1.04.06.26/06	Infected Blood Inquiry	Seek clarity from NHS England on the Infected Blood Inquiry recommendations and their application.	CMO	TB1.01.10.26	NHS England's current work is focussed particularly on Recommendation 7 (transfusion safety). The Transfusion Transformation Strategy and support hospital materials are progressing through governance, with approval expected later this autumn.	Proposed for closure
TB1.04.06.26/07	Assurance on Medical Workforce Data	Present a plan to improve assurance on medical workforce data and delivery at the next Board meeting.	CMO with support from CPO COO	TB1.01.10.26	Verbal update to be provided by CMO at TB1.01.10.26.	Open
TB1.04.06.26/08	Divisional Restructure: Learnings	Present a report to the Board on the impact and learnings of the divisional restructure on both workforce and operations.	CPO	TB1.01.10.26	Circulated to Board members on 24.09.26.	Closed

ACTION LOG: Trust Board (Public) 01.10.26

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.04.06.26/09	Quality Account	Review the inclusion of cancer 62-day performance within the priorities.	I-CN	TB1.01.10.26	Actioned.	Closed
TB1.04.06.26/10	Quality Account	Consider having a clearer objective relating to the reduction of long waiters and bring a revised position back through the Quality and Safety Committee, noting that complete elimination may not be achievable.	I-CN	TB1.01.10.26	Actioned.	Closed
TB1.04.06.26/11	Place Assessments	Include disability considerations/assessments within Place Assessments.	I-CN AD-PE&E	TB1.01.10.26	Assurance provided that disability considerations are fully reflected within the 2026 PLACE Assessment process. The PLACE Assessments will take place between 20 and 22 October 2026.	Closed

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2.1

Trust Board (Public) 1 October 2026					Agenda item: 2.1
Report Title: Chair's Report					
Presented by: Darshana Bawa – Trust Chair					
Prepared by: Darshana Bawa – Trust Chair					
Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	x	

Executive Summary

To provide an update on my work and activities to date and evidence accountability for what I do.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

Not applicable.

Recommendation

The Board is asked to discuss and note the report.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
x	x	x

Relevant legal/statutory issues

Not applicable.

Impact Assessments

Quality	None identified
Equality, Diversity and Inclusion	As the NED Lead for EDI, this continues to guide my work in all areas along with a broader focus on health inequalities and culture.
Health inequalities	None identified
Previously Considered By	Not applicable.
Appendices	Chair's/NEDs Walk Rounds Notes and Action Matrix

1.0 Purpose

This report outlines my activities since my last report to the Board in June 2026. The aim of the report is to make my role as Chair accountable and transparent for colleagues, our partners and the local population.

2.0 Non-Executive Directors (NEDs):

In my last report we noted the departures of 3 NEDs and I am pleased to report that we have successfully recruited 3 new NEDs. Isabelle Parasram OBE and Mark Gammage, both joined us on 1/8/26, and Lucie Butler joins us on 1/10/26.

Oge Austin-Chukwu and Ben Molyneux have been appointed as the Trust's Senior Independent Director and Vice-Chair respectively, and the NED Champion roles have been updated as below:

NED Champion Roles (*mandated)	
Colin McCready	* Freedom to Speak Up
Oge Austin-Chukwu	* Maternity Safety Champion
David Baines	* Security Management
Isabelle Parasram	* Doctors' Disciplinary
Mark Gammage	* Wellbeing Guardian
Darshana Bawa	EDI
Ben Molyneux	Mental Health
Ralph Coulbeck	NHP & Strategic projects

3.0 Recent activity:

Culture
This remains a priority for the Trust - our behaviours, communication and decision-making have a direct impact on patient safety, the quality of care we provide, staff morale and performance.

Since the last report, the Board held a second development session focussing on personality types and how our understanding of each other impacts on our effectiveness as a unitary board, linking through to key strategic objectives. A follow-up session will be scheduled for early next year, allowing sufficient time for the new Board members to settle in.

Max& held a separate session for the NEDs to link into the work that was previously done with the executive directors, providing an insight into some of the key areas where better two-way engagement could enhance teamwork going forward.

Recruitment
There has been a lot of recruitment activity over the last 3 months; in addition to the new NEDs, we have recruited a new Chief People Officer, Catrin

Asbrey, with the recruitment for a Director of Corporate Governance is under way.

In addition, I have supported 2 other Trusts in their respective recruitment for a Chair at HPUT and 3 NEDs at ENHTT. Both occasions provided useful networking opportunities with panel members from varying NHS organisations including regional directorate.

Essex ICB
One of my objectives following my substantive appointment this year is to adopt an external focus, starting with our ICB. We held our first Essex ICB Chairs event earlier in the summer, which was a good introductory forum to meet fellow Chairs.

I also had meetings with Tom Abel (CEO) and separately with Beverley Flowers (Director for Neighbourhood Health), to hear their perspectives of the ICB strategy. I was very pleased to hear the positive feedback on PAHT, which is seen as open, responsive and a good partner to work with.

Next month, I will be visiting the Homerton to meet their Chair, Mary Elford and hear how they overcame challenges as part of their move into community and adult services.

4.0 Board visibility:

The hot weather this summer resulted in very high demand for our services and on behalf of the Board I would like to note our thanks and appreciation for everything our amazing teams continue to do, providing the best possible health care for our patients. The heatwave made this more challenging and our staff health and well-being teams continued to support colleagues as needed.

As part of our commitment to board-level visibility and staff engagement, we are maintaining regular Chairs walk rounds having completed four 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 from both patients and staff.

The Board is asked to note the report.

Author: **Darshana Bawa**
Trust Chair

Date: 24.9.26

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

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Chair's Walk Rounds - Action Matrix

Team: PAHT Chair and Non-executive Directors – Update @ 24 Sept. 2026

Non-Executive Directors initials:		Key for others
DBawa: Darshana Bawa (Chair) CM: Colin McCready OA: Oge Austin-Chukwu (SID) RB: Ralph Coulbeck (Associate) BM: Dr Ben Molyneux (Vice-Chair)	DBaines: David Baines IP: Isabelle Parasram OBE MG: Mark Gammage (Associate)	PP: Patient Panel FTSUG: Freedom to Speak Up Guardian Facilitator – SS: Shahid Sardar – Associate Director, Patient Experience & Engagement

Visit Date	Attendees	Venue	Feedback	Lead / Facilitator	Actions
17.07.26	Colin, Darshana	Maternity	• Antenatal capacity pressures • Triage under significant strain • NICU staffing vulnerability due to sickness • Postnatal delays affecting flow • Labour ward culture positive	Shahid	-Strengthen antenatal capacity planning and review estates options. -Urgent review of triage staffing, bay expansion and senior decision maker cover. -Enhance NICU resilience planning and sickness mitigation. -Streamline postnatal discharge processes.
06.08.26	Ben Darshana	Paediatric ED (postponed from June)	• Improved paediatric environment: The new Paediatric ED provides a secure, calm and child-focused environment, including a dedicated mental health suite and two-bay resuscitation area. • Integrated children's services: NELFT CAMHS support is available across ED and Dolphin Ward, with opportunities to strengthen the integration of specialist children's services. • More care delivered locally: Diabetes, epilepsy and shared-care oncology services provide opportunities to expand local treatment and reduce the need for children and families to travel elsewhere.	Shahid	Review signage and wayfinding for Paediatric ED to ensure that children and families can easily identify and access the appropriate department.

			• Staff morale was good and team cohesion was evident, the new environment engenders a feeling of pride and the ability to do the best for patients.		
06.08.26	Ben Darshana	SDEC	• Developing SDEC model: Medical and surgical SDEC services are now established, including a dedicated urology hot clinic, providing alternatives to traditional ED pathways. • Enhanced acute assessment capacity: The 27-bed AAU has an increased skill mix to manage higher-acuity patients and support direct clerking and assessment. • Patient flow and demand: SDEC is managing approximately 80 patients per day, demonstrating significant activity and the potential to further develop same-day pathways. • Reducing avoidable ED attendances: There is an ambition to increase direct GP referrals into SDEC and AAU, supporting more appropriate patient pathways and reducing pressure on ED.	Shahid	Review the SDEC patient pathway in the context of the current case mix
11.08.26	Darshana	Occupational Health/SHaW	• Supportive and flexible service: Small, cohesive team using hybrid and virtual clinics effectively. • Growing demand and changing needs: Increasing demand, particularly around neurodiversity and musculoskeletal conditions, requiring workplace adjustments. • Proactive staff support: Strong focus on vaccination, sickness absence support, pre-employment checks and staff wellbeing. • Income generation: Existing partnerships with Harlow College and St Clare's Hospice provide income, with potential to expand OH services externally, including to GPs and dentists. • Facilities: Operate in a tight space, on the 1st floor with no lift making accessibility for some staff difficult. Overall: Occupational Health provides an important proactive service supporting staff health, wellbeing and retention.	Catherine O'Maloney-Court	Additional clinic space dedicated to wellbeing and a protected space for breastfeeding facilities would improve the service.

Rise
Our strategy 2026–2031

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2.2

Trust Board (Public) – 1 October 2026

Trust Board (Public) **1 October 2026**								**Item No: 2.1**
Report Title: Executive Report								
Presented by: Executive Directors								
Prepared by: Executive Directors								
Purpose: *(please tick)*	**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.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

The Executive Report links with all the BAF risks.

Recommendation

The Trust Board is asked to note the update.

Link to Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
X	X	X

Relevant legal/statutory issues

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

Impact Assessments

Quality	None identified
Equality, Diversity and Inclusion	None identified
Health inequalities	None identified
Previously Considered By	N/A

Rising Hope, Rising Communities, Rising Standards

Appendices	None

Executive Report
Trust Board (Public)
1 October 2026

1.0 CHIEF'S EXECUTIVE'S REPORT

1.1 Personal Reflections

Within this month's report, we are trialling the inclusion of reports from other Executive Directors in addition to myself, in order to raise the profile of Directorate-specific issues and to allow each voting Director to provide a high-level overview of directorate priorities, outside of the transactional business of the Board.

I would very much welcome Board members' feedback on the new approach.

1.2 Rise strategy: moving from launch to delivery

Since launching our Rise strategy in June, we have been focused on turning its ambitions into action across the Trust.

Rise is our plan to move forward by being honest about where we are starting, believing in what we can achieve together and committing to a brighter future for our people, patients and communities. As we move through autumn, work is progressing across its three priorities: rising hope by looking after our people, rising standards by driving improvement at pace, and rising communities by working with partners to provide care tailored to local needs.

We are building momentum and remain committed to recovering, renewing and rising together.

1.3 Care Quality Commission (CQC) Adult Inpatient Survey results show significant improvement

The latest national CQC Adult Inpatient Survey results show significant improvement in the experience of patients receiving inpatient care at PAHT.

Based on feedback from 422 people who received care in 2025, scores improved across 40 of the 42 questions that could be compared with the previous year, with no areas showing a decline. Patients continue to rate the Trust highly for kindness and compassion, respect and dignity, cleanliness, privacy, pain control, confidence and trust in nurses, and being able to get help when needed. This encouraging progress reflects the hard work and commitment of our teams and shows that listening to patients and acting on their feedback can make a real difference to their experience of care.

Together with our clinical teams, we are building on this progress through a clear programme of work focused on improving the experience of our inpatients. Our actions are centred on two key themes identified as most in need of improvement: effective communication throughout a patient's hospital stay and a seamless, well-coordinated discharge home**.**

1.4 CQC Reports

The CQC has published its latest Well-Led assessment of PAHT, rating the Trust as requires improvement.

We fully acknowledge the findings and the need to respond with clear, sustained action. The report provides a balanced assessment, recognising visible and capable leaders, positive partnership working, progress on sustainability and the important role of our Patient Panel, while highlighting areas for further improvement including organisational culture, colleague engagement, equality, diversity and inclusion, speaking up, governance, learning from experience and the consistency of inpatient care.

Since the assessment period, we have continued to make progress, including achieving significant improvements in the latest Adult Inpatient Survey. We remain focused on listening, learning and embedding improvements so that patients receive consistently compassionate, high-quality care.

Alongside the Well-Led assessment, the CQC published its inspection report for The Princess Alexandra Hospital following visits between November 2025 and January 2026. While the hospital's overall rating remains requires improvement, the report recognises areas of good practice, including a good overall rating for medical care and good ratings for caring and effectiveness, alongside positive feedback from patients about the kindness and dedication of our colleagues.

Since the inspection, we have taken clear action and made significant and sustained improvements for patients. Operational changes have reduced waiting times and improved access to care, with further progress reflected in Referral to Treatment, Emergency Department and Friends and Family Test performance. We take confidence from the improvements being made, while remaining honest about the work still ahead and continuing to embed improvements across our services.

1.5 Annual General Meeting (AGM)

Thank you to everyone who joined our Annual General Meeting (AGM) in Harlow and helped make it such a welcoming and informative event. We shared the progress being made across our hospitals and our plans for the future, including our new Rise strategy, improvements to care and patient flow, the New Hospital Programme and neighbourhood health centres. Attendees also met our community ambassadors and had the opportunity to ask questions of the executive team.

I am grateful to everyone who attended, presented and supported the event, and for the thoughtful questions and feedback that will help us continue to shape services with our communities.

2.0 DEPUTY CEO/CHIEF FINANCE & INFRASTRUCTURE OFFICER'S REPORT

2.1 Our Challenging Financial Position

The financial position remains challenged within the Trust, as is the case across a number of providers both within the East of England and nationally. We are indicating that we will struggle to live within our financial plan for the current year due to pressures arising from the need to provide additional capacity to meet demand (and to aid in maintaining planned performance levels), ongoing issues with our estate which impact on productivity and we are still looking to identify all aspects of our Patient Quality and Productivity (PQP) plan.

To address this, we have developed a revised approach to financial recovery that seeks to balance our operational delivery alongside patient quality and patient risks that we believe will deliver an improvement to the current forecast position for 2026/27. We continue to work with regulators on the delivery of the plan and will provide further updates in due course.

2.2 New Hospital Programme Update

The New Hospital Programme (NHP) continues to be developed with the national team from NHSE and with DHSC. While we remain in wave 2 of the NHP scheme for development of the 7a site, our current efforts are focused on developing a solution for redevelopment of the PAH site. We are only able to consider these plans as we are committed fully to the concept of left shift and moving as many services out of the acute hospital environment and into the community.
These plans are being developed in situ, and we have submitted bids to develop existing sites into Neighbourhood Health Centres and are considering expanding our offer on initiatives such as 'Health on the High Street' to help enable this shift in health provision. Following our AGM earlier in the week, we are keen to showcase our thinking on how we will safeguard the future of provision of services within PAH and the broader community, to the people of West Essex.

2.3 Children's Emergency Department reopens following refurbishment

We were delighted to reopen the Children's Emergency Department in its original location following completion of a major refurbishment that took place over the winter of 2025/26. The newly designed department provides a bright, calm and welcoming environment for children and young people aged 0 to 16, with additional clinical space offering greater privacy and comfort, as well as an improved working environment for colleagues and was co designed by our staff to optimise the space. A bespoke safe space with en-suite facilities has also been created to better support young people presenting in a mental health crisis. This is an important improvement for our patients, families and teams, and I would like to thank everyone involved.

3.0 CHIEF MEDICAL OFFICER'S REPORT

3.1 Research

Research remains healthy at the trust. 57 studies are open to recruitment or under follow up, 51 of which are non-commercial and 6 commercial. Opportunities to increase exposure to research for patients are continually explored with NIHR, and the trust remains open and engaged in supporting commercial research which can support improvements in patient care financially as well as clinically. A positive assessment was received from NIHR RDN during their assessment visit in April 2026.

3.2 Resident Doctors

The People Committee considered the Trust's board assurance framework for improving the working lives of resident doctor. This indicates that we are fully compliant with 17 of 21 elements, and partially compliant with 4 elements, covering rota provision and annual leave management. Active plans are in place working through divisional teams to improve both and we expect to be able to report an improved position in future assessments.

3.3 Medical Education

The results of the annual GMC survey of doctors in training has shown that for 17 elements the trust response is in the interquartile range for 16 elements, with out of hours clinical supervision scoring below average. This has been incorporated into specialty level improvement plans and is managed through the medical education committee. The Executive Cabinet agreed to support more focussed improvements in Obstetrics & Gynaecology and Emergency Medicine.

3.4 Responding to National recommendations

The CMO has coordinated responses to the Amos and Ockenden reports between maternity, estates and mortuary services. All submissions required by NHS England have been made on time, including most recently the Maternity Triage baseline assessment. He has also met with Consultant Obstetricians & Gynaecologists to understand their working and professional lives in the context of the significant scrutiny placed on their specialty now, and to assist them in meeting the expectations of pregnant people and their families. More recently, the Thirlwall report has been published into the events at the Countess of Chester Hospital surrounding neonatal deaths. Whilst the trust response to this is being led by the CNO, the CMO is considering the implications on safety culture, particularly as applied to the medical profession, as this was a clear theme from Lady Justice Thirlwall's Inquiry.

3.5 Job planning and medical productivity

The 2026/27 job planning exercise has commenced with service level job planning, and the CMO is working with divisional colleagues to establish a baseline level of training of operational and clinical leaders and confirmed dates for service job planning meetings. This year financial as well as clinical and operational approval is being sought prior to the completion of service level job plans to ensure that maximum clinical productivity is achieved from the exercise. Individual job planning will follow from December 2026, to be completed by April 2027. Alignment of service level and individual job plans to theatre and outpatient schedules is being sought to maximise productivity.

3.6 Strengthening Senior Medical Leadership

The limited consultation to review the structure of senior medical leadership concluded in August 2026 and the Deputy Chief Medical Officer for Quality and Safety recruitment process was held on 24 September 2026. One position remains vacant (Workforce Lead) that will be appointed to in early October, finalising a senior medical leadership structure that meets the needs of the trust.

3.7 Learning from Deaths

A full summary paper on learning from deaths is included on the agenda for this meeting and this remains an important area of focus for the CMO. Further opportunities to scrutinise signals in the data are being explored.

3.8 Internal Professional Standards

An exercise to review the Trust's Internal Professional Standards is due to complete soon. These guide the flow of patients through the hospital and the behaviours of staff, and the current standards are widely agreed by clinical staff to be sub-optimal. Three focus groups were held with resident doctors to help understand the principles that underlie good patient flow, and a writing group was held with consultants representing all ages (including children) to write a set of standards, which are now starting the drafting and approvals process.

4.0 CHIEF NURSING OFFICER'S REPORT

4.1 Fundamentals of care: nurse leadership, greater visibility

The Fundamentals of Care Programme continues to deliver measurable improvements in the quality and safety of care across our inpatient services. Through the ward accreditation programme, we have strengthened our ability to assess care standards, celebrate excellence and identify areas requiring enhanced support. Accreditation results are providing clearer intelligence on where high-performing teams can share best practice and where targeted improvement interventions are needed to accelerate progress.

Importantly, these efforts are translating into tangible patient outcomes. Trust-acquired pressure ulcers have shown a sustained reduction over the last six months, demonstrating improved reliability in the delivery of fundamental care and the effectiveness of local quality improvement initiatives. Alongside this, ward accreditation scores continue to provide an objective measure of quality, helping teams monitor progress and maintain a focus on delivering safe, compassionate, and person-centred care.

Visible leadership remains a key enabler of improvement. Feedback from the Nursing, Midwifery and AHP Leadership Visibility Survey was overwhelmingly positive, with staff reporting increased access to senior leaders, greater opportunities to raise concerns and share ideas, and stronger support for improvement activities. This is being further strengthened through the introduction of "Back to the Floor Fridays", where senior Nursing, Midwifery and AHP leaders work alongside frontline teams to better understand operational challenges, provide real-time support and role model the behaviours and standards expected across the Trust.

Over the coming months, our focus will be on further improving ward accreditation performance, sustaining the reduction in avoidable harm, sharing the success of high-performing teams and providing intensive support to areas requiring improvement. By maintaining visible clinical leadership, using quality metrics to drive improvement and leading by example, we will continue to strengthen patient outcomes, staff experience and the consistency of care delivered across the organisation.

4.2 Community Ambassador Programme strengthens local connections

We have launched our Community Ambassador Programme, a new initiative designed to build stronger, more meaningful connections between PAHT and the communities we serve.

Led by Anne Wafula Strike, our Community Engagement and Partnerships Lead, the programme brings together respected community leaders who will act as a trusted bridge between the hospital and local people by sharing information, ensuring residents' voices are heard and supporting the co-production of health and wellbeing activities. The programme has made a strong start, with its first ambassadors appointed and further recruitment under way. It is an important example of our Rise strategy in action, helping us to listen more closely, build trust and work alongside local people to shape services that reflect their needs.

4.3 Thirlwall Inquiry

The Trust recognises the gravity of the findings of the Thirlwell Inquiry and is responding with urgency and seriousness. The Chief Nursing Officer is leading this work to ensure lessons are embedded and patient safety remains paramount. A detailed update is provided in a separate paper to the Public Board.

5.0 CHIEF OPERATING OFFICER'S REPORT

5.1 Review of how we book appointments and answer phones

We are doing a lot of work at the moment looking to understand and improve how our clinical administrative processes are working. We know we cause patients a lot of frustration due to difficulties getting through to specialties on the phones, and with anxiety waiting to find out about next appointments. In the coming months we will be re-designing our admin structures to improve them for both patients and staff. We will also be booking all our patients currently on our waiting lists, so patients know when their next appointment is. In some cases where specialties still have quite long waits, this appointment might be quite far away, but we think this will be better than waiting for an appointment and not knowing when it will be. We hope these changes will make a big difference for patients.

5.2 Utilisation of our resources to the maximum

The Chief Operating Officer has also kicked off a major piece of work, in conjunction with the clinical divisions, looking to better utilise our existing clinical capacity particularly in outpatients and in theatres. This piece of work is linked to two key transformation programmes – Outpatient Transformation and Theatres Transformation, which are clinically led programmes of work. We know we have too many cancellations in both theatres and outpatients, and we also know that our booking teams are under lots of pressure and sometimes are not able to book into all our available capacity. We have a plan for how to get on top of this, and this is already underway and we expect to see substantial improvement this year. We have already seen some significant improvements in theatre productivity.

5.3 Waiting times in the Emergency Department and for outpatient appointments

PAH continues to perform strongly against the national 18 week targets and the 4 hour emergency department targets. In the latest National Oversight framework publication for quarter 1 26/27 PAH is ranked 42nd out of 134 Trusts for its 18 week performance, and 21st for its 4 hour waiting time performance. This is really good news and shows that our efforts to treat more patients and see patients quickly are working.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board 1 October 2026				Agenda item: 2.2
Report Title: Board Strategy Update				
Presented by: Michael Meredith				
Prepared by: Michael Meredith				
Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	

Executive Summary

The NHS is entering a period of significant transformation driven by the 10-Year Health Plan, ongoing structural reform, increasing fiscal constraint and growing expectations of integrated, neighbourhood-based care.
Nationally, whilst there remains uncertainty regarding the future operating model following proposed changes to NHS England, the strategic direction of travel remains largely unchanged:

- Care closer to home.
- Prevention and population health management.
- Digital transformation.
- Stronger local partnerships and neighbourhood working.

Locally, the Trust faces a challenging operating environment characterised by sustained demand growth, workforce pressures, estate constraints, financial challenge and growing expectations around collaboration with community, primary care and local authority partners.

Against this backdrop, the Board's recently agreed RISE Strategy remains highly relevant. The Trust's focus on closer integration with community services, strengthening local partnerships, continuous improvement of services and maintaining organisational independence reflects the emerging national policy direction whilst supporting both clinical and working towards financial sustainability.

Board Assurance

This paper concludes that, whilst the external environment remains uncertain, the strategic direction agreed through the RISE Strategy remains valid and increasingly aligned with emerging national NHS policy.
The Board is asked to:

- Note the strategic risks and opportunities set out in this paper.
- Recognise the increasing alignment between national reforms and the Trust's existing strategic direction.
- Reaffirm its commitment to organisational independence, partnership working, selective integration, continuous improvement to drive long-term clinical and financial sustainability.

Risks and Issues

- **Financial Sustainability Risk**: The Trust may be unable to deliver required financial performance while maintaining service quality and strategic priorities.
- **Operational Performance Risk**: Demand, capacity and workforce pressures may impact delivery of key access, quality and productivity targets.
- **Strategic Change Risk**: National policy changes and local system reform may affect the Trust's ability to deliver its strategic objectives and planned transformation.
- **Partnership and Integration Risk**: Changes in system leadership, governance and partner engagement may hinder progress towards integrated models of care.
- **Workforce Risk**: Challenges in recruiting, retaining and developing staff may affect organisational performance and future service delivery

Recommendation

Whilst the external environment remains uncertain in terms of structures, leadership arrangements and funding, the strategic direction of travel is increasingly clear. The NHS is moving towards neighbourhood health, stronger integration, prevention, digital transformation and population-based delivery.

The Trust's existing RISE Strategy remains strongly aligned to these developments. Its emphasis on partnership working, closer integration with community services, organisational independence, continuous improvement and sustainable service delivery places the Trust in a strong position to respond to the changing landscape.
The principal challenge for the next 12-24 months will be maintaining operational performance and financial discipline whilst continuing to invest in the transformation necessary to secure the Trust's long-term clinical and financial sustainability.

The Board should take assurance that the strategic direction already agreed remains relevant and appropriate. The focus should now be on disciplined delivery, strengthening partnerships, building organisational capability and ensuring that the Trust is well positioned to thrive within an increasingly integrated and neighbourhood-based NHS

Strategic Objectives		
Rising Hope	Rising Communities	Rising Standards
x	x	x

Relevant legal/statutory issues

Impact Assessments	
Quality	Please state or None identified
Equality, Diversity and Inclusion	Please state or None identified
Health inequalities	Please state or None identified
Previously Considered By	Name and date of any committee/group where the paper has already been presented.
Appendices	List appendices that accompany the paper/report. Ensure each appendix is referenced in the main text.

1. Macro Context: National Environment

1.1 The 10-Year Health Plan Remains the Strategic Framework

Despite significant NHS organisational change and national leadership transition, the core ambitions of the 10-Year Health Plan remain intact:

- Hospital to community.
- Analogue to digital.
- Sickness to prevention.
- Population health and neighbourhood health models.
- Stronger integration across providers, primary care, social care and local government.

The emphasis nationally is increasingly shifting away from policy development towards implementation and local delivery.

1.2 National Leadership and Operating Model Uncertainty

The proposed abolition of NHS England and transfer of responsibilities into DHSC continues to create uncertainty regarding:

- National leadership arrangements.
- Future regional structures.
- Accountability frameworks.
- System oversight mechanisms.

While the strategic direction remains broadly understood, the detailed operating model is not yet well defined, creating uncertainty for providers and systems attempting to plan long-term transformation.

1.3 Devolution

The Government's wider devolution agenda is likely to increase the influence of mayors on health and population outcomes.

Potential implications include:

- Increased local democratic scrutiny.
- Greater alignment between health, housing, employment and wider determinants of health.
- Stronger place-based working.
- Potential future changes to commissioning and accountability arrangements.

The direction of travel supports more locally driven, population-focused models of care.

1.4 Financial Outlook

The national financial environment remains highly constrained.

Key considerations include:

- Limited fiscal headroom.
- Ongoing efficiency requirements.
- Uncertainty around future spending review settlements.
- Continued pressure on providers to deliver transformation within existing resources.

The forthcoming Budget is unlikely to materially relieve these pressures. The challenge for NHS organisations remains delivering transformation whilst maintaining financial balance.

2. Micro Context: NHS Policy, Commissioning and System Reform

2.1 Emerging Financial and Payment Reform

National policy increasingly recognises that existing payment mechanisms continue to incentivise activity rather than prevention.

Current discussions focus on:

- Population-based commissioning.
- Outcomes-focused payment mechanisms.
- Financial flows that support neighbourhood care.
- Greater investment in primary, community and preventative services.

Although the final models remain under development, providers, including us, should anticipate changes designed to encourage integrated care and reduce reliance on acute activity.

2.2 New Contracting Models

Several new provider models are emerging under the neighbourhood health agenda.

Multi-Neighbourhood Providers (MNPs)

Lead provider arrangements coordinating services across multiple neighbourhoods and pathways.

Single Neighbourhood Providers (SNPs)

Single contractual arrangements designed around defined local populations and integrated care delivery.

Integrated Health Organisations (IHOs)

Longer-term models bringing together budgets, care delivery and population health accountability. Early adopter organisations are already beginning to test this approach.

These developments represent a significant shift towards place-based delivery and population accountability. However, Essex ICB has indicated that they will not be implementing these models soon (circa 2 years). Therefore, local commissioning arrangements between the Trust and local providers (e.g. GPs and community) should be prioritised.

2.3 Digital and AI

National policy continues to place significant emphasis on:

- The NHS App.
- The Single Patient Record.
- The Federated Data Platform.
- AI-enabled productivity and care redesign.

AI deployment remains focused primarily on:

- Clinical documentation.
- Administrative productivity.
- Decision support.
- Population health analytics.

Investment in digital maturity and workforce capability will be increasingly important strategic differentiators.

3. Local Context

3.1 System Pressures

The local health economy continues to experience sustained demand growth across urgent care, elective pathways and frailty services.

Key risks include:

- Rising emergency demand.
- Operational fragility.
- Continuing workforce shortages.
- Competing demands between recovery and transformation.

Winter planning will require particular attention given ongoing capacity pressures.

3.2 Mental Health System Challenges

Essex Partnership University NHS Foundation Trust (EPUT) continues to face significant external scrutiny and pressure associated with the ongoing Lampard Enquiry.

Implications include:

- System leadership distraction.
- Increased regulatory focus.
- Capacity constraints across partner organisations.
- Reputational and public confidence impacts.

This remains a significant factor within the wider Essex system landscape.

3.3 Primary Care Pressures

Primary care remains under significant pressure due to:

- Workforce shortages.
- Demand growth.
- Increasing clinical complexity.
- Financial constraints.

Given the national shift towards neighbourhood health, the ability of the local system to support primary care sustainability will be critical.

3.4 Delegation and Commissioning Uncertainty

Planned delegation of commissioning responsibilities has been delayed due to wider ICB changes, organisational reset activity and uncertainty around future system arrangements.

This has delayed clarity around:

- Future commissioning responsibilities.
- Local decision-making structures.
- Service redesign opportunities.
- Resource allocation decisions.
- The pace at which neighbourhood health arrangements can be implemented locally.

Whilst the overall direction of travel remains towards greater local accountability and neighbourhood working, the timing and mechanisms for delivery remain uncertain.

3.5 Local Government Reform and Partnership Engagement

The proposed transition to unitary local government arrangements across Essex has introduced a period of uncertainty for local authority partners.

Whilst local government leaders remain committed to partnership working across health and care, the scale and complexity of local government reorganisation have, inevitably, required significant leadership attention and organisational capacity to be directed towards planning future arrangements.

For the Trust and wider health and care system, this has had several practical implications:

- Reduced capacity within some local authorities to engage fully in longer-term transformation initiatives.
- Slower progress in some areas of system-wide partnership working.
- Challenges in maintaining momentum within Local Health and Care Partnerships.
- Reduced focus on neighbourhood health development and place-based planning.
- Uncertainty regarding future local authority structures, leadership arrangements and decision-making responsibilities.

The continuing delay in reaching decisions regarding future unitary council arrangements has created uncertainty across the wider Essex partnership landscape. As a consequence,

local authority partners have understandably been less able to engage in the strategic development of Local Health and Care Partnerships at the pace originally anticipated.

This is particularly important given the increasing national emphasis on neighbourhood health, prevention and population health management, all of which depend upon strong collaboration between the NHS, local government, community organisations and wider public services.

The Trust should continue to work closely with local authority colleagues, recognising both the pressures they are managing and the critical role they will play in delivering future integrated models of care.

3.6 Workforce, Culture and Leadership

The workforce remains one of the most significant strategic risks facing the organisation.

Challenges include:

- Recruitment and retention.
- Wellbeing and burnout.
- Cultural maturity.
- Leadership capacity.
- Developing the skills needed for system working, collaboration and transformation.

The future NHS operating environment will require leaders who can operate effectively across organisational boundaries rather than within traditional institutional structures.

3.7 Estates

The Trust continues to face estate constraints which impact:

- Clinical productivity.
- Patient experience.
- Service redesign opportunities.
- Workforce experience.

However, plans for a new hospital on the existing site present a significant strategic opportunity to modernise pathways, improve clinical flow and support future models of care.

What Does This Mean for Us?

The Board has previously endorsed the direction of travel outlined in the RISE Strategy, and the emerging national policy environment increasingly validates many of the assumptions upon which that strategy was built.

1. Closer Integration, Not Isolation

National policy is clearly moving towards neighbourhood health, integrated care and population-based delivery.

For the Trust, this reinforces the importance of:

- Working alongside community providers.
- Strengthening relationships with primary care.

- Collaborating with local authority partners.
- Integrating services where this improves outcomes and sustainability.

The emphasis in RISE is on partnership working is therefore aligned to the national direction.

2. Organisational Independence Remains Appropriate

Whilst collaboration and integration are increasingly important, there is currently no national policy expectation that all organisations should merge.

The Board has previously supported a strategy focused upon:

- Partnership rather than organisational merger.
- Service integration where it benefits patients.
- Retaining local accountability and organisational agility.
- Preserving organisational focus on service improvement and delivery.

Whilst there may be circumstances where merger becomes strategically advantageous, there is currently no compelling evidence that organisational merger would improve quality, performance or financial sustainability.

The Trust's preferred approach remains to achieve the benefits of scale and integration through partnership and collaborative delivery rather than structural consolidation.

3. Continuous Improvement is Essential

The emerging NHS environment is unlikely to provide substantial additional funding to solve operational challenges. Consequently, clinical and financial sustainability will increasingly depend upon:

- Continuous service improvement.
- Productivity gains.
- Digital enablement.
- Workforce innovation.
- Improved patient flow.
- Reducing variation.

Improvement capability therefore becomes a core strategic asset rather than a supporting function.

4. Clinical Sustainability and Financial Sustainability Are Increasingly Linked

The Trust cannot view quality, workforce and finance as separate agendas.

Future sustainability will depend upon:

- Delivering care in the most appropriate setting.
- Reducing unnecessary hospital demand.
- Supporting prevention and early intervention.
- Working across organisational boundaries.

- Improving productivity and reducing unwarranted variation.

The strategic challenge is, therefore, to achieve both financial sustainability and improved patient outcomes through redesigned care models rather than through traditional cost-reduction approaches alone.

5. The New Hospital Creates a Once-in-a-Generation Opportunity

The proposed redevelopment of the existing site should be viewed not simply as an estates programme but as a transformation opportunity.

The Trust can design services around:

- Modern pathways.
- Digital-first approaches.
- Improved patient flow.
- Neighbourhood health models.
- Future workforce needs.

The redevelopment programme has the potential to become the Trust's single biggest transformation opportunity over the next decade, enabling the redesign of care pathways, improved productivity, enhanced patient and staff experience and supporting delivery of the RISE Strategy.

Emerging Strategic Risks

The following risks should continue to be monitored by the Board as the strategic landscape continues to develop:

- Ongoing uncertainty regarding national NHS operating arrangements, accountability structures and future leadership arrangements.
- Continued financial pressures and limited funding growth across the NHS, alongside increasing expectations for service transformation and productivity improvement.
- Failure of neighbourhood health reforms to be matched by a genuine shift of resources from acute services into community and preventative settings.
- Workforce supply, retention, leadership capacity, wellbeing and organisational culture challenges.
- Delays to commissioning reform and the delegation of responsibilities within the wider Essex system.
- Reduced pace of partnership development and neighbourhood health implementation arising from uncertainty associated with local government reorganisation and the transition to future unitary council arrangements across Essex.
- Reduced engagement and capacity within Local Health and Care Partnerships as local authority leaders and organisations focus on local government reform and future organisational arrangements.
- Increasing operational pressures during winter reducing organisational capacity and leadership bandwidth available for transformation.

- Estate constraints limiting productivity, service redesign opportunities, patient experience and workforce experience.
- Potential instability within the wider Essex health and care system arising from organisational pressures and ongoing external scrutiny of key partners.
- Continuing uncertainty regarding future payment mechanisms, neighbourhood contracts, Integrated Health Organisations and population-based commissioning arrangements.
- The risk that organisations become overly focused on structural change and system reorganisation at the expense of service improvement, transformation and delivery.

Strategic Considerations

Taken together, these risks highlight the importance of maintaining a clear strategic focus. Whilst many elements of the external environment remain outside the Trust's direct control, the Board can continue to influence those factors most critical to long-term success, including:

- The delivery of RISE.
- Strengthening relationships with community, primary care, local authority and voluntary sector partners.
- Workforce engagement, leadership development and culture.
- Continuous improvement and productivity.
- Preparation for neighbourhood health and emerging commissioning models.
- Maximising the strategic opportunity presented by the new hospital development.
- Maintaining financial discipline whilst continuing to invest in transformation.

This balanced approach will help ensure the Trust remains resilient in the short term whilst positioning itself successfully for a more integrated, neighbourhood-based NHS in the future.

The Princess Alexandra Hospital NHS Trust

3.1

Trust Board (Public) Date: 1 October 2026					Agenda item: 3.1
Report Title: Corporate Risk Register					
Presented by: Andrew Kelso – Chief Medical Officer					
Prepared by: Lisa Flack – Compliance and Clinical Effectiveness Manager Erin Walters – Associate Director of Clinical Quality and Governance					
Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	x	

Executive Summary

This paper presents a summary of open risks scoring 15 and above for all our services. It is a snapshot taken from our Datix database on 31.08.2026.
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 19.
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 is 1 new risk scoring 16
Section 5 - There is 1 new risk scoring 15
Section 6 – There is 1 new risk scoring 12
Section 7 – There are 8 risks that meet the criteria for the corporate level register but are on the operational level register
Section 8 – There are 7 corporate register risks passed their review date

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

There is a risk that the Trust does not have complete and timely oversight of its highest-scoring risks, as eight risks scoring 15 or above have not yet progressed to the Corporate Risk Register and seven corporate risks are overdue for review. This may affect the timeliness of escalation, scrutiny and assurance regarding the effectiveness of mitigating actions.

Recommendation

- Note the contents of the corporate risk register

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
x	x	x

Relevant legal/statutory issues

The effective identification, escalation and management of risk supports the Trust in meeting its statutory duties in relation to quality, patient safety, workforce, regulatory compliance and good governance. Any specific legal or statutory implications associated with individual risks are managed through the relevant risk controls and action plans.

Impact Assessments

Quality	Identified with controls
Equality, Diversity and Inclusion	None identified
Health inequalities	None identified
Previously Considered By	Name and date of any committee/group where the paper has already been presented.
Appendices	N/A

The Princess Alexandra Hospital NHS Trust

3.1

Corporate Risk Register

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 31.08.26 and considers the divisional re-structure. It also reflects the changes agreed by Executive Board in August 2026, as to how the data is presented, with Tables 1 and 2 now only showing those risks that have been accepted onto the corporate risk register. The change improves alignment between the tables, strengthening auditability and transparency.

Trust wide oversight of risk is via the Risk Management Group (RMG) that meets monthly to review risk by exception. The group operates in accordance with 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 have been agreed for placement onto the corporate risk register.

2.0 Risk Data

There are 42 risks that meet the criteria and have been approved for inclusion onto the corporate level risk register.

The breakdown by service of the 42 approved corporate risks can be seen in table 1

Table 1 – Corporate Risks	Risk Score						Totals
	10	12	15	16	20	25	
Family Diagnostics and Community		7	3	7			17
Corp – Estates and Facilities			1				1
Corp – IM&T		1					1
Integrated Emergency and Medical Pathways	1		1	2			4
Planned Pathways		1	1	1			3
Trust Wide	1	9	1	5			16
Totals	2	18	7	14	0	0	42

Table 1 - Corporate Risks

The breakdown of approved corporate risks by category can be seen in table 2

Table 2 – Number of Corporate Risks by Category That Exceed Appetite Tolerance	Risk Appetite Tolerance	Risk Score					Totals
		10	12	15	16	20	
Quality – Safety	≥10	2	10	6	7	0	25
Quality – Patient Experience	≥12		1		2		3
Quality – Clinical Effectiveness	≥12		6		5		11
People	≥15				1		1
Statutory Compliance & Regulation	≥12		1	1			2
Finance	≥12						0

Reputation	≥15						0
Infrastructure	≥15						0
Information and Data	≥10						0
Systems and Partnerships	≥15						0
Totals		2	18	7	15	0	42

Table 2 - Number of Corporate Risks by Category That Exceed Appetite Tolerance

3.0 Summary of Risk 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

Quality – Patient Experience

1. **ID 820:** Risk relating to increased demand for Category 4 caesarean sections that exceed capacity
   Assurance: tracking additional lists and daily oversight
   Action: Business plan to be developed for increasing elective caesarean section list capacity

5.0 New Risks to Corporate Level Register Scoring 15

Quality - safety risk

1. **ID 747**: paediatric risk associated with current medical staffing model and ability to provide robust cover, particularly in emergency situations in competing departments
   Assurance: Escalation criteria in place
   Action: New rota due to start in September

6.0 New Risks to Corporate Level Register Scoring 12

Quality – clinical effectiveness

1. **ID 961:** relates to risk arising from frequent closures of the Serenity Birth Centre due to staff redeployment
   Assurance: Anticipated roster gaps put out to NHSP and internal redeployments undertaken
   Action required: Staffing template to align with Birth Rate Plus recommendations

7.0 Risks Scoring 15 and Above Not Yet on the Corporate Risk Register

On 31.08.26 there were 8 risks that have a current score of 15 or above that are not on the corporate level risk register for the following reasons:

- Risk on Datix but has not yet been submitted by exception to RMG
- New or existing risks on an exception report to be reviewed by RMG/Executive Board (EB)
- Under review by the division / service following feedback given from either RMG / EB
- Under review by EB

The Princess Alexandra Hospital NHS Trust

3.1

Table 3 – Risks with a score of 15 and above not on the corporate risk register	On Datix but not on exception report / submitted to RMG	On exception report for review in line with annual work plan	Further review by divisional / corporate team board requested by RMG	Further review by divisional / corporate team requested by EB	Under review by EB	Total
Corp - Estates			1 (risk id, 553)			**1**
Corp – RD&I			1 (risk id 233)			**1**
Planned Pathways	1 (risk id 283)					**1**
FDC - Paediatrics				1 (risk id 974)		**1**
FDC – Women's Health	1 (risk id 760,60)	1 (risk id 56, 899)				**4**

Table 3 – Risks with score of 15 and above not on the corporate risk register

8.0 Corporate Register Risks Passed Their Review Date

There are 7 risks that are overdue review (as of 31.08.26).

9.0 Recommendation

Trust Board is asked to:

- Note the contents of the corporate risk register

Author: Lisa Flack – Compliance and Clinical Effectiveness Manager
Erin Walters – Associate Director of Clinical Quality and Governance
Date: 31 August 2026

The Princess Alexandra Hospital NHS Trust

3.2

Meeting Title: Trust Board Date: 1 October 2026				Agenda item: 3.2
Report Title: Board Assurance Framework 2026/27				
Presented by: Heather Schultz – Director of Corporate Governance				
Prepared by: Executive Directors				
Purpose: *(please tick)*	**Approval/Decision**	x	**Information/Assurance**	

Executive Summary

The BAF risks have been updated by executive leads and discussed at committees during September 2026. There are no changes to the risk scores however there are changes to the risk descriptions for the EHR and Cyber risks (as attached, Appendix 1 and 2).
The BAF risks are being moved onto Datix to enable linkage with the Corporate Risk register, and a revised reporting format will be presented in December 2026.

A summary of the BAF risks is attached as Appendix 3 and the full BAF is available in resources for Board members to review.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

As per attached BAF.

Recommendation

Trust Board is asked to review and approve the amendments to the EHR and Cyber risks and note the remaining risks.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
x	x	x

Relevant legal/statutory issues

Compliance with NHS Code of Governance.

Impact Assessments

Quality	As described in the attached BAF risks
Equality, Diversity and Inclusion	None identified
Health inequalities	Considered as part of the process of reviewing the risks and reflected in the relevant risks as appropriate.
Previously Considered By	Committees in September 2026
Appendices	Appendix 1- EHR risk Appendix 2 – Cyber risk Appendix 3 – BAF summary Appendix 4 – BAF 2026/27 in resources

Risk Key														
Extreme Risk		15-25												
High Risk		8-12												
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	RISING STANDARDS RISING HOPE													
BAF 1.4		EHR:There is a risk to the delivery of safe, effective and financially sustainable care if Alex Health is not fully adopted, optimised and supported as the Trust's principal electronic health record. The risk arises from inconsistent workflow adoption, data quality and documentation issues, clinical-safety dependencies, limited operational and digital capacity, interface and integration complexity, and delays in delivering optimisation and benefits. This may result in missed, delayed or incorrectly recorded care, inefficient clinical and administrative processes, unreliable operational or financial reporting, reduced income capture and failure to realise the anticipated benefits of the EHR investment.	Causes: 1.Inconsistent adoption of agreed clinical and administrative workflows across divisions. 2. Incomplete, inaccurate or inconsistent clinical and operational data, including discharge summaries, outcomes, encounters, waiting-list and coding information. 3 .Insufficient recurrent capacity in EHR application support, clinical informatics, training, change management and business intelligence. 4 Clinical-safety assurance dependencies for changes, interfaces, modules and replacement systems, including compliance with DCB0129 and DCB0160. 5 High volume and complexity of interfaces and integration traffic following EHR implementation. 6 Dependence on Oracle Health and other suppliers for fixes, cloud migration, upgrades and change requests. 7 Fragmentation or duplication caused by retaining or introducing systems outside the principal EHR without full integration. 8 Variable clinical engagement and resistance to standardised digital workflows. 9 Insufficiently mature benefits measurement, meaning that original productivity and workforce benefits may not be realised. 10 Downtime, infrastructure or cyber events affecting access to critical clinical information.	4 X 5= 20	Chief Clinical Transformation Officer **Performance and Finance Committee**	1 Digital governance structure comprising the Digital Committee, Digital Optimisation Board, Clinical Digital Advisory Board and operational/divisional digital oversight. 2 DCB0160 clinical risk-management process for deployment and use of health IT, supported by clinical-safety officers, hazard logs and formal safety acceptance. 3 Requirement for satisfactory DCB0129 supplier assurance before deployment of applicable digital products or modules. Controlled change, release and configuration-management processes for EHR changes, interfaces and upgrades. 4 Structured data-quality governance, with identified workstreams for discharge summaries, clinic outcomes, encounters, coding, waiting-list reporting and income-critical data. 5 Role-based access controls, CIS2 authentication, leaver and mover processes, and auditable monitoring of access to patient records. 6 EHR training and recurrent competency support, including induction, refresher training, targeted retraining, at-the-elbow support and support for high-risk workflows. 7 Formal incident management through Datix, with clinical-safety review, trend analysis and escalation of high-risk incidents. 8 Alex Health downtime and business-continuity arrangements, including accessible downtime Aex health downtime SOP	i) Digital Board ii) PAF meetings iii) Alex Health governance in place: Digital adoption work streams being overseen by Operational Board led by the divisions. Alex health workstreams being overseen by the PMO BI Monthly clinical-safety and digital incident report to the Digital Committee. Digital roadmap and optimisation highlight reporting. Data Quality Group reports and delivery trajectories. Internal audit reports relating to data quality, coding, DSPT and digital governance.	ii)Digital Board which reviews progress, risks and issues on a monthly basis iii) Quarterly digital reports to Performance and Finance Committee iv) Structured cells looking at data validation, end user training for bookers and data quality and cleansing	4 X 4= 16	i) Resource availability to support AI and robotic, increased digitisation and demand ii) Capacity within operational teams to ensure delivery of change required iii) Oracle capacity to deliver on the timeline of change requests) Actions to strengthen controls : Deployment of an EHR training programme with mandatory competency assessments for all clinical users Prior to access being granted 2) Dedicated BI informatics team providing on-site and virtual support during stabilisation. Including additional resource from Oracle health 3) Weekly monitoring reviewed by digital operational board and escalations fed to the Digital Board and divisional leads. 4) Enhanced data quality checks pre- and post-migration with support from Oracle health 5) Escalation protocol for system issues with defined SLAs for resolution. Actions: 1) Comprehensive EHR training programme with mandatory competency assessments for all clinical users. 2) Dedicated clinical informatics team providing on-site and virtual support during stabilisation. 3) Weekly adoption monitoring dashboards reviewed through digital governance structure 4) Enhanced data quality checks pre- and post-migration with automated validation scripts. 5) Escalation protocol for system issues with defined SLAs for resolution. 6) Clinical cell structure established with key workstreams associated with end user training validation and data quality leads	1 No consolidated Board-level dashboard currently demonstrates EHR adoption, competency, data quality, downtime readiness, clinical safety and benefits realisation in one place. 2 Limited quantified evidence that training and targeted support have produced sustained workflow compliance. 3 Incomplete independent assurance over post-implementation benefits and the effectiveness of operational adoption controls. 4 Downtime and recovery exercise outcomes are not routinely reported as part of the EHR BAF but EPRR report through PAF and Executive board	11/09//2026	**Score unchanged**	**4x3=12** **March 2027**
			Effects: I)Patient safety risks and inability to plan and deliver patient care appropriately ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12												
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	RISING STANDARDS **RISING HOPE**													
BAF		**Cyber** There is a risk of Trust-wide loss of IT infrastructure and systems from Cyber attack There is a risk that a cyber incident, malicious or unauthorised activity, supplier compromise or failure of critical technology controls could affect the confidentiality, integrity or availability of Trust information, clinical systems, connected medical devices and infrastructure. This could disrupt clinical care for a prolonged period, compromise patient or staff information, prevent access to critical records, create patient-safety risks, cause financial loss and result in regulatory, contractual and reputational consequences.	Causes: 1. Lack of End User Cyber Awareness 2. Core IT Infrastructure/Hardware reaching end of life 3 Insufficient ICT cyber resources 4. Constant demand to patch software and hardware against cyber security vulnerabilitiesPhishing, credential theft, social engineering and low end-user cyber awareness. Unsupported or end-of-life hardware, operating systems, applications and network devices. 5. Delays in patching critical and high-risk vulnerabilities. 6. Insufficient cyber-security, network and infrastructure capacity. 7. Weak or incomplete multifactor authentication and privileged-access controls. 8. Third-party and supply-chain compromise. 9. Misconfiguration of cloud, network, endpoint or identity services. 10. Inadequate asset visibility, including connected medical devices and shadow IT.	**5 X 4= 20**	Chief Clinical Transformation Officer **PAF**	i) DSP toolkit results ii) Information governance training compliance iii) IT service desk reports iv) Cyber status and monitoring processes v) Data security breach numbers vi) Weekly cyber security meetings vii) Business cases to replace infrastructure/hardware reaching end of life viii) Smart cards issued to relevant staff ix) Board cyber training session September 2025 x) SIRO/Caldicott Guardian training session 22 September 2025Security-awareness training, phishing exercises and targeted training for high-risk and privileged roles. Information-access monitoring, including inappropriate access to Alex Health and formal conduct escalation. Cyber risk register and weekly technical review, with escalation through Digital Committee, IGSG, PAF and BoardComplete a formal gap assessment against the 2026/27 DSPT version 9 requirements, including the mandatory Extended Detection and Response policy, revised multifactor authentication requirements and updated CAF provisions. Report the resulting improvement plan and investment requirements to the Digital Committee, IGSG and PAF.	i) Performance and Finance Committee ii) Digital Board iii) ICT Programme Board iv) Risk Management Group	i) 6 Monthly Cyber Security update paper for PAF ii) Bi-Monthly report for IG Steering Group iii) Cyber Risks managed on a more granular level at Risk Management GroupResidual risk remains high because the threat landscape is continuously evolving; recurrent investment and specialist resource remain constrained; end-of-life and supplier dependencies persist; and complete Board assurance over restoration testing, MFA coverage, endpoint detection coverage, high-severity alert compliance and critical supplier resilience is not yet consolidated. iv) Weekly Cyber Security meeting to review new vulnerabilities v) DSPT toolkit review by internal audit (low risk/high confidence rating)	**5x3=15**	I) Funding ii) ICT/ Cyber Resources iii) Constantly changing cyber security threats Actions: DSPT (CAF aligned) Version 9 baseline assessment to be completed and submitted by December 2026	No consolidated evidence against all seven NHS foundational cyber outcomes and the new DSPT version 9 requirements.	Sep-26	**No change to score**	**5x2 =10** **~~June 2026~~** **June 2027**
			Effects: i) IT infrastructure failure ii)Patient safety risks and inability to plan and deliver patient care appropriately iii) National reporting targets may not be met/ missed. iv) Financial loss to organisation v) Reduce the capacity of the Trust to deliver patient care for an undefined period											

Board Assurance Framework Summary 2026.27

Strategic Objective/ Committee	Risk description	Year-end score (Apr 26)	June 26	October 2026	December 2026	February 2027	April 2027		Trend	Target risk score	Executive lead
Rising Standards QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16					⟷	12	ICN CMO
Rising Standards PAF	Operating Plan: Risk of poor outcomes and patient harm due to inability to deliver the national access standards.	15	15	15					⟷	10	COO
Rising Standards/ Hope PAF	EHR There is a risk to the delivery of safe, effective and financially sustainable care if Alex Health is not fully adopted, optimised and supported as the Trust's principal electronic health record. The risk arises from inconsistent workflow adoption, data quality and documentation issues, clinical-safety dependencies, limited operational and digital capacity, interface and integration complexity, and delays in delivering optimisation and benefits. This may result in missed, delayed or incorrectly recorded care, inefficient clinical and administrative processes, unreliable operational or financial reporting, reduced income capture and failure to realise the anticipated benefits of the EHR investment.	16	16	16					⟷	12	CCTO
Rising Standards/ Hope PAF	Cyber There is a risk of Trust-wide loss of IT infrastructure and systems from Cyber-attack There is a risk that a cyber incident, malicious or unauthorised activity, supplier compromise or failure of critical technology controls could affect the confidentiality, integrity or availability of Trust information, clinical systems, connected medical devices and infrastructure. This could disrupt clinical care for a prolonged period, compromise patient or staff information, prevent access to critical records, create patient-safety risks, cause financial loss and result in regulatory, contractual and reputational consequences.	15	15	15					⟷	10	CCTO
Rising Hope 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.	16	16	16					⟷	12	CPO

Board Assurance Framework Summary 2026.27

Rising Standards PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20					⟷	8	CFIO
Rising Communities 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					⟷	12	CSO
Rising Standards PAF **Closed**	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	8						**Risk closed in June 2026**	8	CFIO
Rising Standards PAF	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	16	16	16					⟷	8	CFIO

Board Assurance Framework Summary 2026.27

	increasing the likelihood of regulatory intervention.										
Rising Standards PAF	Climate Change: There is a risk that the Trust may be unable to maintain safe, effective and sustainable services due to the increasing impacts of climate change -including extreme heat, flooding, storms, and supply chain disruption which may result in harm to patients and staff, service interruption, damage to estate and infrastructure, and regulatory non-compliance.		12	12					⟷	8	CMO
Rising Standards PAF	NHSE Net Zero Strategy: There is a risk that the Trust may be unable to align with National Net Zero targets. That is caused by insufficient progress in reducing carbon emissions, limited resources or funding for sustainability initiatives, and potential delays in implementing required energy efficiency and decarbonisation measures. That will result in non-compliance with national sustainability requirements, reputational damage, reduced access to future funding linked to Net Zero performance and continued environmental impact from higher than target emissions.		12	12					⟷	8	CMO

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
1.6 QSC Annual Effectiveness Review 25/26	√			N	N	QSC noted the outcome of the review. It also approved the suggested changes to the Committee's Terms of Reference (ToR), and requested two additional corrections on Membership. The revised ToR are attached at **appendix 1.**
2.1 M5 Integrated Performance Report (IPR) Under 18s Elective Waiting List Update	√ √			N N	N N	**IPR:** Key areas requiring continued focus include diagnostic waits over six weeks, Cancer 62-day performance, Cancer Faster Diagnosis performance, emergency department 4-hour performance and delivery of the Cost Improvement Programme. Recovery plans remain in place across operational, clinical and financial performance areas and continue to be monitored through established governance arrangements. For a future meeting QSC requested an update on mixed sex breaches and progress on the health inequalities work. **Under 18s Elective Waiting List Update:** This report provided a review of the Trust's elective waiting list position for patients aged under 18 years, incorporating findings from a detailed performance analysis and the recent East of England SiC ODN review. Significant progress has been made in

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DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						reducing long waits, with remaining performance challenges concentrated within a small number of specialties where targeted recovery actions are in place.
2.2 Nursing & Quality Dashboard	√			Y	N	The paper defined the distinct but complementary purposes of the Nursing Quality Dashboard and the Documentation Compliance Dashboard and sought to inform the decisions and assure the Committee of the methodology to support oversight of nursing clinical outcomes through the separate development, and triangulation of both dashboards. QSC was assured of future visibility of nursing metrics across the organisation.
2.3 Deep Dive on Discharge/Outflow	√			Y	N	The paper reviewed inpatient discharge and outflow between 1 August 2025 and 31 July 2026 and provided assurance that PAHT has established flow arrangements and is not an outlier for overall length of stay, while identifying opportunities to improve timely, safe discharge. Although anticipated discharge dates were recorded for 90.7% of patients, only 65.0% were discharged on that date and 26.0% of patients with a medically fit-for-discharge date left later. Improvement through the existing Flow Programme should focus on earlier planning, support

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						for complex wards, timely discharge, clearer action ownership and better data to distinguish internal process delays from external capacity constraints.
2.4 Bi-Monthly Update on Work List Programme	√			N	N	The paper provided an update on delivery of the Worklists Programme and reported the findings of the pathway profiling exercise requested by the Committee in July 2026. The analysis provided assurance that the remaining pathways are expected to have limited impact on RTT waiting time metrics. The programme is now focused on completing outstanding booking activity, implementing bulk deletion functionality and embedding sustainable business-as-usual processes. QSC requested the next bi-monthly paper include an update on harm reviews.
3.1 Infection Prevention & Control Update	√			N	N	Key headlines were: C-diff numbers are currently higher than normal but this is a picture that is mirrored nationally. • There are plans for 24/7 respiratory virus testing for winter which are hoped to be in place by November.

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						• Water safety remains a key risk/focus. A robust water safety group is in place with a good Authorising Engineer. • Fit testing compliance has been low but is now improving following the implementation of an electronic tracking system. • Recent E.coli data will undergo validation given the Trust has previously held a very low position in the East of England in terms of numbers of cases.
3.2 CQC Update	√			N	N	The Committee: • Noted the progress made in addressing historic and current CQC regulatory actions. • Noted the remaining areas requiring improvement and ongoing executive oversight. • Took assurance from the governance arrangements in place to monitor delivery of CQC actions and Well-Led improvement priorities. • Noted the planned Board development session and Board self-assessment against the CQC Well-Led quality statements scheduled for January 2027.

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						QSC requested some changes to the presentation of the report to include the date the action was opened and the current position.
3.3 Learning from Deaths Update	√			N	N	Reporting period May 2025 – Apr 2026: Hospital Standardised Mortality Ratio (HSMR+) and Standardised Mortality Ratio (SMR) continue to improve and within expected variance. These improvements are largely a reflection of education and validation between clinicians and coders, correcting data quality issues. Improvements in palliative coding reflects development of community pathways. Review of significant diagnostic outliers did not identify any care and treatment issues. Prevention of future deaths workstreams have been selected. QSC requested the SHMI 'range' be added to the IPR going forward.
3.4 Patient Safety Monthly Report		√		N	N	The report provided QSC with a consolidated overview of the Trust's patient safety, legal services, regulatory compliance and clinical effectiveness position for July and August 2026. Incident reporting rates and reported harm remained broadly stable and within expected statistical thresholds, with no special

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						cause variation identified. However, assurance was limited by the volume and age of open incidents, including 529 patient safety incidents open for more than 30 working days, together with 283 overdue procedural documents, 113 national audit reports under review or unassessed, 45 overdue local project reports and 87 overdue NICE guidance reviews. Sustained divisional action, oversight and exception reporting are required to support timely closure, evidence learning and demonstrate measurable improvement.
3.5 Sharing the Learning Update		√		N	N	The paper provided assurance on learning identified through patient safety incident reviews and learning summaries shared through the Quarter 3 2025/26 cycle. Themes included documentation, handover and patient identification, diagnostic follow-up and escalation, retained item controls, paediatric rapid tranquillisation, medicines/monitoring practice and safeguarding documentation.
3.6 Update from Patient Panel	√			N	N	August was a productive month for the Patient Panel, with increased involvement in discharge improvement, urgent care, women's health and the What Matters Most programme. The Panel has also strengthened engagement with senior clinicians, expanded community partnerships and continued to

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						ensure that patient experience remains at the heart of service improvement across the Trust.
3.7 Revised Nutrition Strategy	√			Y	N	The paper provided QSC with an update on key work led through the Nutrition and Hydration Steering Group, responsible for the delivery of the Nutrition and Hydration strategy. This includes; staff catering and patient food, specialist nutrition and parenteral nutrition, eating-disorder care, assurance data and patient-safety risks. Progress is evident, but further work is required to strengthen pathways, communication, training, data and delivery capacity.
3.8 BAF Risk 1.1 Clinical Outcomes	√			N	N	In line with the recommendation it was agreed that the risk score would remain at 16.
4.1 Medicines Optimisation Annual Report	√			N	N	The report provided an account of the work of the Medicines Optimisation Group (MOG) over 2025/26. It provided assurance that the MOG is reacting appropriately to incidents, safety alerts and the results of audits.
4.2 Reports from Feeder Groups	√			N	N	<u>Patient Safety Group</u> No items for escalation.
		√		Y	N	<u>Compliance Group</u> Of concern was the proportion of overdue procedural documents sitting within Corporate Services.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Ben Molyneux (Acting Chair)

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
		√		Y	N	Clinical Effectiveness Group The Trust has national outlier status within the Neonatal Audit Programme and associated assurance requirements.
	√			N	N	Patient Experience Group No items for escalation.
4.3 Horizon Scanning Update	√			N	N	Items highlighted were: • Thirlwall Report. • Townsend v Epsom and St Helier University Hospitals NHS Trust. • 2026 MBRRACE-UK Saving Lives, Improving Mothers' Care report.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board 01.10.2026 **AGENDA ITEM: 4.1**

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

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

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
1.6 Committee Effectiveness Review and Terms of Reference	✓			Yes	No	The Committee reviewed the annual effectiveness assessment and agreed amendments to the Terms of Reference. Feedback confirmed effective governance arrangements, increasing strategic focus and continued development of membership and reporting structures. Minor amendments relating to external stakeholder representation and organisational references will be incorporated. The Terms of Reference are recommended to Board for approval (see appendix to QSCI report to Board)
2.1 Maternity Dashboard		✓		Yes	No	The Committee noted continued challenges across several maternity performance indicators, including BSOTS compliance, pre-term birth rates and obstetric anal sphincter injuries. However, evidence of improvement was demonstrated, particularly in maternity triage performance, with compliance improving to 80%. Robust improvement plans, workforce actions and enhanced clinical oversight were in place.
2.2 Monthly Maternity Report		✓		Yes	No	The Committee noted increasing patient acuity and complexity, with 51% of the caseload now classified as high acuity. Workforce pressures remain a significant risk across both midwifery and medical staffing. Assurance was received regarding active recruitment, approved establishment growth, workforce modelling

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board 01.10.2026 **AGENDA ITEM: 4.1**

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

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						and development of a medical workforce business case.
2.3 Ockenden and AMOS Review Actions Update	✓			Yes	No	Good progress was demonstrated against Ockenden and AMOS delivery requirements. Robust governance arrangements have been established, including Board oversight, Executive accountability and patient engagement through the Maternity and Neonatal Voice Partnership. Staff engagement activity has commenced through the national 'Your Voice' programme.
2.4 Ten Point Plan Baseline Assessment		✓		Yes	No	The baseline assessment identified several areas requiring further development, particularly listening to women and families, inequalities improvement and home birth services. The Committee received assurance that improvement initiatives are underway and that further evidence of progress will be presented later in the year.
2.4.1 National Triage Specification - Baseline Assessment and Improvement Plan		✓		Yes	No	The Committee noted the Trust's baseline assessment against the national maternity triage specification. The report had previously been approved by Executive Board under delegated authority from the Board. Whilst a number of standards remain rated amber or red, active improvement programmes are already in place. Risks remain around estate configuration,

BOARD OF DIRECTORS: Trust Board 01.10.2026 **AGENDA ITEM: 4.1**

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

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DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						staffing and digital capability, although evidence of rapid improvement was noted.
2.5 Induction of Labour Improvement Project		✓		Yes	No	Induction of labour continues to be recognised as a patient experience and operational challenge. The Committee was assured that a comprehensive improvement programme is underway covering pathway redesign, outpatient induction, data quality, digital functionality and operational oversight. Benefits are not yet fully realised and further monitoring is required.
2.6 Maternity Assurance Report	✓			Yes	No	The Committee received assurance regarding patient safety, compliance, governance and risk management arrangements. Positive progress was noted in the reduction of complaint backlogs, incident management and guideline review compliance, with expected achievement of the 80% guideline target by October 2026.
2.7 Quarterly Thematic Reviews	✓			Yes	No	The Committee welcomed the introduction of the quarterly thematic review process. Learning from incidents, complaints and investigations is being effectively triangulated into clear themes and improvement plans. Particular assurance was received regarding the focus on health inequalities and deprivation.

BOARD OF DIRECTORS: Trust Board 01.10.2026 **AGENDA ITEM: 4.1**

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

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

DATE OF COMMITTEE MEETING: 25 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
2.8 Perinatal Transformation Report		✓				Progress continues against Maternity Incentive Scheme requirements and Saving Babies' Lives actions. However, risks remain relating to MDT training compliance, delayed cord clamping audit performance, diabetes service provision and future training facilities. Mitigations are in place and progress remains under close review.
2.9 Neonatal Update		✓		Yes	No	The Committee received a significant update regarding neonatal services, including the Trust's response to the Thirlwall Inquiry. Assurance was received regarding governance reviews, safeguarding, medicines management and family engagement. However, several neonatal patient safety investigations remain underway, workforce gaps persist, and National Neonatal Audit Programme outlier indicators require further review and validation.
2.10 Horizon Scanning	✓			No	No	External stakeholders advised that maternity and neonatal services remain a significant national priority and will continue to attract considerable regulatory and political attention. The Committee was assured that the service is engaging proactively with emerging national requirements.

4.1

Rise
Our strategy 2026–2031

NHS
The Princess Alexandra Hospital
NHS Trust

Quality and Safety Committee
Terms of Reference 2026/27

1.0 Purpose:

The Quality and Safety Committee (QSC) is a formal Committee of the Trust Board responsible for providing assurance that effective systems of quality governance, patient safety, clinical effectiveness, patient experience and organisational learning are in place across the Trust.

The Committee supports the Board in discharging its responsibilities for the delivery of safe, effective, equitable, person-centred and continuously improving services.

In alignment with the NHS Quality Strategy, the Committee will oversee the Trust's Quality Management System and arrangements for quality planning, quality control, quality assurance, quality improvement and organisational learning.

The Committee will provide assurance that the Trust meets its statutory, regulatory and professional obligations, including those arising from:

- The Health and Care Act 2022.
- The National Health Service Act 2006 (as amended).
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Care Quality Commission registration requirements and assessment frameworks.
- NHS England statutory guidance, national quality requirements and patient safety frameworks.
- Professional standards, national clinical standards and best practice guidance.

The Committee will identify gaps in assurance, monitor improvement actions and escalate significant quality and safety concerns to the Trust Board.

2.0 Duties:

2.1 Quality Governance, Quality Strategy and Assurance

The Committee shall:

- Provide assurance to the Trust Board regarding the effectiveness of the Trust's Quality Governance Framework and Quality Management System.
- Review and recommend the Trust's Quality Strategy and associated quality plans to the Trust Board for approval.
- Seek assurance that quality planning, quality control, quality assurance, quality improvement and organisational learning are embedded throughout the Trust.
- Review quality-related risks on the Board Assurance Framework and seek assurance that effective controls and mitigations are in place.
- Assess the adequacy of assurances received from committees, groups and forums reporting to QSC.
- Identify gaps in assurance and commission additional scrutiny where necessary.

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- Escalate significant quality, safety, compliance or governance concerns to the Trust Board.

2.2 Patient Safety

The Committee shall:

- Seek assurance that systems are in place to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including Safe Care and Treatment (Regulation 12), Good Governance (Regulation 17) and Duty of Candour (Regulation 20).
- Receive assurance regarding the management of incidents, patient safety investigations, Never Events, claims, inquests, Prevention of Future Death reports and external safety reviews.
- Monitor trends, themes and emerging risks arising from patient safety intelligence.
- Oversee the Trust's Patient Safety Incident Response Framework (PSIRF) and receive assurance that patient safety incidents are responded to proportionately, in accordance with the Trust's Patient Safety Incident Response Plan and national patient safety requirements.
- Review the Trust's Patient Safety Incident Response Plan, recommend it to the Trust Board for approval, and receive assurance on its implementation and effectiveness.

2.3 Organisational Learning and Improvement

The Committee shall:

- Receive assurance that learning from incidents, complaints, claims, mortality and safeguarding reviews, audits, feedback, inspections and external reviews is systematically triangulated, shared across services and translated into sustained, measurable improvement.
- Seek assurance that learning is embedded and sustained through measurable improvements in practice and outcomes.
- Promote a culture of continuous learning, improvement, innovation and openness.

2.4 Clinical Effectiveness

The Committee shall:

- Seek assurance that services deliver evidence-based care and achieve expected clinical outcomes.
- Oversee implementation and monitoring of NICE guidance, national clinical audits, NCEPOD recommendations and other nationally mandated standards.
- To receive assurance regarding the implementation of National Patient Safety Alerts, national inquiries, confidential enquiries and other externally mandated quality improvement requirements
- Review outcome measures, benchmarking data, mortality intelligence and variation in clinical performance.

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- Receive assurance that recommendations arising from clinical audit are implemented and monitored for effectiveness and sustainability.
- Approve the annual Clinical Audit Programme
- To receive assurance regarding the Trust's mortality governance arrangements, including compliance with the National Learning from Deaths Framework, Structured Judgement Reviews, learning from mortality reviews, preventable death themes, Medical Examiner activity and the implementation of actions arising from mortality review processes.
- To monitor mortality indicators, benchmarking, learning and improvement actions to ensure that learning from deaths is translated into sustainable improvements in patient care, safety and clinical outcomes.

2.5 Research, Innovation and Development

- To oversee the implementation of the Trust's Research, Innovation and Development Strategy and receive assurance, through an annual report, that research and innovation activities contribute to improvements in patient outcomes, safety, experience, clinical effectiveness and organisational learning.
- To receive assurance that effective governance, ethical oversight and regulatory compliance arrangements are in place for all research and development activity undertaken by or on behalf of the Trust, including clinical ethics, research governance and information governance requirements.
- To promote the adoption of research, innovation and evidence-based practice across the organisation, ensuring that learning from research activity is translated into service improvement, quality improvement and improved patient care.

2.6 Patient Experience and Person-Centred Care

The Committee shall:

- Oversee arrangements for obtaining, analysing and responding to patient, family and carer feedback.
- Monitor themes, trends and learning arising from complaints, PALS, surveys, compliments and patient engagement activity.
- Seek assurance that patient experience intelligence informs service improvement and decision-making.
- Promote partnership working, co-production and meaningful patient involvement in the design and improvement of services.
- Receive assurance that services remain person-centred, compassionate and responsive to the needs of the communities served.

2.7 Equity and Health Inequalities

The Committee shall:

- Seek assurance that the Trust identifies, monitors and addresses inequalities in access, experience and outcomes.

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- Consider quality and safety intelligence through an equality, diversity and health inequalities lens.
- Monitor actions intended to reduce unwarranted variation and improve outcomes for underserved and disadvantaged populations.
- Receive assurance that quality improvement and transformation programmes support equitable care.

2.8 Regulatory Compliance and External Assurance

The Committee shall:

- Receive assurance regarding compliance with Care Quality Commission registration requirements and associated regulations.
- Oversee delivery of action plans arising from inspections, accreditation reviews, external audits and regulatory assessments.
- Monitor compliance with safeguarding legislation and national safeguarding requirements.
- Receive assurance regarding compliance with the Mental Capacity Act 2005, Liberty Protection Safeguards (when enacted), infection prevention and control requirements and other relevant quality-related legislation.
- Recommend the Quality Account to the Trust Board and monitor progress against delivery of the priorities throughout the year.
- Maintain oversight of quality and patient safety indicators within national oversight arrangements.

2.9 Quality Impact Assessment and Major Change

The Committee shall:

- To provide assurance to the Trust Board and the Performance and Finance Committee that major service change, transformation programmes and cost improvement schemes have been subject to appropriate Quality Impact Assessment and that identified quality and safety risks are appropriately mitigated.
- Seek assurance that quality is considered alongside financial, operational and workforce considerations in organisational decision-making.
- To review Trust strategies within the Committee's remit prior to Board approval and obtain assurance regarding their implementation, progress, effectiveness and alignment with the Trust's Quality Strategy and organisational objectives.

2.10 Maternity (Perinatal) Oversight QSC Part II:

QSC Part II: Maternity (Perinatal) Oversight shall receive assurance regarding the quality, safety, performance, governance and continuous improvement of maternity and perinatal services, including compliance with national, regional and local standards, regulatory requirements, incentive schemes, safety investigations, improvement programmes and performance indicators. This includes oversight of maternity transformation programmes, learning from patient safety incidents, Maternity and Newborn Safety Investigations (MNSI),

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cultural improvement initiatives, sustainability plans and delivery of action plans arising from external reviews, inspections and assurance frameworks. The Committee will receive assurance that improvement actions are implemented, monitored and embedded to achieve sustainable improvements in outcomes, safety, experience and quality of care.
Assurance will be provided through a dedicated session of the Quality and Safety Committee known as QSC Part II: Maternity (Perinatal) Oversight.

3.0 Accountable to:

The Trust Board, for providing assurance on the quality, safety and effectiveness of services, the effectiveness of the Trust's Quality Management System and compliance with relevant statutory and regulatory requirements.

4.0 Reporting:

A report prepared by the Chair of the Quality and Safety Committee, supported by the Chief Nurse and Chief Medical Officer, shall be presented to the next meeting of the Trust Board, summarising key areas of assurance, risks, concerns, decisions and matters escalated for Board attention.
A report from QSC Part II: Maternity (Perinatal) Oversight, reviewed by the Chief Nurse and Chief Medical Officer and supported by the Executive and Non-Executive Maternity Safety Champions, shall be presented to the next meeting of the Trust Board, providing assurance on the quality, safety and improvement of maternity and perinatal services.

5.0 Chair:

The Quality and Safety Committee shall be chaired by a Non-Executive Director appointed by the Trust Board Chair.
QSC Part II: Maternity (Perinatal) Oversight shall be chaired by a Non-Executive Director appointed by the Trust Board Chair, who is independent of the Non-Executive Maternity Safety Champion role, to provide appropriate scrutiny and oversight of maternity and perinatal services.

6.0 Composition of Membership:

6.1 QSC Part I:

The Quality and Safety Committee shall comprise Executive and Non-Executive Directors appointed by the Trust Board. Membership shall include:

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

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- Deputy Chief Medical Officer (Quality and Safety)
- Deputy Chief Nurse

6.2 QSC Part II: Maternity (Perinatal) Oversight

Membership of QSC Part II: Maternity (Perinatal) Oversight shall include:

- Chair (Non-Executive Director)
- Chief Nurse
- Chief Medical Officer
- Chief Operating Officer
- Chief Clinical Transformation Officer
- Non-Executive Director(s)
- Non-Executive and Executive Maternity and Neonatal Safety Champions
- Director of Midwifery
- Deputy Director of Midwifery
- Divisional Director of Nursing
- Head of Nursing – Babies, children and young people
- Divisional Director (FDC)
- Divisional Director of Operations (FDC)
- ~~Clinical Director (Obstetrics)~~
- Divisional Medical Director ~~Womens Health~~
- Divisional Obstetric Director
- Director of Clinical Quality and Governance
- ~~Associate Medical Director (Quality)~~Deputy Chief Medical Officer (Quality and Safety)
- Deputy Chief Nurse
- Maternity and Neonatal Voices Partnership Chairs (alternating between the Maternity and Neonatal Chairs)
- Head of Women's Health Governance and Assurance

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The Chairs of the Quality and Safety Committee and QSC Part II: Maternity (Perinatal) Oversight shall be appointed by the Chair of the Trust Board and should possess relevant experience and expertise in quality, safety and governance.

One of the Non-Executive Director members of the Quality and Safety Committee shall also be a member of the Trust's Audit Committee to support coordination of assurance and governance matters across Committees.

6.3 Ex Officio Members

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

6.4 Attendees by Invitation

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The Chair of the Audit Committee may attend any meeting of the Committee if not already a standing member.
Other Executive Directors, senior managers, clinical leaders, subject matter experts or external stakeholders may be invited to attend meetings where their expertise or assurance is required.

6.5 Voting Rights

Each Committee member shall be entitled to one vote. In the event of an equality of votes, the Chair shall have a casting vote.
Deputies attending on behalf of members may participate fully in discussions but shall not be entitled to vote.

7.0 Attendance:

7.1 Members

Members are expected to make every effort to attend all meetings of the Committee. Members of the Quality and Safety Committee are expected to attend a minimum of nine of the eleven scheduled meetings held during each reporting year. Members of QSC Part II: Maternity (Perinatal) Oversight are expected to attend a minimum of five of the six scheduled meetings held during each reporting year.

An attendance register shall be maintained for all meetings and an annual record of attendance shall be included within the Committee's Annual Effectiveness Report to the Trust Board.

The Trust Chair and Chief Executive, in their capacity as ex officio members, will be invited to attend all meetings and are expected to attend regularly to support the effective discharge of the Committee's responsibilities.

The Chair of the Patient Panel shall be invited to attend meetings as a lay representative and contribute to discussions relating to patient experience, engagement and quality improvement.

7.2 Attendees by Invitation

The Committee may invite individuals to attend meetings to provide assurance, expert advice or present reports on matters within the Committee's remit.
For divisional deep dives or specific agenda items, attendees may include:

- Divisional Directors
- Divisional Directors of Nursing
- Associate Director of Clinical Quality and Governance
- Associate Director of Patient Engagement and Experience
- Clinical and operational leads relevant to the subject under review

In addition to the membership of QSC Part II: Maternity (Perinatal) Oversight, the following stakeholders may be invited to attend as appropriate:

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- Office of the Regional Chief Midwife
- Regional Obstetric Lead, NHS England
- Representatives from ~~Hertfordshire and West~~ Essex Integrated Care Board
- Regional Maternity Quality Lead, NHS England
- Representatives from the Local Maternity and Neonatal System (LMNS)
- Other regional or national maternity and neonatal experts as required

Internal Auditors may be invited to attend meetings to present audit findings or provide assurance on matters falling within the Committee's remit.
Deputising Arrangements:

In the absence of the Chair, the meeting shall be chaired by another Non-Executive Director nominated by the Committee members present.

Executive members may nominate an appropriately senior deputy to attend on their behalf, provided that the deputy is suitably briefed and, wherever practicable, notified to the Committee Chair and Secretariat in advance of the meeting.

Deputies may participate fully in discussions and provide assurance on behalf of the substantive member.

7.3 For QSC Part II:
Maternity (Perinatal) Oversight, deputies should possess sufficient knowledge and authority to provide assurance and respond to matters relating to maternity and perinatal quality, safety and performance.

Quorum:
The quorum shall be three voting members, including at least one Non-Executive Director and two Executive Directors, one of whom must be the Chief Nurse or Chief Medical Officer.

Declarations of Interest:
All Committee members, ex officio members and attendees shall declare any actual, potential or perceived conflicts of interest, which shall be recorded in the minutes. Where a conflict of interest is identified, the Chair shall determine whether the individual may participate in any discussion or decision relating to the matter under consideration. Members are expected to manage conflicts of interest in a transparent and appropriate manner.

Lead Executive:
The Chief Nurse and the Chief Medical Officer shall serve as Joint Executive Leads for the Quality and Safety Committee and QSC Part II: Maternity (Perinatal) Oversight.

Meeting Frequency:
The Quality and Safety Committee shall meet 11 times per year, ~~monthly~~ in accordance with the Trust's Board cycle, ordinarily on the final Friday of the cycle.

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QSC Part II: Maternity (Perinatal) Oversight shall meet bi-monthly, or more frequently if required to provide appropriate oversight and assurance regarding maternity and perinatal services. Any urgent matters arising between scheduled meetings shall be escalated to the next available meeting of the Quality and Safety Committee or considered through an extraordinary meeting where necessary.

Additional meetings of the Committee or QSC Part II may be convened at the discretion of the Chair to address urgent quality, safety, regulatory or governance matters.

Meeting Organisation:

- The annual schedule of meetings shall be approved and published before the commencement of each financial year.
- Meetings shall be held in private and will not be open to the public. Lay representatives and other attendees may be invited to attend where appropriate.
- The Director of Corporate Governance shall ensure that appropriate administrative, secretarial and governance support is provided to the Committee.
- The agenda shall be developed by the Joint Executive Leads and Director of Corporate Governance and approved by the Committee Chair no fewer than ten clear days before the meeting.
- Committee reports shall be submitted no fewer than six clear days before the meeting to allow appropriate review, scrutiny and quality assurance.
- Agendas and supporting papers shall be circulated to Committee members and invited attendees no fewer than three clear days before the meeting.
- The Committee may receive verbal updates or late papers where the Chair considers that urgent matters require consideration and that it is in the interests of patient safety, quality or effective governance to do so.
- Accurate records of proceedings, decisions, actions and assurances shall be maintained and reported through the Committee's governance arrangements.

For the purposes of these Terms of Reference, a "clear day" means any day that is not a Saturday, Sunday or public holiday.

Authority:

The Quality and Safety Committee is established as a Committee of the Trust Board and shall operate in accordance with these Terms of Reference, as approved and amended by the Trust Board from time to time.
The Committee is authorised by the Trust Board to investigate any matter within its remit and to seek any information it requires from any employee, officer or committee of the Trust. All employees are expected to cooperate fully with any request made by, or on behalf of, the Committee.

The Committee is authorised to obtain such assurance, advice and information as it considers necessary to fulfil its responsibilities and may request the attendance of any

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employee, officer, professional adviser, subject matter expert or external stakeholder to provide information or assurance on matters within its remit.

The Committee may commission reviews, deep dives or additional assurance activities into any aspect of quality, patient safety, clinical effectiveness, patient experience, organisational learning or regulatory compliance where it considers this necessary to support its assurance responsibilities.

The Committee shall report significant matters, risks, concerns and recommendations to the Trust Board and may escalate matters where additional oversight, intervention or decision-making is required.

Review arrangements:
The Committee shall undertake an annual review of:

- Delivery against its work programme.
- The quality and adequacy of assurance received.
- The effectiveness of challenge and escalation.
- Attendance and quoracy.
- Membership, skills and development requirements.
- Alignment with the Trust's strategic objectives, Quality Strategy and NHS Quality Strategy.
- The effectiveness of its Terms of Reference.

The outcome of the review shall be reported to the Trust Board.

Date Approved:
By QSCI and II: 25 September 2026
By Trust Board:

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The Princess Alexandra Hospital NHS Trust

4.2

Public Trust Board 1 October 2026					Agenda item: 4.2
Report Title: Maternity Assurance Report: Quarter 1 April – June 2026					
Presented by: Linda Machakaire, Director of Midwifery					
Prepared by: Emma Rose, Head of Women's Health Governance & Assurance					
Purpose:	**Approval/Decision**		**Information/Assurance**	X	

Executive Summary

There were no new Patient Safety Incident Investigations (PSIIs) declared between April – June 2026. The Maternity Service has one ongoing PSII investigation with MNSI which is anticipated to close by October.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

- Open PALS and complaints – challenge in closing the backlog but with increased focus and additional resource, the service is now closing the equivalent received month-on-month so the overall total is no longer increasing.
- Incidents open >30 days – trajectory for closure to <30 open over 30 days by end of February not achieved. A revised trajectory for <100 by end of May was achieved in June and the service aims to reduce this to <50 by end of September 2026.
- BAF 1.1

Recommendation

To provide assurance to the Board that the maternity service is continually monitoring incidents, risks, complaints/PALS, document compliance and learning from complaints and incidents.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
		X

Relevant legal/statutory issues

Maternity (and perinatal) Incentive Scheme Year 8
Perinatal quality oversight model (2025)
Patient safety incident response framework (PSIRF)

Impact Assessments

Quality	None identified
Equality, Diversity and Inclusion	None identified
Health inequalities	None identified
Previously Considered By	Monthly Women's Health and BCYP PSQ governance meeting Monthly FDC Board
Appendices	None

The Princess Alexandra Hospital NHS Trust

4.2

Maternity Assurance Report: Quarter 1 Apr-Jun'26

1.0 Introduction

This paper is to provide assurance to the Trust Board that the maternity service has effective governance processes to meet the requirements of national regulatory and reporting frameworks.

2.0 Background

Monitoring of safety, quality and effectiveness of maternity services via governance processes is a mandatory requirement reviewed by the independent regulator (CQC). Monitoring, actions and escalations are reported monthly by the maternity service to the divisional Patient Safety & Quality Group up to FDC Board. Patient safety incidents within maternity are undertaken in line with the Patient Safety Incident Response Framework (PSIRF), additionally reporting into the Trust Incident Management Group and Patient Safety Investigation Assurance Panel.

3.0 Analysis

Patient Safety Incident Investigations (PSII)

There were no new PSIIs report in Q1. Open actions against PSIIs are monitored via the Women's Health Incident Management Group (WHIMG) and PSIAP. At the end of June there were thirteen open PSII action plans, progress issues were escalated through WHIMG and action-holders contacted for updates.

Ongoing PSIIs:

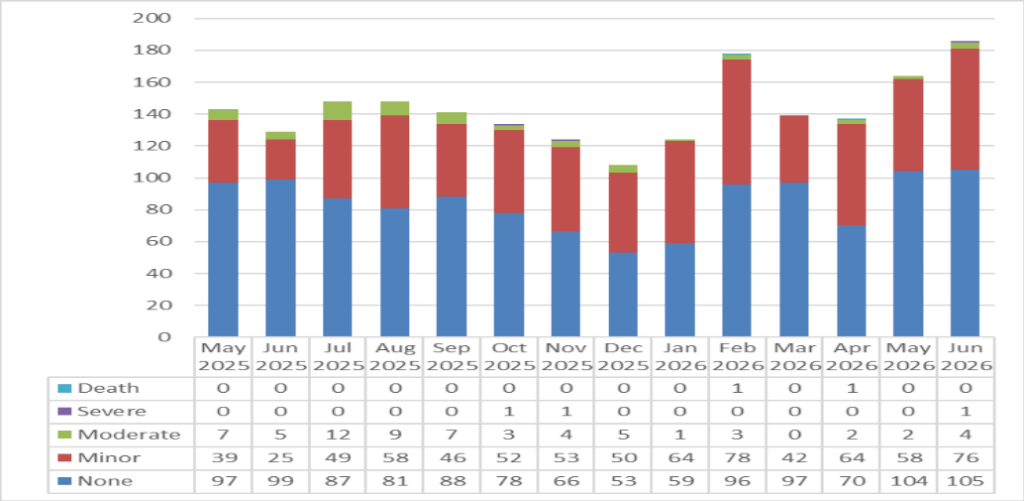
- Unexpected term infant neonatal death (Feb'26, PAweb178196). Final MSNI report received 3 Sept. Action plan in draft and a meeting with the family is planned for 24 September.
- The July PSII report to QSCII reported on a case being triaged by MNSI (PAweb184503). The baby was transferred to a tertiary centre for cooling. The parents did not grant MNSI consent to investigate thus a local harm review was completed (confirmed moderate harm) and learning is in the process of being shared. Duty of candour will be offered via a face to face meeting.

The Princess Alexandra Hospital NHS Trust

4.2

Incidents

Figure 1: Women's Health: Maternity incidents reported by harm



	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Death	0	0	0	0	0	0	0	0	0	1	0	1	0	0
Severe	0	0	0	0	0	1	1	0	0	0	0	0	0	1
Moderate	7	5	12	9	7	3	4	5	1	3	0	2	2	4
Minor	39	25	49	58	46	52	53	50	64	78	42	64	58	76
None	97	99	87	81	88	78	66	53	59	96	97	70	104	105

April-June incidents: open and closed

- The number of incidents reported in Q1 2026 was 483. Four incidents have been confirmed as moderate harm and one death. Harm reviews have been completed for all five cases and learning has been captured in the quarterly thematic review paper presented separately at QSCII.
- The death which occurred in early April (PAweb178196) was presented to IMG and not deemed to require a PSII. This was an in-utero twin death. The surviving twin was delivered at term via planned caesarean birth. Recognition and escalation of CTG concerns in the early third trimester did not take place when the mother attended triage for assessment of fetal movements. She had a high risk twin pregnancy. At her next ultrasound scan twin 2 was found to have died. Immediate reflective discussions and additional education provided to staff involved. Verbal DOC was undertaken by the Head of Women's Health Governance & Assurance with the mother, her partner and her mother. PMRT completed in August and care was graded as D (care issues likely to have made a difference to the outcome). Written duty of candour will be undertaken and a follow-up sensitive clinic appointment is scheduled for November.
- At the end of June 75 incidents were open over 30 days. The service aim is to reduce this to <50 by end of September 2026.

Table 1: Maternity Incidents open over 30 days by harm (as of end June)

	None	Minor - minimal harm/minor treatment	Moderate - short term harm	Death	Total
Jun 2024	0	0	2 (MOH cluster)	0	2
Jun 2025	2	0	0	0	2
Aug 2025	1	1	0	0	2
Oct 2025	1	2	0	0	3
Nov 2025	2	1	0	0	3
Dec 2025	0	0	0	0	0

Jan 2026	1	2	0	0	3
Feb 2026	1	5	0	1 (PSII NND)	7
Mar 2026	4	6	0	0	10
Apr 2026	8	10	2	0	20
May 2026	10	12	1	0	23
Total	30	39	5	1	75

- Support to close the oldest incidents has been escalated to FDC Board.
- No/minor harm are discussed at the daily Datix meeting at the time of reporting to ensure appropriate allocation and identification of immediate actions required.

Duty of Candour (DOC) Update

Table 2: DOC compliance for closed maternity patient safety incidents

	No	Yes	Compliance
25/26 Q1	0	18	100%
25/26 Q2	0	24	100%
25/26 Q3	1	12	92%
25/26 Q4	2	4	50%
26/27 Q1	2	3	33%
Total	5	61	92%

- Overall compliance = 92%. (Trust target >95%)
- Delays are due to vacancy in team. Outstanding DOC letters escalated for completion.
- High numbers of DOC in 2025-26 were due to reporting process for massive obstetric haemorrhage (MOH) and obstetric anal sphincter injuries (OASI). These were previously all graded as moderate harm and written DOC completed. Process has changed so that all women experiencing MOH or OASI receive a generic information leaflet about what has happened and reassurance that their care will be reviewed with contact information if they have any concerns to escalate. Formal DOC is only undertaken when clinical harm is identified in line with PSIRF principles. This is escalated through the Trust incident reporting processes and harm is then upgraded on Datix and DOC undertaken.

MBRRACE-UK and Perinatal Mortality Review Tool (PMRT) Summary: April-June 2026

- There were two perinatal deaths which met the criteria for MBRRACE-UK and PMRT reporting. This is a reduction of compared to the previous quarter (n=5) and one less death than the same quarter in 2025 (n=3).
- There were no other cases eligible for reporting to MBRRACE-UK.
- For all 2026 PMRT cases the views of all parents have been sought and an external member has been present at the MDT review meeting.
- In view of the above three points, the service therefore remains fully compliant with MIS Safety Action C.

The Princess Alexandra Hospital NHS Trust

4.2

Complaints/PALS: April-June 2026

- 12 complaints received
- 25 complaints closed
- **Total complaints open at the end of June = 24**

- 23 PALS received
- 24 PALS closed
- **Total PALS open at the end of June = 28**

Significant progress was made with Q1 complaint closures due to additional resource provided from Patient Experience Team, payment of additional bank hours, improved MDT engagement and staff also working significant unpaid overtime.

Complaint themes are captured in the quarterly thematic review report submitted to QSCII as a separate paper.

Claims and inquests: April-June 2026

	New	**Closed**
Claims	Three x maternity (two relating to births in 2023 and one without allegations regarding pregnancy in 2024)	One x maternity (>15 year old case) Alleged failure to advise expectant mother appropriately on 25.02.2011. Claim settled (20% PAHT / 80% GP). Trust denied both breach and causation.
Inquests	Two inquests closed Neonatal death from fetal anaemia (September 2026) - inquest March/ April 2026. Coroner conclusion: Neonatal death due to natural causes, to which neglect was determined to have contributed. Learning shared at June M&M and action plan in progress. Neonatal brain injury inquest – antenatal care provided by PAHT but intrapartum care with outcome of HIE following homebirth was at another Trust. Finding was that PAHT counselling had been adequate and that the Trust had not pressured her into having a homebirth.	

Procedural document compliance

June compliance was not monitored due to team vacancy. Therefore, the below is reported based on end of July 2026.

- Total compliance = 74% (115/155 documents in date)
- Expired documents = 23% (n=35)
- 3% due to July TPG (n=5)

Table 3: Document status by type

Document Type	Competencies	PGDs	PILs	Guidelines	Policies	Clinical SOPs	Non-clinical SOPs
Number	2 (1%)	4 (3%)	21 (13.5%)	71 (46%)	9 (6%)	21 (13.5%)	27 (17%)
Number expired (non-compliance %)	0 (0%)	0 (0%)	2 (1%)	18 (12%)	4 (3%)	6 (4%)	5 (3%)

All expired documents have been allocated reviewers and the trajectory is to increase compliance to >80% by end of October and this considers documents expiring before October. A monthly MDT Women's Health procedural documents forum supports with the review and approval, and the oversight of expired documents.

There are four outstanding Maternity NICE Baseline Assessments, these have all had clinical leads allocated to progress the assessments. Progress is monitored via the procedural documents forum and escalated to FDC Board.

Audit

Fifteen local audits remain active from April 2023 to March 2026, with eleven requiring the final report prior to completion. All audit leads have been contacted requesting the outstanding reports.

Against the 2026/2027 Women's Health audit plan, sixteen audits have been approved and registered, ten on which are on track, five have reports overdue and one has been reported.
Challenges: delay in local approval process and completion of audit reports following presentations. Audit process tutorials are provided for all new doctors during induction and annually at the audit meeting. Certificates are provided once the audit cycle has been completed in full. However, completion of reports remains an ongoing issue, particularly due to those involved leaving the Trust during the audit cycle.

Risk Register

- Twenty-eight maternity risks were open on the register as of end June 2026.
- One risk is on the corporate risk register: 614 (Antenatal Clinic evacuation score 15).
- Risks are reviewed quarterly at the Women's Health Risk meeting and ad hoc as improvements are made by the risk owner and clinical governance team.
- Risks overdue review have been escalated and an interim risk management meeting scheduled to support this.

The Princess Alexandra Hospital NHS Trust

4.0 Oversight

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

5.0 Recommendation

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

Author: Emma Rose, Head of Women's Health Governance & Assurance

Date: 14 September 2026

NHS
The Princess Alexandra Hospital

4.2

Meeting Title: Public Board **Date: 1 October 2026 Agenda item: 4.2**					
Report Title: Maternity and Neonatal 10 Point Plan Baseline Assessment					
Presented by: Aimen Aref, Divisional Medical Director Women's Health, or Linda Machakaire, Director of Midwifery					
Prepared by: Linda Machakaire, Director of Midwifery					
Purpose:	**Approval/Decision**		**Information/Assurance**	X	

Executive Summary

This paper presents the Trust baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan. It incorporates the current position, the delivery trajectory for areas rated red, and the Board decision on 10 September 2026 to approve Birthrate Plus (BR+) funding. The national reporting tool was signed off by Executive Board on 16 September 2026 and submitted to NHS England on 21 September 2026. A progress update is required by NHS England on 31 December 2026.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

BAF 1.4 Digital/ Alex Health
BAF 3.1 Estates and infrastructure; **Risk 56** (Rated 16) Maternity estates
Risk 60 Midwifery staffing levels

Recommendation

To note the approval of the Maternity and Neonatal 10 Point Plan by Executive Board on 16 September 2026 through delegated authority by Trust Board on 10 September 2026. To note submission of the Maternity and Neonatal 10 Point Plan to NHS England on 21 September 2026.

Rising Hope	Rising Communities	X	Rising Standards

Relevant legal/statutory issues

Impact Assessments	
Quality	Positive impact expected through stronger assurance, workforce investment, service-user insight and focused improvement across maternity and neonatal services.
Equality, Diversity and Inclusion	Point 2 strengthens the systematic inclusion of women and families. Improvement actions will include representative engagement and transparent reporting.
Health inequalities	Current inequalities data require further development. Digital enablement is needed to support reliable analysis by ethnicity and deprivation and to demonstrate action on variation.
Previously Considered By	NA
Appendices	

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Introduction

The Maternity and Neonatal 10 Point Plan sets out national actions to strengthen the safety, quality, responsiveness and accountability of maternity and neonatal services. NHS England requires each Trust Board to provide visible ownership and scrutiny, complete the mandatory baseline assessment once, and submit it to the regional team by 25 September 2026. A progress update is due on 31 December 2026. The Trust has submitted the baseline assessment to NHS England East of England team on 21 September 2026 through a process of delegated authority to Executive Board.

2.0 Executive Summary

This paper provides an updated account of the baseline position, explains the red-rated areas and sets out the route to improvement. The attached reporting tool records the evidence available, identified assurance gaps, actions and dependencies.

3.0 High-Level Assessment Against the Maternity and Neonatal 10-Point Plan baseline assessment

The assessment covers 26 deliverables across the national actions included in the reporting tool. It demonstrates established assurance in several areas, alongside requirements that are partially compliant or not yet fully embedded. The current red areas do not represent a static position: improvement plans are active, and the December submission will evidence delivery against the baseline.

Key areas requiring focused oversight are:

- **Point 2: Listening to women and families.** The current baseline is red because the monthly, integrated and transparently reported cycle of experience, outcomes and clinical audit intelligence is not yet fully embedded. Significant preparatory work has already been completed, with further implementation under way. This action is expected to be achieved by the end of November 2026.
- **Point 5: Inequalities.** Work is progressing to strengthen the use of inequalities data and demonstrate how identified variation is acted upon. The principal constraint is digital enablement, including data completeness and the ability to report consistently by ethnicity and deprivation. This dependency will continue to be escalated through the appropriate digital and governance routes.
- **Point 6: 24/7 safety and responsiveness.** Funding to align budgeted establishment to BirthRate Plus recommendations from the report finalised in November 2025 was approved by Trust Board on 10 September 2026. This provides a clear route to improving assurance against additional funded midwifery establishment requirement. Associated workforce assurance will need to demonstrate implementation and sustained impact.

4.0 Priority actions

a) Complete and evidence the Point 2 monthly listening and assurance cycle, including women's experience, outcomes, clinical audit, MNVP intelligence and Board-level action tracking, with a target to achieve this by the end of November 2026.
b) Progress digital improvements needed for robust inequalities reporting, including analysis by ethnicity and deprivation and clear demonstration of action taken in response to variation.
c) Mobilise the approved BR+ funding and update the workforce evidence to demonstrate that the establishment is funded, implemented and responsive to professional judgement and service pressures.
d) Continue the comprehensive home birth service review. The Trust is awaiting the national strategy; the position, risks, mitigations and proposed action plan will be reported to QSC2 in November 2026.
e) Strengthen the evidence log and governance trail so that the December return clearly demonstrates delivery, scrutiny, action and impact.

5.0 Recommendation

To note the approval of the Maternity and Neonatal 10 Point Plan by Executive Board on 16 September 2026 through delegated authority from Trust Board on 10 September 2026. To note submission of the Maternity and Neonatal 10 Point Plan to NHS England on 21 September 2026.

Author: Linda Machakaire, Director of Midwifery

Date: 11 September 2026; updated 18 September 2026

4.3

Meeting Title Public Board **Date: 1 October 2026**	**Agenda item: 4.3**

Report Title: Trust Response to the Thirlwall Inquiry and Progress on Implementation

Presented by: Jo Ward – Interim Chief Nurse

Prepared by: Jo Ward – Interim Chief Nurse

Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	√

Executive Summary

The publication of the Thirlwall Inquiry provides an important opportunity for the Trust to strengthen patient safety, safeguarding, governance and organisational culture.

The Trust has responded proactively, with a comprehensive neonatal action plan already in place and being led by the Divisional Director of Nursing for Family, Diagnostics and Community (FDC). This programme addresses the neonatal-specific recommendations arising from the Inquiry and is supported by clear governance, accountability and assurance arrangements.

Alongside this, a Trust-wide programme of work will ensure the wider lessons from the Inquiry are embedded across all services, with a focus on speaking up, safeguarding, quality oversight, mortality surveillance, medicines governance and organisational learning.

The Board is asked to note the actions already underway, endorse the proposed Trust-wide response and receive ongoing assurance that learning from the Inquiry continues to strengthen patient safety and quality of care across the organisation.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

BAF: 1:1 Variation in Clinical Outcomes

Recommendation

The Committee is asked to:

- Note the significance of the Thirlwall inquiry and the actions that the Trust must take to provide assurance.
- Approve the proposed way forward.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
√	√	√

Relevant legal/statutory issues

Thirlwall Inquiry (2026). *Report and Recommendations of the Public Inquiry into Events at the Countess of Chester Hospital 2015-2018*. Presented to Parliament by the Secretary of State for Health and Social Care, September 2026

Impact Assessments

Quality	Positive impact through assurance of compliance with National directive and oversight of quality.
Equality, Diversity and Inclusion	No adverse equality impacts identified.
Health inequalities	No direct impact identified.
Previously Considered By	n/a

Appendices	

Executive Cabinet Report

Trust Response to the Thirlwall inquiry and Progress on Implementation

Purpose

This paper provides the Executive Cabinet with an overview of the findings of the Thirlwall Inquiry, the implications for the Trust, and the actions already underway to address the recommendations. It also presents a Trust-wide implementation framework and seeks Executive Cabinet endorsement of the proposed approach to assurance, oversight and delivery. The paper highlights the significant work already commenced within neonatal services through a comprehensive action plan led by the Divisional Director of Nursing for Family, Diagnostics and Community (FDC).

Executive Summary

The publication of the Thirlwall Inquiry represents one of the most significant patient safety reviews undertaken within the NHS in recent years. The Inquiry identified failures in leadership, governance, safeguarding, escalation, organisational culture and oversight which contributed to opportunities to recognise and respond to patient harm being missed.

Whilst the Inquiry focused on events within a neonatal service, the lessons are applicable across all healthcare settings. It challenges NHS organisations to assure themselves that concerns raised by staff are acted upon, that unusual clinical patterns are identified and investigated promptly, and that patient safety remains the overriding priority.

The Trust has undertaken an initial review of the Inquiry findings and has already commenced implementation activity. A detailed neonatal-specific action plan has been developed and is being led by the Divisional Director of Nursing for Family, Diagnostics and Community (FDC). The plan translates the recommendations arising from the Inquiry into a comprehensive programme of work with clear ownership, milestones, assurance arrangements and reporting requirements.

The Trust's response extends beyond neonatal services and includes broader organisational actions relating to safeguarding, Freedom to Speak Up, leadership accountability, mortality surveillance, governance, patient safety intelligence and organisational culture.

Background

The Thirlwall Inquiry examined the circumstances surrounding serious failures at the Countess of Chester Hospital and made recommendations directed at NHS Trusts, NHS England, the Department of Health and Social Care, regulators and professional bodies.

The Inquiry concluded that concerns raised by clinicians were not always heard, investigated or acted upon with sufficient pace or rigour. It highlighted the importance of organisational curiosity, robust governance, independent challenge, safeguarding vigilance and effective escalation processes.

Following publication of the Inquiry findings, NHS organisations have been asked to review the recommendations, consider local applicability and provide assurance that effective systems are in place to identify and respond to potential risks to patients.

Trust Response

The Trust welcomes the Inquiry findings and is committed to ensuring that learning is fully embedded across all clinical services.

An initial assessment has identified that many of the recommendations align with existing programmes of work, including:

- Implementation of the Patient Safety Incident Response Framework (PSIRF)
- Freedom to Speak Up arrangements
- Safeguarding governance
- Maternity and Neonatal Improvement Programmes
- Mortality review processes
- Quality governance and triangulation of intelligence
- Board assurance and oversight arrangements

Whilst the Inquiry focused on neonatal care, its findings are relevant to all healthcare services. The Trust's response has therefore been structured in two parts: firstly, a detailed neonatal improvement programme led through the Family, Diagnostics and Community Division; and secondly, a Trust-wide programme focused on strengthening patient safety culture, safeguarding, speaking up, clinical governance and organisational learning. This dual approach ensures both the specific recommendations and the broader lessons arising from the Inquiry are fully addressed across the organisation.

The Trust recognises that compliance with processes alone cannot provide assurance. The Inquiry emphasises the importance of culture, professional curiosity and visible leadership in ensuring concerns are recognised and acted upon promptly. For this reason, our response is centred on both technical assurance and cultural improvement.

Work Already Underway

The Board should note that significant work has already commenced within neonatal services.

Under the leadership of the Divisional Director of Nursing for Family, Diagnostics and Community (FDC), a detailed implementation plan has been developed to respond to the recommendations arising from the Inquiry. The plan establishes a structured programme of actions with identified executive oversight, committee assurance routes, milestones, evidence requirements and reporting mechanisms to ensure delivery and sustained improvement.

The neonatal action plan provides a strong foundation upon which the wider organisational response is being developed and demonstrates the Trust's commitment to implementing lessons learned at pace.

Key Areas of Focus

1. Neonatal Safety and Surveillance

Actions include:

- Completion of a gap analysis regarding neonatal CCTV and incubator monitoring.
- Preparation for national direction regarding camera technology and parent livestream capability.
- Strengthening surveillance and evidence systems within neonatal services.
- Reviewing local arrangements to ensure early identification and escalation of safety concerns.

2. Medicines Safety

A significant area of learning from the Inquiry relates to insulin governance.

Planned actions include:

- Comprehensive review of insulin storage, access, prescribing, administration and traceability.
- Implementation of auditable access controls.
- Enhanced monitoring arrangements pending national guidance.
- Strengthening independent checking processes.
- Enhanced laboratory escalation arrangements where insulin-related concerns arise.

3. Safeguarding and Deliberate Harm Response

Key actions include:

- Review of safeguarding training compliance for all staff, Board members and Non-Executive Directors.
- Development of local arrangements pending publication of national protocols.
- Clear pathways for escalation, safeguarding referrals and engagement with external agencies.
- Training for managers and clinical leaders regarding professional curiosity, escalation and decision-making.

4. Monitoring Deaths and Escalation of Concerns

Actions include:

- Strengthening Board oversight of all baby and child deaths.
- Defining escalation thresholds for mortality concerns and unusual clinical trends.
- Testing governance escalation routes through exercises and assurance reviews.
- Strengthening reporting arrangements through mortality surveillance processes.

5. Freedom to Speak Up and Organisational Culture

The plan includes:

- Review of Freedom to Speak Up effectiveness.
- Assessment of accessibility and staff confidence in raising concerns.
- Strengthened escalation processes for patient safety concerns.
- Improved communication regarding internal and external reporting mechanisms.

Proposed Trust-Wide Action Plan

In addition to the neonatal action plan, the Executive Team proposes a Trust-wide programme of work under five strategic themes.

Theme 1: Safety and Safeguarding

- Review safeguarding governance arrangements.
- Review Board and staff safeguarding training compliance.
- Strengthen oversight of concerns relating to deliberate harm.
- Review compliance with Sudden and Unexpected Death in Childhood (SUDIC) requirements.

Theme 2: Speaking Up and Culture

- Undertake a Trust-wide Freedom to Speak Up review.
- Strengthen staff confidence in escalation pathways.
- Increase Board engagement with frontline teams regarding psychological safety.
- Improve triangulation of Speak Up, complaints, workforce and patient safety intelligence.

Theme 3: Quality Governance

- Review quality surveillance arrangements.
- Test escalation routes for emerging clinical concerns.
- Review mortality, complaints and incident triangulation.
- Undertake a Board assurance assessment against national best practice.

Theme 4: Women's, Children's and Neonatal Services

- Deliver the neonatal action plan.
- Review medicines governance.
- Strengthen mortality surveillance.
- Review bereavement and family support pathways.

Theme 5: Leadership and Accountability

- Review leadership accountability frameworks.
- Strengthen learning regarding professional curiosity and challenge.
- Embed patient safety responsibilities within leadership development programmes.

Governance and Assurance

Delivery of the neonatal-specific actions will be overseen through the governance structures within the Family, Diagnostics and Community Division (FDC), with progress reported through the Women's and Children's governance framework, Quality and Safety Committee and Public Board.

The Divisional Director of Nursing for FDC will continue to lead operational implementation of the neonatal action plan, supported by the Chief Nursing Officer as Executive Lead for the Trust-wide response. This approach will ensure clear accountability, effective oversight and robust assurance that improvements are embedded and sustained.

Progress against the action plan will be regularly reviewed and reported through established governance arrangements, with risks escalated where required.

It is proposed that:

- The Chief Nursing Officer acts as Executive Lead for the Trust-wide programme.
- Progress is monitored through the Quality and Safety Committee.
- Quarterly updates are reported to Public Board.
- The neonatal implementation plan forms a key component of the overarching Trust response.
- Internal audit review is incorporated into the assurance programme.

Risks

Failure to fully implement the recommendations presents risks relating to:

- Patient safety.
- Safeguarding effectiveness.
- Organisational culture.
- Regulatory compliance.
- Public confidence.

- Staff confidence in raising concerns.

The development of a detailed implementation programme, alongside clear executive ownership and Board oversight, significantly mitigates these risks.

Conclusion

The Thirlwall Inquiry highlights the fundamental importance of listening to concerns, acting on emerging intelligence and maintaining a culture where patient safety overrides all other considerations.

The Trust has responded promptly by developing a comprehensive neonatal action plan led by the Divisional Director of Nursing for Family, Diagnostics and Community (FDC). This work demonstrates proactive implementation of the Inquiry recommendations and provides a strong foundation for the wider Trust response.

Whilst initial review suggests that many of the required systems and processes are already in place, the Inquiry provides an important opportunity to further strengthen assurance, challenge ourselves on organisational culture, and ensure that the voices of patients, families and staff continue to be heard and acted upon.

The action plan establishes clear accountability, governance and assurance arrangements to ensure lessons are fully embedded within neonatal services and shared across the wider organisation.

Recommendations

The Board is asked to:

1. Note the findings and implications of the Thirlwall Inquiry.
2. Recognise the significant work already undertaken by the Family, Diagnostics and Community Division (FDC) in developing and commencing delivery of a comprehensive neonatal implementation plan responding to the recommendations of the Inquiry.
3. Endorse the proposed Trust-wide response and governance arrangements.
4. Agree that progress updates are reported quarterly through the Quality and Safety Committee and Trust Board.
5. Seek ongoing assurance that lessons arising from the Inquiry are fully embedded across the organisation and that the Trust continues to promote a culture where concerns are raised, heard and acted upon in the interests of patient safety.

Author: Jo Ward Chief Nursing Officer (interim)

Date: 22/09/2026

4.4

Trust Board Date: 1 October 2026					Agenda item: 4.4
Report Title: Safer Staffing Monthly Report – August 2026					
Presented by: Jo Ward – Interim Chief Nurse					
Prepared by: Charlotte Collings – Lead Nurse for Safer Staffing and Workforce					
Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	√	

Executive Summary

Overall, nursing and midwifery staffing remains stable, with workforce, quality and staffing indicators providing assurance that safe care is being maintained across the Trust. Redeployment continues to be used to manage operational pressures and fluctuating demand, with no significant concerns identified through quality or patient safety metrics. While some workforce challenges remain, the data does not indicate any deterioration in the overall staffing position.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

BAF: 1.1 Clinical Outcomes

Recommendation

The Committee is asked to:

- Note the information of the August 2026 safer staffing report.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
√	√	√

Relevant legal/statutory issues

National Quality Board (NQB) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*; NHS Improvement *Developing Workforce Safeguards*; NHS England safe staffing guidance; NIHR *Professional Judgement Framework: A guide to applying professional judgement in nurse staffing reviews*

Impact Assessments

Quality	Positive impact through continued assurance of safe staffing and workforce planning.
Equality, Diversity and Inclusion	No adverse equality impacts identified.
Health inequalities	No direct impact identified.
Previously Considered By	PC.28.09.26
Appendices	Appendix 1: Fill Rates *Diligent Resources:* Appendix 2: Redeployment and trend data Appendix 3: CHPPD Appendix 4. Nursing Red Flags (NICE 2014), Incident Reports and Trend Data Appendix 5: Nursing quality indicators

1.0 Introduction

This report outlines nursing and midwifery staffing across the Trust and has been prepared in accordance with National Quality Board (NQB) Guidance and NHS England's Developing Workforce Safeguards (DWS). The report presents workforce, staffing and quality indicators, together with professional judgement, to support oversight of safe staffing and inform any actions required in response to identified risks or pressures

2.0 Evidence-Based Data: Workforce and Demand

2.1 Workforce Supply

Workforce gaps continue to be managed through a combination of temporary staffing, workforce flexibility and redeployment to support safe staffing levels and respond to fluctuations in patient demand. **(Appendix 5, Table 4).**

At the end of August 2026, registered nursing vacancies stood at 72.5 WTE (5.34%), including 27.06 WTE Band 5 vacancies (4.50%). Midwifery vacancies remained at 0 WTE, reflecting participation in the NHS England-funded maternity over-recruitment programme. However, in September the Trust Board approved an uplift to midwifery establishments to support Birth-rate plus recommendations and maternity triage operating 24 hours a day. Support worker vacancies continue to represent the most significant workforce supply challenge, with 60.04 WTE vacancies (13.67%). Overall vacancy levels remain broadly stable; however, workforce supply continues to present a risk, particularly within support worker roles, requiring ongoing mitigation through temporary staffing, workforce flexibility and redeployment arrangements.

2.2 Staffing Delivery Against Planned Establishment

Overall staffing delivery remained broadly stable during August, with an overall fill rate of 99.1%. Whilst registered nurse fill rates reduced compared to July, this reflected a combination of lower occupancy and service-specific operational factors, particularly within Planned Pathways. Towards the end of the month, four beds within Henry Moore Ward were designated for high dependency care and staffed by the ITU/HDU team, with this arrangement expected to continue throughout September. ITU/HDU also experienced lower occupancy than in previous months, which should be considered when interpreting staffing metrics.

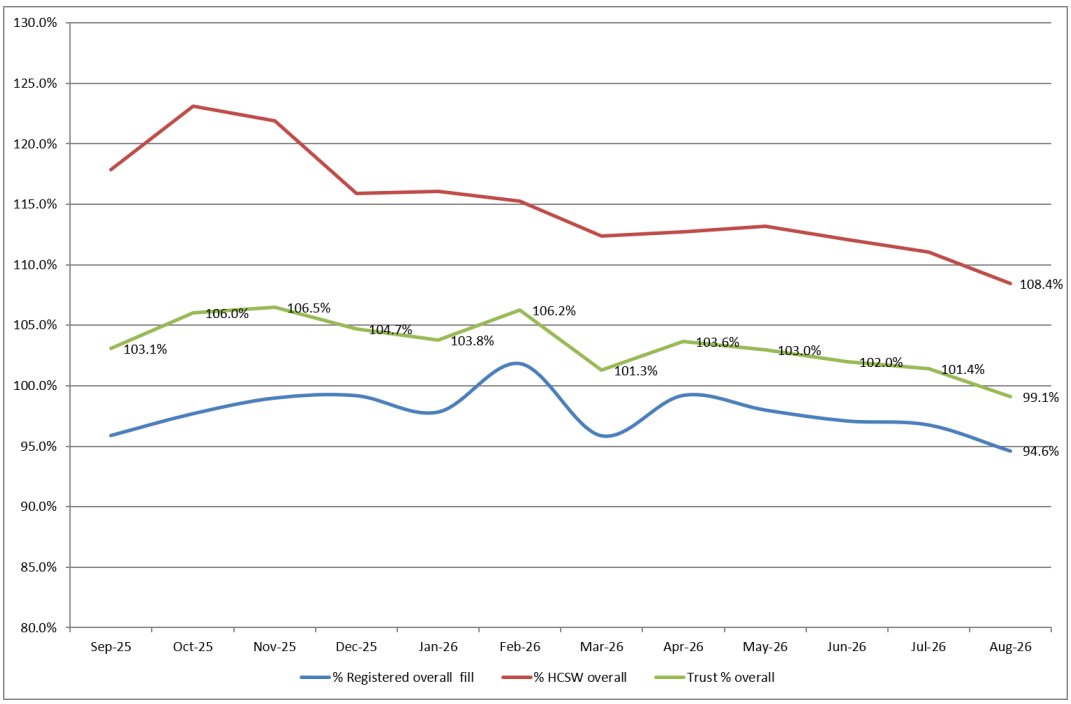
Staffing delivery across other divisions remained broadly consistent and review against actual demand **continues to provide** assurance that staffing resources remained aligned to patient need. A small number of clinical areas continued to fall below the 75% registered staffing threshold on occasion, with an increase observed during August. This was largely concentrated within a limited number of services and should be considered alongside local operational factors, including temporary staffing model changes, ward occupancy and service activity, when interpreting these results. **(Appendix 1, Table 1a)**

Table 1. Overall fill rate

Average day fill rate – registered	Average day fill rate - care staff	Average night fill rate - registered	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate

92.9%	98.5%	96.7%	120.2%	94.6%	108.4%	99.1%

Table 2. Inpatient fill rate inc. Maternity Trend



2.3 Staffing Delivery Against Actual Demand

Actual demand varied throughout August and continued to reflect additional workforce requirements that sit outside planned staffing establishments, including patient acuity, dependency and other patient-specific needs. Review of actual demand alongside fill rates, quality indicators and professional judgement provides assurance that staffing resources remained aligned to patient need throughout the month **(Appendix 1, Table 1e).**

Weekly scrutiny of additional duties continues to support oversight of workforce deployment and provides assurance that the majority reflect identified patient need, whilst enabling duties created outside agreed staffing templates to be identified and corrected in real time. Enhanced care remains a significant driver of additional workforce demand, although associated data should be interpreted with caution given ongoing national work to improve the consistency of enhanced care definitions and recording.

2.4 Key Drivers of Workforce Demand

Emergency Departments

Although Emergency Departments are excluded from national safer staffing reporting, local staffing data continues to be reviewed for assurance (Appendix 1, Tables 1B and 1C).

Adult Emergency Department remained the largest recipient of redeployed staff during August, reflecting ongoing demand associated with ambulance cohort areas and patient flow. Workforce pressures continued to be managed through local escalation processes and workforce flexibility, including redeployment where required.

Within Children's Emergency Department, the revised shift pattern introduced to increase staffing availability during periods of peak demand remains in place. The effectiveness of this approach, alongside future workforce requirements, will be considered as part of the September SNCT review.

Enhanced Care

Enhanced care continued to be a significant driver of workforce demand during August and remains subject to daily review through staffing huddles, SafeCare reporting, matron oversight and professional judgement to support workforce planning and escalation where required.

Education and training continue to support a more consistent approach to enhanced care assessment and recording, including the introduction of a multidisciplinary enhanced care study day from October 2026. In response to sustained enhanced care requirements within Tye Green and Kingsmoor, healthcare support worker establishments have been increased by one staff member per shift, seven days a week, from 1 October 2026 to support a more sustainable approach to meeting patient demand **(Appendix 1, Table 1D).**

2.5 Workforce Utilisation (CHPPD Context)

Care Hours Per Patient Day (CHPPD) provides an indication of workforce utilisation and is reported against both national benchmarking and locally agreed expectations. During August, Trust CHPPD remained broadly stable at 7.9 hours per patient day, providing assurance that overall workforce utilisation remained consistent with previous months **(Appendix 3).**

Model Hospital benchmarking continues to demonstrate a workforce profile with proportionally higher registered nursing hours and lower support worker hours when compared to some peer organisations. As CHPPD does not account for patient acuity, dependency, enhanced care requirements or ward configuration, it should be considered alongside workforce, demand, quality and professional judgement indicators when assessing staffing effectiveness and patient safety. **(Table 3)**.

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

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.1	2.8	7.9

3.0 Outcomes: Quality and Patient Safety Indicators

Quality and patient safety indicators remained broadly stable during August 2026. Whilst variation was observed across individual measures, triangulation of workforce, patient safety and patient experience data has not identified a consistent pattern to suggest staffing pressures are adversely impacting patient outcomes. Falls activity increased during the month, including an increase in falls resulting in harm, whilst both overall skin changes and reportable hospital-acquired pressure ulcers reduced. Continued monitoring is undertaken to identify emerging themes and ensure areas experiencing higher demand remain appropriately supported **(Appendices 4 and 5).**

3.1 Patient Safety Indicators

Falls activity increased during August, including an increase in falls resulting in harm. In contrast, both total skin changes and reportable hospital-acquired pressure ulcers reduced compared to the previous month. Whilst variation was observed across individual measures, patient safety indicators do not demonstrate a consistent pattern of deterioration and continue to be reviewed alongside workforce, quality and staffing data to identify emerging themes and support targeted interventions where required.

3.2 Patient Experience

Patient experience indicators improved during August, with complaints and PALS contacts reducing and compliments increasing. Feedback themes remained broadly unchanged, with communication and delays continuing to be the predominant reasons for contact. No emerging concerns were identified through triangulation with workforce and quality indicators. **(Appendix 5)**.

3.3 Red Flags and Incident reports

Staff-raised red flags and incident reports continue to provide important insight into perceived workforce risks and support real-time oversight of staffing and patient care. During August, the number of red flags raised reduced, whilst the number reviewed and resolved increased, providing assurance that concerns continue to be identified, reviewed and addressed through established governance processes **(Appendix 4, Tables 3a and 3b).**

Reports relating to lack of suitably trained or skilled staff also reduced during the month. Whilst reporting activity is influenced by local reporting culture and practice, triangulation of red flag reporting, incident data, workforce indicators and quality outcomes has not identified any organisation-wide themes or emerging concerns requiring escalation. These indicators continue to be reviewed alongside workforce and quality metrics to support a comprehensive assessment of staffing-related risks and patient outcomes **(Appendix 4 and 5)**.

4.0 Professional Judgement

Professional judgement continues to play a key role in safe staffing decision-making. Daily staffing huddles, matron oversight, red flag reviews and escalation processes are used alongside workforce, demand and quality indicators to support staff deployment and respond to changes in patient need and service pressures.

4.1 Key Themes Identified

Professional judgement identifies several consistent themes across services:

- Workforce demand continues to be influenced by patient acuity, dependency, enhanced care requirements and service-specific operational pressures, resulting in variation between planned establishments and actual demand.
- Enhanced care remains a significant driver of workforce demand across inpatient services and has informed targeted investment in healthcare support worker establishments within Kingsmoor and Tye Green from October 2026.
- Workforce flexibility, including redeployment and temporary staffing, continues to support operational resilience and the delivery of safe care during periods of higher demand.
- Whilst registered nurse fill rates reduced and occasions where staffing fell below the 75% threshold increased during August, triangulation of workforce, quality, patient safety, patient experience and incident reporting data does not identify any organisation-wide themes to suggest staffing pressures adversely impacted patient care.

- Ongoing review of staffing demand through SafeCare, red flag reporting, daily staffing huddles and the current SNCT data collection continue to support assessment of whether workforce establishments remain aligned to patient need.

4.2 Actions and Escalation

In response to these themes, a range of actions continue to support safe staffing:

- Daily review of staffing levels through Trust-wide staffing huddles and divisional oversight.
- Targeted use of redeployment and temporary staffing to respond to changes in patient acuity, dependency and demand.
- Ongoing review of enhanced care requirements through SafeCare, professional judgement and escalation processes.
- Additional investment in healthcare support worker establishments within Kingsmoor and Tye Green to support sustained enhanced care demand.
- Continued scrutiny of additional duties to support appropriate workforce utilisation and oversight of demand.
- Delivery of safer staffing education, including enhanced care training and support for staff participating in the September 2026 SNCT review.
- Completion of September 2026 SNCT data collection to inform the year-end establishment review and future workforce planning.

5.0 Overall Interpretation

Triangulation of workforce, demand, quality, patient safety and professional judgement indicators provides assurance that safe care was maintained throughout August 2026. Whilst registered nurse fill rates reduced and occasions where staffing fell below the 75% threshold increased during the month, review against actual demand, workforce deployment, red flag reporting and quality indicators does not identify evidence of a corresponding deterioration in patient outcomes.

Enhanced care, patient acuity and dependency continue to be significant drivers of workforce demand across inpatient services. Workforce flexibility, redeployment and established staffing governance processes have supported services in responding to operational pressures, with targeted investment in healthcare support worker establishments within Kingsmoor and Tye Green agreed in response to sustained demand requirements.

Whilst variation was observed across individual quality and patient safety indicators, patient experience indicators improved during the month, with reductions in complaints and PALS contacts and an increase in compliments received. Overall, the evidence does not identify any organisation-wide themes to suggest staffing pressures adversely impacted patient care. September 2026 SNCT data collection is currently underway and will inform the year-end establishment review, providing a further opportunity to assess whether nursing and midwifery establishments remain aligned to patient demand and service requirements.

Reporting note: Workforce supply data are provided by separate departments and remained subject to final validation at the time of drafting. Sections 2.1 will be updated once the August data is available.

4.4

Appendix 1: Fill Rates

Table 1a: Ward level data – Average fill rates against Standard Template (%) August 2026

>100%	95 - 100%	75 - 95%	<75%

	Day		Night				
Ward name	**registered (%)**	**Unregistered (%)**	**registered (%)**	**Unregistered (%)**	**% Registered Overall**	**% Unregistered Overall**	**% Overall fill rate**
Harvey	97.6%	112.8%	133.4%	112.5%	112.2%	112.7%	112.4%
Henry Moore	90.7%	101.5%	93.5%	114.9%	92.0%	107.9%	98.0%
ITU & HDU	78.7%	52.3%	82.2%	74.2%	80.4%	63.3%	78.9%
John Snow	86.2%	43.4%	79.0%	35.5%	82.8%	39.6%	68.4%
Penn	88.5%	111.4%	98.4%	133.8%	92.7%	119.9%	102.4%
Saunders	87.5%	124.6%	99.2%	176.1%	92.5%	144.1%	111.0%
PP Total	86.6%	102.8%	94.0%	117.9%	90.0%	109.4%	95.7%
Fleming	84.4%	88.6%	98.5%	103.1%	90.4%	95.5%	92.0%
Harold	89.5%	90.0%	98.9%	108.5%	93.6%	98.8%	95.3%
Kingsmoor	104.5%	124.2%	128.2%	141.7%	113.5%	132.6%	120.6%
Lister	91.3%	100.0%	100.9%	124.3%	95.3%	111.6%	101.8%
Locke	91.2%	108.2%	98.8%	139.2%	94.4%	123.0%	105.8%
Nightingale	100.5%	69.8%	100.0%	97.4%	100.3%	83.1%	91.7%
Opal	126.9%	88.5%	75.6%	114.2%	102.4%	100.8%	101.8%
Ray	101.9%	107.6%	119.4%	160.1%	109.3%	127.5%	115.8%
Tye Green	88.5%	122.2%	93.7%	158.3%	90.7%	136.9%	108.7%
Winter	96.5%	105.5%	99.2%	140.1%	97.6%	122.0%	107.4%
AAU	85.9%	127.6%	98.5%	147.9%	91.5%	137.3%	101.1%
Charnley	92.1%	117.4%	89.7%	132.3%	90.9%	124.5%	100.5%
IEMP Total	94.2%	105.6%	100.1%	131.5%	96.8%	117.6%	104.1%
Birthing	97.4%	68.5%	96.0%	90.3%	96.7%	78.9%	90.8%
Chamberlen	90.0%	75.4%	90.8%	90.3%	90.4%	82.5%	88.4%
Dolphin	87.8%	64.5%	89.1%	95.7%	88.4%	74.9%	85.0%
Labour	110.8%	79.4%	97.5%	87.2%	104.4%	83.2%	99.7%
Neo-Natal Unit	89.5%	58.1%	86.5%	74.2%	88.0%	66.1%	84.3%
Samson	100.8%	77.2%	97.0%	91.8%	98.9%	84.1%	90.5%
FDC Total	97.3%	72.7%	92.7%	89.2%	95.1%	80.3%	90.7%
Total	92.9%	98.5%	96.7%	120.2%	94.6%	108.4%	99.1%

Table 1b: ED data – Average fill rates against Standard Template (%) August 2026

Average day fill rate - registered	Average day fill rate - care staff	Average night fill rate - registered	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
105.8%	91.1%	115.3%	118.6%	110.1%	103.4%	107.9%

Table 1c: Children's ED data – Average fill rates against Standard Template (%) August 2026

Average day fill rate - registered	Average day fill rate - care staff	Average night fill rate - registered	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
98.8%	44.4%	122.2%	84.6%	109.2%	64.5%	95.4%

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

Registered	**Hours**
Overall number of ETOC hours provided in month	1762
Number of ETOC hours provided by substantive staff	0
Number of ETOC hours provided by bank staff	1762
Number of ETOC hours provided by agency staff	0
Number of unfilled hours for staff relating to ETOC	2314
Unregistered	
Overall number of ETOC hours provided in month	6557
Number of ETOC hours provided by substantive staff	790
Number of ETOC hours provided by bank staff	5767
Number of ETOC hours provided by agency staff	0
Number of unfilled hours for staff relating to ETOC	16545

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Table 1e: Average Fill Rate % - Standard Template and All Demands with Associated Variances – August 2026

	Day						Night					
Ward name	Average fill rate - registered (%) STANDARD TEMPLATE	Average fill rate - registered (%) ALL DEMAND	Variance	Average fill rate - unregistered (%) STANDARD TEMPLATE	Average fill rate - unregistered (%) ALL DEMAND	Variance	Average fill rate - registered (%) STANDARD TEMPLATE	Average fill rate - registered (%) ALL DEMAND	Variance	Average fill rate - unregistered (%) STANDARD TEMPLATE	Average fill rate - unregistered (%) ALL DEMAND	Variance
Harvey	97.6%	79.6%	18.0%	112.8%	97.4%	15.4%	133.4%	96.9%	36.5%	112.5%	98.8%	13.7%
Henry Moore	90.7%	89.7%	0.9%	101.5%	93.1%	8.4%	93.5%	92.9%	0.6%	114.9%	96.9%	18.0%
ITU & HDU	78.7%	79.8%	-1.1%	52.3%	45.0%	7.3%	82.2%	83.6%	-1.4%	74.2%	67.7%	6.5%
John Snow	86.2%	83.6%	2.6%	43.4%	40.2%	3.2%	79.0%	79.0%	0.0%	35.5%	32.3%	3.2%
Penn	88.5%	84.0%	4.5%	111.4%	99.5%	11.9%	98.4%	97.5%	0.9%	133.8%	98.8%	35.0%
Saunders	87.5%	85.4%	2.1%	124.6%	95.5%	29.1%	99.2%	99.2%	0.0%	176.1%	100.6%	75.5%
Fleming	84.4%	82.8%	1.5%	88.6%	85.7%	2.9%	98.5%	96.2%	2.3%	103.1%	97.9%	5.2%
Harold	89.5%	89.6%	-0.1%	90.0%	81.2%	8.8%	98.9%	98.4%	0.5%	108.5%	98.3%	10.1%
Kingsmoor	104.5%	86.9%	17.6%	124.2%	89.8%	34.4%	128.2%	98.2%	30.1%	141.7%	100.0%	41.7%
Lister	91.3%	90.2%	1.1%	100.0%	86.5%	13.5%	100.9%	99.2%	1.6%	124.3%	98.1%	26.2%
Locke	91.2%	88.9%	2.3%	108.2%	79.8%	28.4%	98.8%	96.5%	2.4%	139.2%	98.4%	40.8%
Nightingale	100.5%	100.6%	-0.1%	69.8%	131.9%	-62.0%	100.0%	98.4%	1.6%	97.4%	97.8%	-0.4%
OPAL	126.9%	97.1%	29.9%	88.5%	83.3%	5.2%	75.6%	101.2%	-25.6%	114.2%	96.8%	17.4%
Ray	101.9%	89.0%	12.9%	107.6%	82.5%	25.1%	119.4%	99.3%	20.0%	160.1%	94.4%	65.6%
Tye Green	88.5%	88.0%	0.5%	122.2%	86.4%	35.8%	93.7%	93.7%	0.0%	158.3%	98.2%	60.1%
Winter	96.5%	90.5%	6.0%	105.5%	81.1%	24.3%	99.2%	97.5%	1.7%	140.1%	96.0%	44.1%
AAU	85.9%	82.3%	3.5%	127.6%	91.5%	36.1%	98.5%	93.7%	4.8%	147.9%	98.3%	49.6%
Charnley	92.1%	92.1%	0.0%	117.4%	95.2%	22.2%	89.7%	88.5%	1.1%	132.3%	100.0%	32.3%
A&E	105.8%	93.3%	12.5%	91.1%	87.2%	3.9%	115.3%	96.3%	19.0%	118.6%	108.5%	10.1%
Birthing Unit	97.4%	93.8%	3.7%	68.5%	61.8%	6.6%	96.0%	92.8%	3.1%	90.3%	90.8%	-0.5%
Chamberlen	90.0%	86.9%	3.2%	75.4%	74.5%	0.9%	90.8%	89.1%	1.7%	90.3%	90.3%	0.0%
Dolphin	87.8%	82.4%	5.4%	64.5%	64.5%	0.0%	89.1%	86.6%	2.6%	95.7%	92.7%	3.0%
Labour Ward	110.8%	92.7%	18.1%	79.4%	79.3%	0.1%	97.5%	96.3%	1.2%	87.2%	87.4%	-0.1%
Neo-Natal Unit	89.5%	88.4%	1.1%	58.1%	60.0%	-1.9%	86.5%	85.4%	1.0%	74.2%	74.2%	0.0%
Samson	100.8%	94.3%	6.5%	77.2%	76.9%	0.3%	97.0%	97.0%	0.0%	91.8%	91.8%	0.0%
Childrens ED	98.8%	99.9%	-1.1%	44.4%	44.7%	-0.3%	122.2%	99.8%	22.4%	84.6%	87.4%	-2.8%
Total	94.7%	88.9%		90.5%	80.6%		99.3%	94.4%		113.3%	92.0%	

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4.5

Meeting Title: Trust Board Date: 1st October 2026				Agenda item: 4.5
Report Title: Learning from Deaths				
Presented by: Dr Andrew Kelso				
Prepared by: Nicola Tikasingh				
Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	✓

Executive Summary

Reporting period May 2025 – Apr 2026.
Hospital Standardised Mortality Ratio (HSMR+) and Standardised Mortality Ratio (SMR) continue to improve and within expected variance. These improvements are largely a reflection of education and validation between clinicians and coders, correcting data quality issues. Improvements in palliative coding reflects development of community pathways. Review of significant diagnostic outliers did not identify any care and treatment issues. Prevention of future deaths workstreams have been selected.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

Outstanding SJRs for Planned Pathways Division – a trajectory has been presented which plans clearance by April 2027.

BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.

Recommendation

To take assurance that the trust has a robust and effective programme to learn from deaths.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
X	X	X

Relevant legal/statutory issues

Learning from Deaths - National Quality Board, March 2017

Impact Assessments

Quality	Quality of care delivered to patients
Equality, Diversity and Inclusion	None
Health inequalities	None
Previously Considered By	Quality & Safety Committee, 25th October 2026
Appendices	Appendix A: Figures and Tables Appendix B: Mortality Data Explained

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1. **Purpose**

To provide monthly assurance on learning from deaths, highlight key pieces of learning and provide updates on improvement work.

2. **Background**

PAHT has a learning from death process that meets national requirements. The trust utilises Dr Foster healthcare analytics to review and compare mortality data.

3. **Mortality Indicators**

Reporting period May 2025 – Apr 2026.

3.1 Hospital Standardised Mortality Ratio (HSMR+) for Apr-26 is 84.93 and "within expected" (Figure 1). HSMR+ for the period May-25 to Apr-26 is 94.72 and "within expected" (Figure 2).

3.2 Standardised Mortality Ratio (SMR) for Apr-26 is 84.8 and "within expected" (Figure 3). SMR for the period May-25 to Apr-26 is 93.73 and "lower-than-expected" (Figure 4).

3.3 Emergency Weekend HSMR+ and **Emergency Weekday HSMR+** both report as "within expected", with values below 100, (Figures 5 & 6).

3.4 Palliative Care Coding data suggests that there has been a shift in mortality, away from palliative patients towards non-palliative patients (Figure 7).

3.5 There are no new **CUSUM** alerts, reinforcing that current mortality performance does not reflect deficiencies in care.

4. **Mortality Programme Updates**

4.1 Themes from Reviews

- Advanced Disease & Poor Prognosis
- Appropriate Clinical Management
- Goals of Care & Advance Care Planning
- Expected Deterioration & Death

Learning is shared at speciality M&M meetings. Themes feed into the Prevention of Future Deaths (PFD) planned work stream which include:

- Falls Prevention
- Medicine Management
- Pressure Ulcer Care
- Nutrition and Hydration
- Corridor Care and Capacity Management

5. **Risks**

No risks for escalation.

6. **Recommendation**

To take assurance from the Learning from Deaths programme.

The Princess Alexandra Hospital NHS Trust

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Appendix A:

Figures & Tables

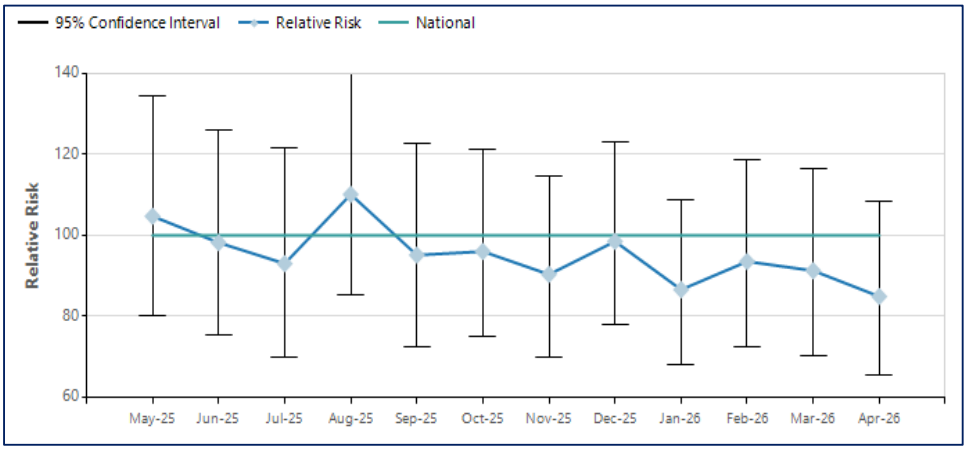

Fig 1 – Mortality (In-Hospital) Monthly Trend, May 25 to Apr 26

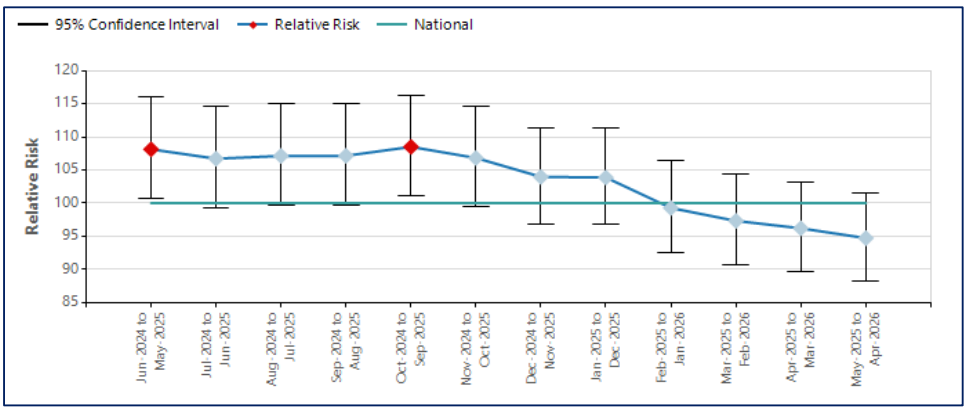

Fig 2 – Mortality (In-Hospital) Rolling 12 Month Trend, May 25 to Apr 26

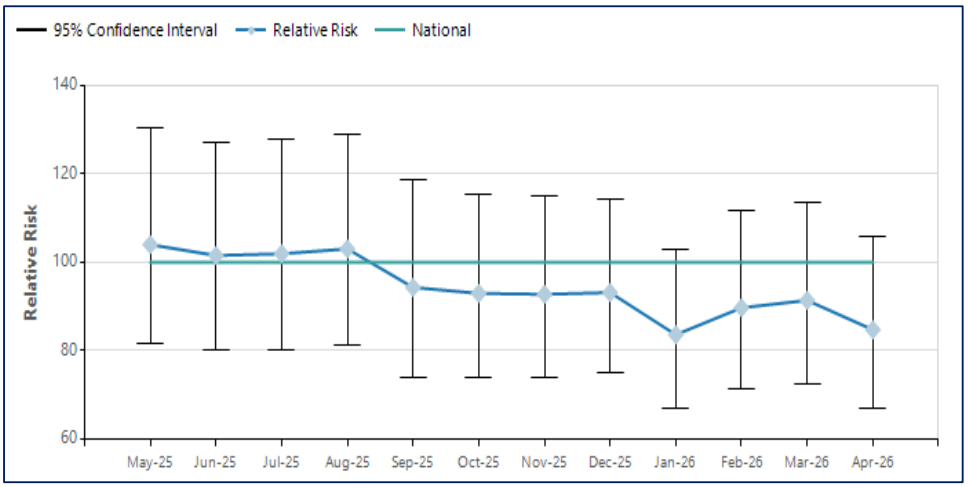

Fig 3 – SMR Monthly Trend, May 25 to Apr 26

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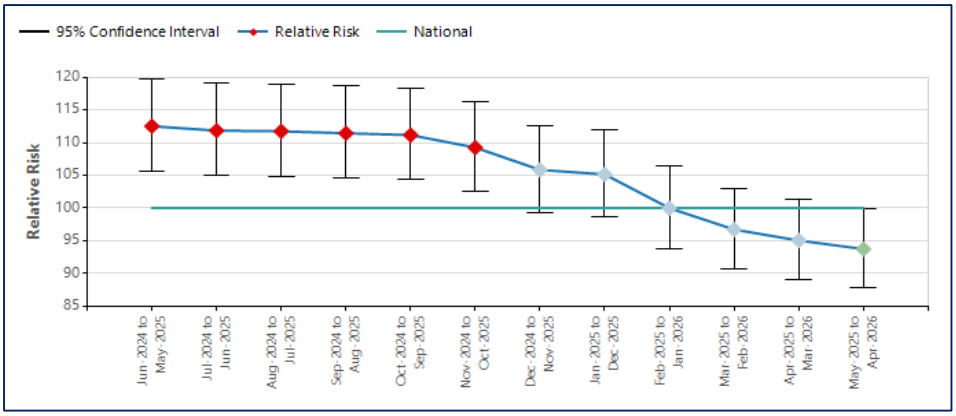

Fig 4 – SMR Rolling 12 Month Trend, May 25 to Apr 26

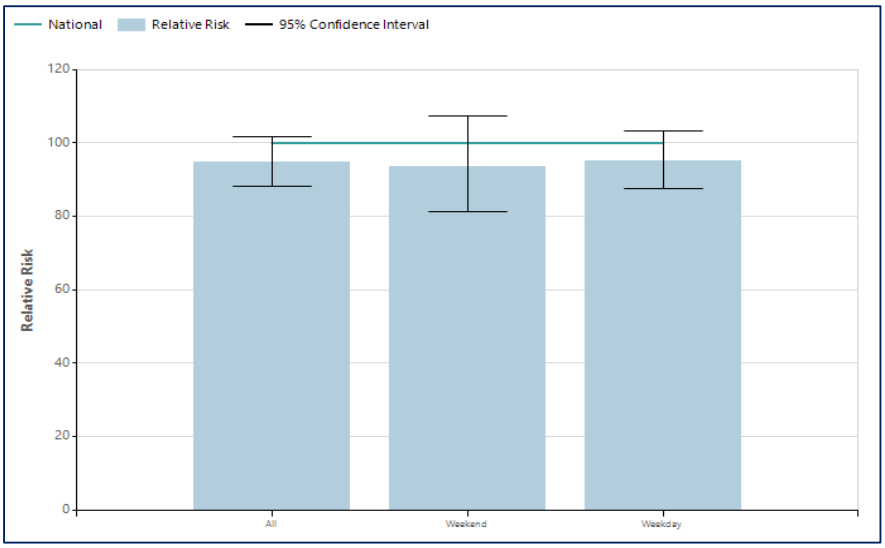

Fig 5 – HSMR Weekend/Weekday Admission, Emergency only, May 25 to Apr 26

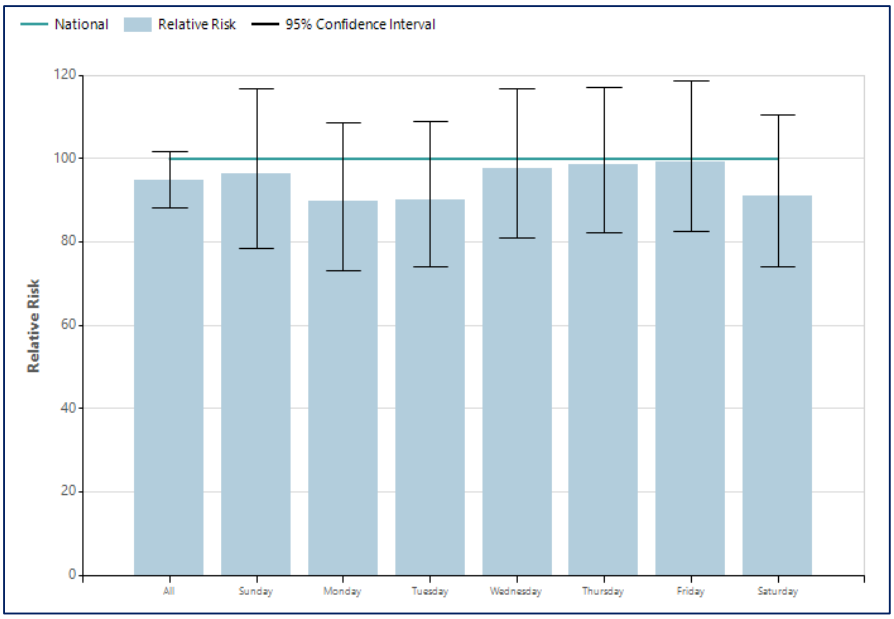

Fig 6 – HSMR Day of Admission, Emergency only, May 25 to Apr 26

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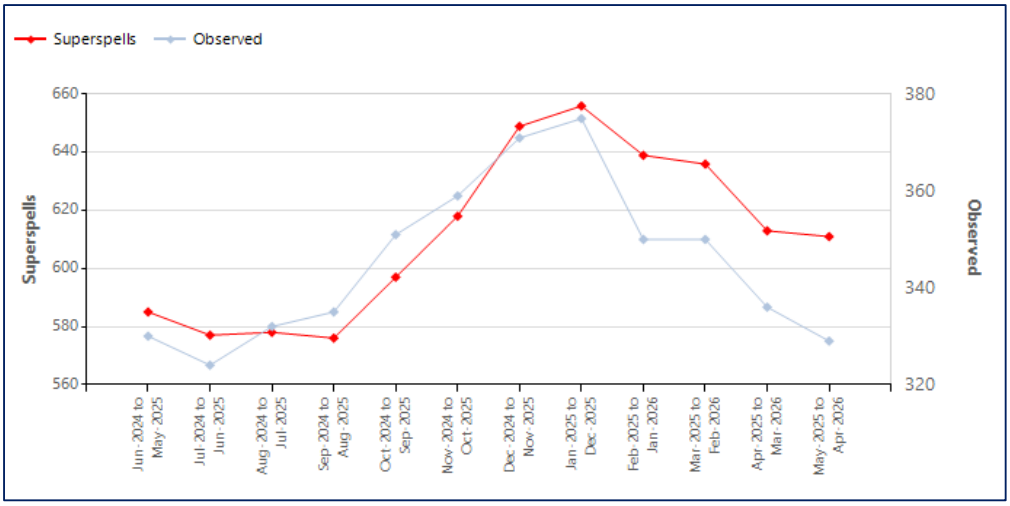

Figure 7. Palliative Care Coding (Palliative Observed Mortality v Superspell Count), May-25 – Apr-26

Appendix B:

Mortality Data Explained

Dr Foster 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.

Dr Foster 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

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BOARD OF DIRECTORS: **Trust Board 1st October 2026** **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: **People Committee**

REPORT FROM: Darshana Bawa, Acting Committee Chair/Trust chair

DATE OF COMMITTEE MEETING: 28 September 2026

Agenda Item:	**Level of assurance**			**Further work Y/N**	**Referral elsewhere Y/N**	**Recommendation to Board**
	Full	**Partial**	**Limited**			
2.1 People Report		✓		Yes	No	The Committee noted the continued improvement in key workforce indicators, including vacancies, turnover and agency expenditure. It is recognised that appraisal compliance and long-term sickness absence remain areas of concern and support the ongoing targeted interventions and strengthened divisional accountability arrangements intended to improve performance.
2.2 Lord Mann Review Update		✓		Yes	No	The Committee supported the proposed approach to the Lord Mann Review, including the decision not to adopt the definitions at this stage, and approved the associated action plan and governance arrangements. The Committee will receive a further update following completion of the organisational diagnostic and implementation of agreed actions.
2.3 Expenses Fraud Audit Actions		✓		Yes	No	The Committee noted the progress made in strengthening expenses controls and reducing identified risks. Further assurance will be sought following completion of the outstanding audit recommendations and post-implementation testing of the revised controls.
2.4 Clinical Administration Review Programme	✓			Yes	No	The Committee was assured regarding the progress of the Clinical Administration Review Programme and

BOARD OF DIRECTORS: Trust Board 1st October 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Darshana Bawa, Acting Committee Chair/Trust chair

DATE OF COMMITTEE MEETING: 28 September 2026

Agenda Item:	Level of assurance			Further work Y/N	Referral elsewhere Y/N	Recommendation to Board
	Full	Partial	Limited			
						the extensive engagement undertaken to date. The Committee supported progression to formal consultation and will continue to oversee delivery of the programme, including workforce, operational and financial impacts.
2.5 Nursing, Midwifery and Allied Health Professional Strategy	✓			Yes	No	The Committee welcomed the refresh of the strategy and its alignment with organisational and national priorities. Further engagement and refinement will be undertaken before the final strategy is presented for approval.
2.6 Safer Nurse Staffing	✓			Yes	No	The Committee received assurance that nurse staffing levels remained above the agreed safety threshold and that nursing vacancies continued to improve. The Committee will continue to monitor Healthcare Support Worker recruitment and retention as a key workforce risk.
2.7 Nursing Associates	✓			No	No	The Committee supported the decision to pause recruitment through the Nursing Associate pathway and focus on direct Registered Nurse apprenticeships. Members were satisfied that this approach better reflects local workforce requirements and career progression opportunities.

BOARD OF DIRECTORS: Trust Board 1st October 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Darshana Bawa, Acting Committee Chair/Trust chair

DATE OF COMMITTEE MEETING: 28 September 2026

Agenda Item:	Level of assurance			Further work Y/N	Referral elsewhere Y/N	Recommendation to Board
	Full	Partial	Limited			
2.8 Improving Resident Doctors' Lives (10 Point Plan)	✓			Yes	No	The Committee welcomed the significant progress made against the 10 Point Plan, with 17 of 21 standards now fully compliant. Ongoing work to address the remaining areas of compliance will continue to be monitored through regular updates.
2.9 Annual Report on Medical Revalidation and Compliance	✓			No	No	The Committee recommend the Annual Report on Medical Revalidation and Compliance to Board for approval and received full assurance regarding medical appraisal, revalidation and professional governance arrangements across the Trust. *This item is on the Board agenda*.
2.10 GMC National Training Survey and Postgraduate Medical Training Improvement Plan	✓			Yes	No	The Committee welcomed the continued improvement in trainee experience and the reduction in negative survey outliers. Focused improvement plans remain in place for identified specialties and progress will continue to be monitored through established governance arrangements.
2.11 BAF Risk 2.1 – Staff Engagement and Morale		✓		Yes	No	The Committee reviewed the risk position and supported maintaining the current risk rating. Whilst acknowledging the continuing impact of organisational change within the People Directorate, the Committee was assured that actions are in place

BOARD OF DIRECTORS: Trust Board 1st October 2026 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Darshana Bawa, Acting Committee Chair/Trust chair

DATE OF COMMITTEE MEETING: 28 September 2026

Agenda Item:	**Level of assurance**			**Further work Y/N**	**Referral elsewhere Y/N**	**Recommendation to Board**
	Full	**Partial**	**Limited**			
						to strengthen capacity, stabilise services and support workforce engagement.
2.12 Horizon Scanning	✓			Yes	No	The Committee reviewed a range of forthcoming workforce, leadership and employment-related developments and was assured that appropriate preparations are underway. The Committee will continue to monitor emerging national policy and legislative changes and their implications for the Trust.

NHS
The Princess Alexandra Hospital
NHS Trust

5.2

Meeting Title: Public meeting of the Board of Directors **Date 1st October 2026** **Agenda item: 5.2**					
Report Title: Annual report on Medical Revalidation and Compliance					
Presented by: Andrew Kelso, Chief Medical Officer					
Prepared by: Jane Bryan, Medical Professional Standards Manager					
Purpose: *(please tick)*	**Approval/Decision**	X	**Information/Assurance**	X	

Executive Summary

Each designated body has a duty under the regulations to assure their compliance with regulations and commitment to continual quality improvement in the delivery of professional standards

The report gives a summary of Appraisal & Revalidation metrics, processes and actions relating to **1st April 2025- 31st March 2026** for quality assurance

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

N/A

Recommendation

To provide assurance and sign off statement of compliance

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards

Relevant legal/statutory issues

The Medical Profession (Responsible Officers) Regulations 2010 and 2013

Impact Assessments

Quality	None identified
Equality, Diversity and Inclusion	None identified
Health inequalities	None identified
Previously Considered By	People Committee
Appendices	N/A

NHS England

Designated Body Annual Board Report and Statement of Compliance

Section 1 Qualitative/narrative

Reporting period 1 April 2025 – 31 March 2026

1A – General

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

5.2

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

1A (ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. The People Team restructure will be in place from 1st September 2026. To review the needs of the service, to continue to provide assurance of delivery of timely appraisal and revalidation functions.

1A (iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained. The medical professional standards team continue to monitor and maintain accurate records of all practitioners with a prescribed connection to our organisation, as part of our appraisal and revalidation processes. Regular reports are received from the People Information team listing all starters and leavers and are actioned appropriately on GMC connect.

1A (iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed. All policies are monitored and reviewed on a 3 yearly basis, last updated 2026.

1A (v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes. Our last peer review meeting was held in October 2024. Positive feedback was received in the peer review report which highlighted the following:

- Great monitoring of upcoming revalidations, this includes a weekly meeting between the Deputy RO/Medical Professional standards manager to discuss doctors under notice/issues.
- A *Doctors under notice list / progress sheet* is sent weekly by Medical Professional standards manager to RO/Deputy RO, and the Trust also has a 5-year revalidation plan for each Doctor.
- Good communication between the team and the doctors approaching revalidation.

1A (vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance. Robust processes are in place to support all fixed term/locum doctors under the same process as substantive doctors. Each new doctor joining the trust with a prescribed connection is given guidance. Doctors for whom it is their first appraisal in the NHS are given additional support & guidance, also invited to a meeting with the Medical Professional Standards team - progress is monitored and on-going support provided.

1B – Appraisal

1B (i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. All doctors with a prescribed connection have an annual appraisal covering their whole scope of practice. They are required to complete mandatory sections on their portfolio, to include complaints and information regarding significant events, and clinical outcomes

1B (ii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group). It was agreed in 2025 that the reviewed policy would be sent to the JLNC. This was reviewed and agreed by JLNC but some minor comments received from Trust policy group which have been addressed. Policy has been finalised, agreed and is published on intranet.

1B (iii) Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners. We continue to monitor the number of required appraisees to ensure that there are sufficient numbers and equal distribution of appraisals, amongst appraisers, usually an average of around 10-12 per annum, spread throughout the year. We have mitigated this risk as one of the lead appraisers if required will complete additional appraisals, as well as the Deputy RO. We will continue to monitor numbers and recruit additional appraisers where needed.

1B (iv) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent). Medical Appraisers are required to attend annual refresher training. The next appraisers' annual refresher training is scheduled for 12th November 2026. Appraisers attend internal bi-monthly appraisal forums, where they are updated on changes, developments, and changes to guidance. This forum gives an opportunity to provide updates raise queries and have open discussions. Appraisers also attend network events, and development events. This is supported

by access to regular Medsu webinars as appropriate. We continue to perform annual appraisal quality assurance audits

1B (v) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. We have a quality assurance process in place, this has been reviewed and detailed in our policy and will report to the People Committee There is a quality assurance process in place for appraisal and revalidation recommendations. The deputy RO completes a quality assurance form prior to due date to confirm recommendation to the GMC following review of evidence. The Deputy RO quality assures the last five appraisals of all doctors undergoing revalidation each year (approximately 20%) of the appraisees. Any themes are raised with appraisers at meetings. The Clarity system ensures that the minimum standard of quality assurance is met as the appraisals cannot be 'completed' otherwise. Anonymous feedback forms are completed by appraisee as part of the Trust process for individual appraisers and the processes carried out within the organisation. This is discussed at the Appraisers forums and reviewed where necessary.

1C – Recommendations to the GMC

1C (i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood. Records for doctors under notice are maintained, reviewed and discussed on a regular basis, with progress continually monitored by the Medical Professional Standards manager and the Deputy RO. There is a quality assurance process in place for appraisal and revalidation recommendations. The deputy RO completes a quality assurance form on review of evidence prior to the recommendation date, to confirm the timely recommendation to the GMC.

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

1C (iii) Weekly meetings are held with the Deputy RO/Medical professional standards manager regarding doctors under notice. Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, in a timely manner. There is a system in place to ensure that Revalidation recommendations made to the GMC are communicated to the doctor. If a deferral is necessary or in cases of non-engagement, this is discussed with the doctor before the recommendation is submitted. In cases of deferral an action plan will be shared with the doctor clarifying timescales for completion of missing requirements

1D – Medical governance

1D (i) Our organisation creates an environment which delivers effective clinical governance for doctors. Effective systems are in place in line with national guidance and policies. A grievance policy is in place, as well as a disciplinary policy. An MHPS policy is in place with a framework for dealing with conduct and concerns A complaints policy is in place. A quarterly meeting is held with the GMC Employment Liaison advisor to monitor and discuss concerns, cases and outcomes

1D (ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation. The audit was completed, the recommendations were highlighted in the report and are listed in the actions below.

1D (iii)The clinical audit policy was reviewed and approved in January 2026. Clinical governance processes are in place in line with policies and national guidance. There is a clinical effectiveness meeting bi-monthly that is chaired by the Chief Medical Officer and follows an annual work plan. A half day each month is designated protected time for audit/clinical effectiveness/learning and these sessions are led by the Associate Medical Director for Risk and Quality. Clinical effectiveness policies are in place relating to audit, the implementation of NICE guidance and new interventional procedures. These are available on the intranet. There is a quality governance structure in place, Trust wide audit meetings are held quarterly. There is a divisional patient safety and quality board meeting that is held within each division and led by the divisional patient safety and quality lead

1D (iv) All relevant information is provided for doctors in a convenient format to include at their appraisal. The complaints policy was reviewed and updated to ensure named individuals are informed and respond and also reflect within their appraisal, to ensure that where any doctor is named in a incident, complaint or Datix, a discussion is held with an appropriate supervising individual (clinical lead or educational supervisor) and that discussion is reflected upon in the annual appraisal

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

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

1D (vii) The People Committee is provided with data relating to any formal cases, which includes doctors. The Board is provided with and reviews statistical analysis annually included formal cases with analysis including protected characteristics. The nominated Non-Executive Director (NED) is the nominated point of contact for all MHPS investigations.

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

1D (ix) There are robust processes in place which include monitoring starters and leavers and sharing concerns and information effectively between Responsible Officers with timely completion and requests of Medical Practitioner Information Transfer (MPIT) forms with other organisations.

1D (x) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook). Processes for responding to concerns are carried out in line with the NHS England framework. There is a current responding to concerns policy, disciplinary policy as well as an MHPS policy, which has been reviewed, and awaiting ratification due in October 2026.

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

1D (xii) Trust compliance with national reviews, reports and enquiries is reported at the Clinical Compliance and Clinical Effectiveness Committees. These are chaired by the Chief Medical Officer and all divisional Patient Safety and Quality leads are in attendance. This committee reports to the Trust Quality and Safety Committee. Since the implementation of PSIRF we have held patient safety and governance training session with resident doctors, at all new doctor inductions and at the new consultant inductions, we also present at Grand Round and Medical Advisory Committee to ensure all teams learn from incidents, inquests, complaints and claims.

1D (xiii) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review). The trust has policies in place that are applied consistently. The People Team are involved in discussions where concerns are raised regarding professional standards for all health care staff.

1E – Employment Checks

1E (i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties. On-boarding of fixed term locums and substantively employed doctors follow all recruitment processes and doctors are unable to start until all checks are cleared. This includes obtaining references and police checks from previous host organisations and countries. Agency locums obtained via an agency as temporary staff can only be booked/appointed if their CV has been

reviewed by a clinician and must include references, statutory training, DBS and qualification history

1F – **Organisational Culture**

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

1F (ii) Leadership and Management competence is included in the appraisal for all people managers and a rating required. Executive team members must have an objective related to EDI in their annual appraisal The NHS Staff Survey results feed into an annual 'Feedback to Action' plan to address the People Promise elements which include EDI data. All new starters attend a forum to meet the Executives and Non-Executive Directors where culture is discussed and promoted as well as avenues for feedback such as Freedom to Speak up Guardians, raising risks, people team and support through Here for You. New consultants attend a Consultant development programme.

1F (iii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.
Our starting point is that everyone has the right to be treated fairly and equitability. This is true whether they are members of PAHT staff, those from partner organisations that we work with, community groups we seek to engage, or the patients, carers and families who our work is ultimately for.
We maintain and promote a zero-tolerance approach to discrimination in any form, and we are committed to planned and consistent action to reduce and eliminate all practices that allow the continuation of discriminatory behaviours, policies or practices. We value both visible and non-visible difference as a key part of a healthy organisation. We strive to harness people's differences to create an environment in which people feel valued, staff talents are fully utilised, and we deliver against our strategy. We know that celebrating individual difference, and bringing diverse teams together with disparate styles and talent, will foster innovation and continuous improvement for patients, service users, their families, carers and our people. We recognise that equality and diversity are most effective and sustainable if we are inclusive, and all of our people are welcome, valued and able to contribute. We want to build a reputation of being a values-based organisation that focuses on ensuring that all care delivered to patients by our people has a truly person-centred focus. We are in no doubt that equality, diversity and inclusion is a collective responsibility, and the Trust Board has a duty to ensure this work is at the heart of our business. We are asking all our people to adopt and embrace this strategy within their individual roles and workplaces.

Our core goals and objectives are:

- To Put EDI at the heart of our organisation
- Recruit, retain develop and support a diverse workforce.
- Improve patient experience and outcomes for people with protected characteristics and other communities who experience marginalisation.

- Engage our diverse communities across our services and pathways

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

1F (v) All staff are encouraged to speak up, this has been particularly encouraged with our medical staff over the past year. The Trust has freedom to speak up guardians, one of whom is a doctor; alongside this there is a resident doctor who is a FTSU ambassador. Listening events have been held for doctors. Issues are listened to, at both JLNC and RDC and acted upon and shared in order to improve processes

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

1F (vii) All cases are discussed with PPAS/NHS Resolutions as well as the GMC/ ELA to ensure that staff are treated fairly. Each case is dealt with in line with Trust policies to ensure fairness and consistency.

1F (viii) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act. All doctors are treated equally in line with the concerns and disciplinary policy; the level of parity is not assessed but process applied equally to all.

1G – Calibration and networking

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

1G (ii) The Trust participates in peer reviews with partner organisations, including peer reviews with West Hertfordshire Teaching Hospital NHS Trust; engaging with higher level responsible officer reviews with NHSE; attending RO Training network meetings; GMC updates; Accessing Responsible Officer hub and GMC website; attending appraisal and revalidation network groups.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	411
Total number of appraisals completed	376
Total number of appraisals approved missed	34
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	76
Total number of late recommendations	0
Total number of positive recommendations	67
Total number of deferrals made	8
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	0
Total number of trained case investigators	12
Total number of trained case managers	12
Total number of concerns received by the Responsible Officer[1]	7
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March (working days)	469
Median duration of concerns processes closed (working days)[2]	474
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	1

Total number of appeals against the designated body's professional standards processes made by doctors	2
Total number of these appeals that were upheld	2
Total number of new doctors joining the organisation	217
Total number of new employment checks completed before commencement of employment	217
Total number claims made to employment tribunals by doctors	2
Total number of these claims that were not upheld[3]	2

Section 3 – Summary and overall commentary

This box provides detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
• Details of how to ensure complaints and datix incidents are shared with the doctors to detail in their appraisals has been actioned and processes in place • All policies have been reviewed • Continued to monitor appraiser numbers and recruit additional appraisers where needed • Updated participation status of national quality account audit for 2025/2026 • Review national report recommendations to identify learning/actions required to improve compliance • Reviewed and updated NICE guidance, focussing on those that were outside of their review period • Reviewed the findings of the internal audit- (report includes actions for next year) • Reviewed how details of complaints and datix incidents were shared with the doctors to detail in their appraisals. Complaints policy was reviewed and updated, processes put in place to ensure named individuals are informed and respond and also reflect within their appraisal

[3] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- Processes in place to ensure that where any doctor is named in a incident, complaint or Datix, a discussion is held with appropriate supervising individual and that discussion is reflected upon in the annual appraisal

Actions still outstanding

None

Current issues

None

Actions for next year

- Audit MPIT process under new structure of people team
- To continue to monitor appraiser numbers and recruit additional appraisers where needed
- Update participation status of national quality account audit for 2026/2027 Review national report recommendations to identify learning/actions required to improve compliance
- Review and update NICE guidance , focussing on those that are outside of their review period
- Review the finding of the internal audit
- As part of the continuous drive to improve culture, we are in discussion with the GMC regional liaison advisor to deliver sessions during sexual safety week in theatres and maternity

Overall concluding comments:

There are 30 people who attended the Ready to Manage Investigation training

In Autumn 2026 NHS Resolutions shall be delivering investigation training (this will be more specialised MHPS investigation)

A higher level responsible officer visit took place in March 2026 which highlighted areas of good practice including:-

1. Great monitoring of upcoming Revalidations, this includes a weekly *Doctors under notice list / doctors under notice progress sheet* sent weekly by MPS to RO/Deputy RO and a 5-year plan for each Doctor.

2. Good safety nets within appraisal software which means appraisals cannot be signed off without certain sections being completed.
3. Good communication between the medical professions standards, team, and the Doctors approaching revalidation.
4. Good appraisal compliance rate
5. No areas of concern

The Revalidation deferral rate has further decreased from 12 to 8 this by strengthening the Trust 5 year revalidation plan

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

Chief executive or chairman

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

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Jane Bryan, Medical Professional Standards Manager
Email address:	jane.bryan1@nhs.net

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
2.1 M5 Finance Report And 2.5 Report from Finance Recovery Group (FRG)		√ √		Y		The paper within the pack reported a M5 position at £2.2m deficit which is £2.2m adverse to plan and now £5.2m adverse to plan YTD. The position is driven by an under performance against the PQP target, operational performance costs, and a prior period income adjustment. • Underlying position c.£2.6m worse than reported due to additional activity costs and a shortfall in PQP. • Forecast deficit of c. £23m with recovery actions/plans being compiled through Financial Recovery Group. The current position, and following a conversation with region on 23.09.26, is that with no additional mitigations and continuing along the current trajectory, the year-end forecast will be a £27m deficit, assuming £8m of deficit support funding is received. However, we have several mitigations available that we are going to work through into a revised recovery plan which would bring in a position of c. £16m deficit or with all stretch and upside, a £11m deficit. This will be discussed further at Trust Board on 01.10.26.
2.2 PQP Report		√		Y		• The Trust has a challenging financial plan to deliver a breakeven position. This includes £26.5m PQP

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						delivery required and £3.5m additional stretch. PQP identified and added to PM3 in July is £19m. This figure was revised down by Finance Business Partners based on in year performance and trajectory. • At M5 the underlying variance to PQP plan is £690k and this current run rate is not sustainable and risks non-delivery of the plan and claw back of £8m deficit support funding. • There are some key risks to delivery of the financial plan for 26/27 linked to PQP Delivery. • A discussion was also held identifying that while PQP is important, it is not the only means of mitigating the financial position of the Trust.
2.3 Quarterly Procurement Report	√			N		Key headlines for Q1 of FY26/27 are: • Baseline savings target for HWE ICS is £7.34m. • Savings forecast in Q1 FY26/27 is £7.67m across the ICS. • PAHT Q1 savings forecast is £2.54m against baseline target of £1.90m. • At end Q1 the department remained under budget. • Overall operational performance continues to be strong. • Commercial Strategy now live.

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						• Contract Management templates available for Gold contracts. • Procurement Service Level Agreement under review.
2.4 Report from Business Case Review Group	√			N		The following revenue business cases were endorsed for Board approval: • Anaesthetics and Critical Care 4th Tier (endorsed) • ICU expansion to 13 beds (endorsed but further discussion required with Commissioners and Region on funding sources) • Pharmacy (endorsed with opportunity for benefits sharing on drug costs) A capital case for additional Procedure Rooms was also endorsed.
2.6 BAF Risk (Finance 26/27)	√			N		In line with the recommendation it was agreed that the risk score would remain at 16 but it was agreed that the score may be increased at the next review and following conversations with NHSE around the FOT.
3.1 M5 Integrated Performance Report	√			Y		Key areas requiring continued focus include diagnostic waits over six weeks, Cancer 62-day performance, Cancer Faster Diagnosis performance, emergency department 4-hour performance and delivery of the Cost

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						Improvement Programme. Recovery plans remain in place across operational, clinical and financial performance areas and continue to be monitored through established governance arrangements. PAF requested an update on Paediatric Inequalities and it was also noted that the National Oversight Framework slide would be corrected for the next iteration.
3.2 BAF Risk (Operating Plan)	√			N		In line with the recommendation, it was agreed that the risk score would remain at 15 and would remain under review with a view to reducing the risk score.
3.3 Cyber Security Update	√			N		Independent assurance remains strong, with the 2025/26 DSPT internal audit reporting high assurance and no recommendations; however, the four open cyber risks remain scored at 12 and continued focus is required on penetration-test findings, cyber capacity, legacy technology, security monitoring, network resilience, supplier assurance and recovery testing. Key risks are: • Cyber security ICT resources/capacity (12) • Software vulnerabilities (12) • Cyber user awareness (12) • Infrastructure vulnerabilities (12)

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
3.4 Dark Trace Update	√			N		• Darktrace continues to provide effective cyber monitoring and rapid containment.. No confirmed major cyber incidents were identified.
3.5 BAF Risk (Cyber)	√			N		In line with the recommendation it was agreed that the risk score would remain at 15. PAF noted the revised risk description and controls.
3.6 BAF Risk (EHR)	√			N		In line with the recommendation it was agreed that the risk score would remain at 16. PAF noted the revised risk description and controls.
4.1 New Hospital Update	√			Y		PAHT and Harlow District Council continue their collaborative relationship, developing proposals that meet the needs of both for Health on the High Street and a multi-storey car park (MSCP) to aid the redevelopment of the main hospital site. PAF was asked to note the approval given by Trust Board on 10th September to endorse further development of the Harvey Centre health hub and Wych Elm MSCP as an integrated proposal, without committing to the commercial terms but approving a development fund up to £50k. A brief overview was then presented on the current work around the New Hospital Programme and in particular

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						progress on development of the Strategic Outline Case including work around the Schedule of Accommodation.
4.2 Estates & Facilities Quarterly Update	√			N		Core services are being maintained, with strong emergency response, cleaning standards above threshold and around £8.0m of priority clinical investment progressing. The position is not, however, uniformly strong. Estates workforce resilience is weak, Facilities sickness is high and gaps remain in fire capacity, project certification, lift reliability, water controls and EBME compliance. Capital delivery is also dependent on timely approvals, procurement, access and decant arrangements. Moderate assurance is therefore appropriate, provided that future reporting demonstrates measurable recovery and earlier escalation where actions fall behind. It was agreed a proposal would be presented in December on the potential future model of the Estates & Facilities Service including an outsourcing option.
4.4 Health & Safety Update	√			N		The Health & Safety Committee has reviewed the principal health and safety risks and the controls in place up to August 2026. The Committee is assured that appropriate governance, monitoring and mitigation arrangements are operating across the Trust, supported

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

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DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						by established HTM safety subgroups and dedicated action plans. Progress is being made across the principal compliance areas. However, fire safety remains a significant risk, and further improvement is required in relation to the fire alarm cause-and-effect matrix, evacuation plans, fit testing and the completion of agreed actions. These matters remain subject to active oversight and escalation through the Committee. The Health & Safety Committee (H&SC) is programmed to meet every 2 months and recently met in September 2026. The HTM Safety sub-groups set up in 2023/24 continue to feed into the H&S Committee.
4.5 BAF Risk (Estate and Infrastructure)	√			N		In line with the recommendation, it was agreed that the risk score would remain at 20.
4.6 BAF Risk (Climate Change)	√			N		In line with the recommendation, it was agreed that the risk score would remain at 12.
4.7 BAF Risk (National Net Zero Strategy)						In line with the recommendation, it was agreed that the risk score would remain at 12.

BOARD OF DIRECTORS: 1 October 2026 **AGENDA ITEM: 6.1**

REPORT TO THE BOARD FROM: Performance & Finance Committee (PAF)

REPORT FROM: David Baines (PAF Chair)

DATE OF COMMITTEE MEETING: 24 September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
5.1 Report from Information Governance Steering Group)		√		Y		Whilst there were no formal escalations to PAF, it was agreed to provide some detail outside the meeting on some issues relating to the use of smart cards.

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Meeting Title: Trust Board Date: 1 October 2026			Agenda item: 6.2		
Report Title: M5 Integrated Finance Report					
Presented by: Tom Burton, Chief Finance and Infrastructure Officer and Interim Deputy CEO					
Prepared by: Beth Potton, Interim Operational Director of Finance					
Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**	√	

Executive Summary

Month 5 reported position is a £2.2m deficit which is £2.2m adverse to plan, now £5.2m adverse to plan YTD. The position is driven by an under performance against the PQP target, operational performance costs, and a prior period income adjustment.

- Underlying position c.£2.6m worse than reported due to additional activity costs and shortfall in PQP.
- PQP delivery was £1.4m in month against a plan of £2.6m, therefore delivering significantly below the target.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

BAF risk 5.2.

Recommendation

The Board is asked to note the month 5 financial position.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
X	X	X

Relevant legal/statutory issues

Impact Assessments

Quality	None identified
Equality, Diversity and Inclusion	None identified
Health inequalities	None identified
Previously Considered By	PAF – 24 September 2026
Appendices	

6.2

The Princess Alexandra Hospital NHS Trust

6.2

Executive Summary

The reported month 5 position is a £2.2m deficit, £2.2m adverse to plan. The YTD position is an £8.0m deficit, £5.2m adverse to plan driven by unfunded industrial action costs in month 1, operational performance costs, continuing cost pressures and an under performance on PQP delivery in month 4 and month 5.

Table 1: Summary financial results

	FY Budget £'m	Aug-26 Budget £'m	Aug-26 Actual £'m	Aug-26 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	421.4	34.8	34.7	(0.1)	175.1	177.0	1.9
Pass through Income	19.6	1.6	1.5	(0.2)	8.2	7.9	(0.2)
Income Total	**441.0**	**36.4**	**36.2**	**(0.3)**	**183.2**	**184.9**	**1.7**
Pay							
Substantive	(285.6)	(23.5)	(22.1)	1.4	(120.0)	(110.1)	10.0
Bank	(4.2)	(0.3)	(2.4)	(2.0)	(1.7)	(11.7)	(10.0)
Agency	0.0	0.0	(0.4)	(0.4)	0.0	(2.2)	(2.2)
Pay Total	**(289.8)**	**(23.8)**	**(24.8)**	**(1.0)**	**(121.8)**	**(124.1)**	**(2.3)**
Non-Pay							
Drugs & Medical Gases	(10.4)	(0.9)	(1.0)	(0.1)	(4.3)	(4.5)	(0.2)
Pass through expenditure	(19.6)	(1.6)	(1.5)	0.2	(8.2)	(7.9)	0.2
Supplies & Services - Clinical	(16.9)	(1.4)	(1.7)	(0.3)	(7.0)	(7.9)	(0.9)
Supplies & Services - General	(5.8)	(0.5)	(0.5)	0.0	(2.4)	(2.3)	0.1
All other non pay costs	(71.7)	(5.9)	(7.0)	(1.1)	(31.3)	(35.6)	(4.3)
Non-Pay Total	**(124.4)**	**(10.3)**	**(11.6)**	**(1.3)**	**(53.2)**	**(58.3)**	**(5.0)**
Financing & Depn							
Depreciation	(20.6)	(1.7)	(1.6)	0.2	(8.5)	(8.2)	0.3
PDC & Interest	(6.4)	(0.5)	(0.3)	0.2	(2.7)	(2.5)	0.1
Financing & Depn Total	**(27.0)**	**(2.3)**	**(1.9)**	**0.3**	**(11.2)**	**(10.7)**	**0.5**
Total	**(0.3)**	**0.0**	**(2.2)**	**(2.2)**	**(3.0)**	**(8.1)**	**(5.2)**
Technical Adjustment	0.3	0.0	0.0	0.0	0.1	0.1	0.0
Grand Total	**0.0**	**0.0**	**(2.2)**	**(2.2)**	**(2.9)**	**(8.0)**	**(5.2)**

Note: The 2026-27 full year plan includes £8.0m of deficit support funding which is non- recurrent.

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Workforce

Table 3: Workforce

	FY Budget £'000s	Aug-26 Budget £'000s	Aug-26 Actual £'000s	Aug-26 Variance £'000s	Aug-26 Actual %	Aug-26 Budget WTE	Aug-26 Actual WTE	Aug-26 Variance WTE
Pay								
Substantive	285,635	23,492	22,090	1,402	88.9%	4174	3,795	379
Bank	4,187	349	2,374	(2,025)	9.6%	0	376	(376)
Agency	(0)	(0)	386	(386)	1.6%	0	28	(28)
Pay Total	**289,821**	**23,840**	**24,850**	**(1,009)**	**100%**	**4,174**	**4,199**	**(25)**

- The Trust is overspent on pay in month 5 by £1.0m, increasing the YTD overspend to £2.3m which includes £0.4m of unfunded industrial action costs in month 1.

- Pay PQP delivery was strong in the first quarter however the majority has been delivered via non- recurrent slippage (vacancies) rather than recurrently reduced costs. There was an increase in the planned PQP savings in month 4 and 5 which has not been achieved, therefore causing the adverse variance to plan in month and YTD.

- Further agency reductions of 30% are required this financial year, and a 15% reduction in bank is also required. In month 5 this level of reduction has not been achieved. Bank and agency spend was required to be no more than 9.5% of total pay expenditure in month 3 to meet the target, however actual spend was 11.1% of total pay expenditure.

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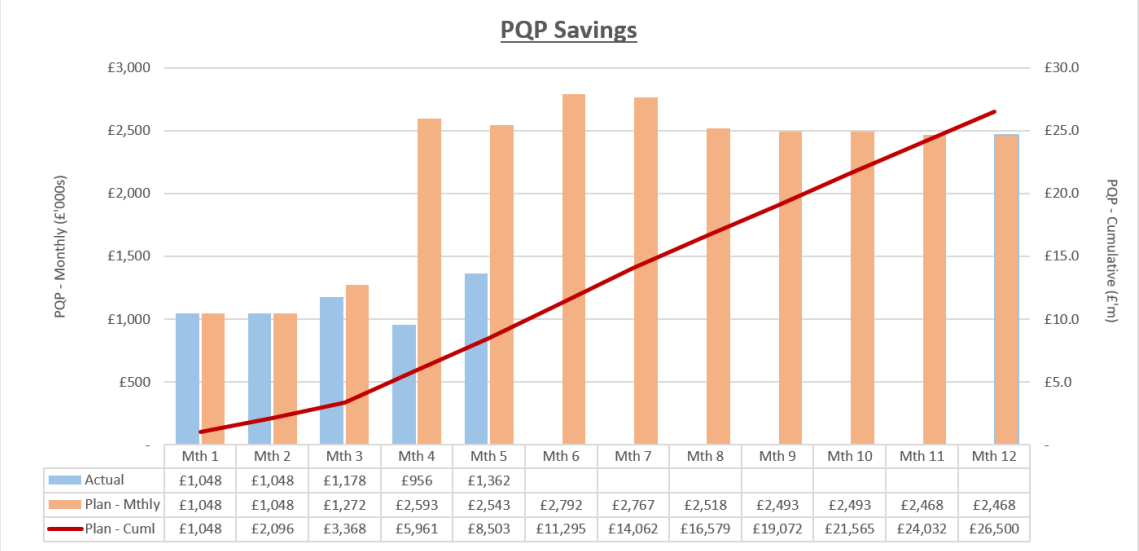
PQP

Graph 3: PQP savings



	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	£1,048	£1,048	£1,178	£956	£1,362							
Plan - Mthly	£1,048	£1,048	£1,272	£2,593	£2,543	£2,792	£2,767	£2,518	£2,493	£2,493	£2,468	£2,468
Plan - Cuml	£1,048	£2,096	£3,368	£5,961	£8,503	£11,295	£14,062	£16,579	£19,072	£21,565	£24,032	£26,500

The Trust PQP plan for the year is £26.5m, phased to increase from quarter 2.

The Trust delivered £1.4m PQP against a plan of £2.6m in month 5, significantly below the target. The target increased by £1.3m per month from quarter 2 as can be seen in the chart above, however a corresponding increase in savings has not been achieved.

Of the £26.5m PQP requirement:

- £19.1m (72%) is fully identified
- £6.4m remains unidentified

This level of unidentified and high risk delivery presents a material risk to financial sustainability.

6.2

The Princess Alexandra Hospital NHS Trust

Statement of Financial Position (SOFP)

Table 8: Statement of Financial Position (SOFP)

	Mar-26 £'m	Jul-26 £'m	Aug-26 £'m	Movement In Month £'m	Movement YTD £'m
Non-current assets					
Property, plant & equipment	209.5	211.5	211.0	(0.5)	1.5
Right of use assets	30.8	32.5	32.3	(0.2)	1.5
Intangible assets	33.9	31.2	30.8	(0.4)	(3.1)
Trade & other receivables	0.5	0.5	0.5	-	-
Non-current assets	**274.7**	**275.7**	**274.5**	**(1.2)**	**(0.2)**
Current assets					
Inventories	5.0	4.4	4.4	(0.1)	(0.7)
Trade & other receivables	14.2	20.8	21.3	0.5	7.1
Cash & cash equivalents	31.9	19.0	15.3	(3.7)	(16.6)
Current assets	**51.1**	**44.2**	**41.0**	**(3.3)**	**(10.2)**
Total assets	**325.8**	**319.9**	**315.5**	**(4.5)**	**(10.4)**
Current liabilities					
Trade & other payables	(56.1)	(54.4)	(52.3)	2.1	3.7
Provisions	(1.9)	(1.8)	(1.7)	0.1	0.2
Borrowings	(2.3)	(2.1)	(2.1)	-	0.2
Current liabilities	**(60.3)**	**(58.2)**	**(56.1)**	**2.2**	**4.1**
Net current assets/ (liabilities)	**(9.1)**	**(14.0)**	**(15.1)**	**(1.1)**	**(6.1)**
Total assets less current liabilities	**265.6**	**261.7**	**259.4**	**(2.3)**	**(6.3)**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(1.3)	(1.3)	(1.3)	-	-
Borrowings	(29.1)	(31.2)	(31.1)	0.1	(2.0)
Total non-current liabilities	**(30.4)**	**(32.4)**	**(32.4)**	**0.1**	**(2.0)**
Total assets employed	**235.2**	**229.3**	**227.1**	**(2.2)**	**(8.3)**
Total taxpayers' equity	**235.2**	**229.3**	**227.1**	**(2.2)**	**(8.1)**

Non-Current Assets:

- PPE reduced by £0.5m which is the excess of depreciation over expenditure in month, with spend driven by CDC and NHP but Estates activity still very low and significantly behind plan.
- ROU assets decreased by £0.2m, as a result of depreciation, with no changes to lease contracts in month.
- Intangible assets fell by £0.4m which is excess of amortisation over expenditure, with only staff recharges against the EHR phase 2 recognised in month.

Trade and Other Receivables increased by £0.5m during the month, primarily due to the raising of backdated charges. This increase was partially offset by a reduction in IT and Estates prepayments where annual invoices had been paid in previous months.

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Trade and Other Payables decreased by £2.1m during the month, driven by the settlement of brought-forward supplier balances.

Capital

YTD Capital expenditure is £5.4m against a plan of £8.9m. This is largely driven by a slow build-up of estates schemes which were evenly phased in the plan, with no further detail received to date.

Total anticipated capital funding has increased from £24.2m to £25.5m, driven by an increase in PDC to £9.8m. This is following discussions with NHSE around phasing forward some of the 4-year diagnostic equipment funding, which has been approved in principle pending formal approval of the business case, and notification from the Eastern Diagnostics Network of indicative allocation pending NHSE approval for expansion of CDS across Gastroenterology and Physiology.

6.2

Table 4: Capital Expenditure

	YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Internally Funded Schemes						
Estates & Facilities						
Estates Schemes	572	609	(37)	930	609	321
ITU	-	24	(24)	-	900	(900)
Backlog Maintenance	835	189	646	2,000	2,170	(170)
Phase 2 UTC Corridor Refurbishment	625	240	385	1,500	900	600
ED Fire Escape	-	-	-	-	600	(600)
Facilities	-	41	(41)	-	41	(41)
CDC						
Phase 1	420	422	(2)	895	851	43
Phase 2	1,350	1,699	(349)	3,243	2,862	381
Isilon Replacement	235	564	(329)	564	564	-
EHR, ICT & Information						
EHR Phase 2	665	594	71	1,728	1,639	89
Pathology Transformation	-	-	-	511	511	-
ICT Equipment	173	355	(182)	500	505	(5)
Digital Schemes	85	179	(94)	184	179	5
Corporate						
IFRS16 Leased Assets	-	-	-	-	-	-
New Hospital Programme	-	-	-	56	56	-
Other Corporate Schemes	-	-	-	400	308	92
Medical Equipment						
Planned Pathways	15	-	15	15	15	-
Family, Diagnostics & Community	113	(35)	148	113	78	35
Equipment (General)	272	(21)	293	1,087	2,407	(1,320)
Unallocated				1,939	469	1,469
Internally Funded Total	5,360	4,860	500	15,665	15,665	-
Externally Funded Schemes						
Estates & Facilities						
NHP	650	431	219	1,560	1,560	-
ED Main Entrance	625	2	623	1,500	1,500	-
Estates Safety Fund	1,625	134	1,491	4,006	4,006	-
IT						
CDS expansion	-	-	-	71	71	-
Medical Equipment						
Diagnostics	667	-	667	2,671	2,671	-
Externally Funded Total	3,567	567	3,000	9,808	9,808	-
TOTAL	8,927	5,427	3,500	25,473	25,473	-

NHS
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Trust Board (Public)
1 October 2026 **Agenda item: 6.3**

Report Title: Trust Integrated Performance Report for August 2026

Presented by: Anna Jebb

Prepared by: Zoe Collis

Purpose: *(please tick)*	**Approval/Decision**		**Information/Assurance**		X

Executive Summary

This paper presents the Trust's Integrated Performance Report (IPR) for August 2026, providing an overview of performance across the Patients, Performance, People, Population and Pounds pillars. The report highlights areas of sustained improvement, including delivery of the 12-hour emergency care standard, RTT incomplete pathways performance and low healthcare-associated infection rates.

Key areas requiring continued focus include diagnostic waits over six weeks, Cancer 62-day performance, Cancer Faster Diagnosis performance, emergency department 4-hour performance and delivery of the Cost Improvement Programme. Recovery plans remain in place across operational, clinical and financial performance areas and continue to be monitored through established governance arrangements.

- Maternity metrics have been reviewed and agreed with Director of Midwifery and Deputy Director of Midwifery. Phase 2 of maternity metrics are expected to be finalised and delivered in October's IPR (delivered in November).
- Health inequalities graph and accompanying narrative reviewed for accuracy.
- RAG rating methodology; The RAG rating is explained in the footer section of the Executive Summary – NHS National Oversight Framework (NOF) slide 2. An extension is requested to fully review the application to the Pounds Pillar metrics and will be provided in September's IPR.

Risks and Issues (including links to BAF/Corporate Risk Register/Other risk registers)

The metrics demonstrating concerning variation and requiring ongoing monitoring in August 2026 are:
Patients - Falls, total of Minor, Moderate and Severe
Patients - Falls with Harm per 1,000 Bed Days
Patients - Number of Complaints Open at Month End
Patients - Number of Complaints Closed Within 60 Day Target
Patients - Mixed Sex Accommodation Breaches
Patients - E-Coli
Performance - Percentage Waiting Over Six Weeks for a Diagnostic Test or Procedure
Performance - Cancer 62 Day Standard
People - Sickness absence
Pounds - Cost Improvement Programme (PQP) Variance to Plan
Pounds - Capital Spend - Variance to Plan

Recommendation

The Board is asked to note the report and discuss key areas of performance variation, risk and improvement.

Strategic Objectives

Rising Hope	Rising Communities	Rising Standards
X	X	X

Relevant legal/statutory issues

6.3

The Princess Alexandra Hospital NHS Trust

There are no direct legal or statutory issues arising from this paper. The Integrated Performance Report supports compliance with NHS regulatory and oversight frameworks through the monitoring of organisational performance.	
Impact Assessments	
Quality	Please state or None identified
Equality, Diversity and Inclusion	Please state or None identified
Health inequalities	Please state or None identified
Previously Considered By	PAF.24.09.26 and QSC.25.09.26
Appendices	M5 IPR

6.3

NHS
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Monthly Integrated Performance Report

Reporting period: August 2026

Your future • Our hospital

Executive Summary – NHS National Oversight Framework (NOF)

Rates of healthcare Associated infection (MRSA, C-DIFF & E-COLI Per 1000 bed days)
0.71
August 2026

Sickness Absence rate
5.0%
August 2026
Target: 4.50%

% of inpatients acquiring a new pressure ulcer
0.78%
August 2026

CQC safe inspection score
Requires Improvement
January 2026

% of people waiting over 6 weeks
31.6%
July 2026
Target: 20%

RTT Over 52-week waiters
377
July 2026
Target: 1% PTL (402)

National maternity survey score
8.2
February 2025
Latest data was in Feb 2025

NHS staff survey engagement theme score
6.56
December 2025
Latest data was in Dec 2025

Variance to Monthly Plan (000's)
-2218
August 2026

Cancer 28 days
70.9%
July 2026
Target: 80%

Summary Hospital Level Mortality Indicator
103.5
January 2026
Target: 100

RTT Incomplete Standards
68.5%
July 2026
Target: 67% (March 27)

% Patients treated within 4hrs
77.1%
August 2026
Target: 82%

Cost Improvement Plan (000's)
-1181
August 2026

Readmission rate 28 days
15.71%
August 2026

% Patient treated over 12hrs
7.08%
August 2026
Target: 11%

CQC Inpatient survey Satisfaction rate
7.4
September 2025
Latest data was in Sept 2025

% of inpatients referred in-house tobacco treatment Services who make a supported attempt to quit stop smoking
55%
August 2026

Under 18s elective wait list
10.1%
July 2026

Cancer 62 Days
60.2%
July 2026
Target: 80%

Executive Summary

Sickness Absence rate
5.0%
August 2026
Target: 4.50%

RTT Incomplete Standards
68.5%
July 2026
Target: 67% (March 27)

% Patients treated within 4hrs
77.1%
August 2026
Target: 82%

% of people waiting over 6 weeks
31.6%
July 2026
Target: 20%

Cancer 62 Days
60.2%
July 2026
Target: 80%

What is going well

- **RTT Incomplete Standard** exceeded trajectory, achieving **68.5%** against the March 2027 trajectory target of 67%, demonstrating continued progress in elective recovery
- **12-hour emergency care performance** remains better than target, with 7.08% of patients treated over 12 hours against a target of 11%
- **Healthcare associated infection rates** remain low, maintaining positive performance in patient safety measures
- **Positive variation on DNA** rate since last October and currently below 5%
- **Staff Turnover** – 6.6% and on decreasing trend
- **Complaints Closed Per month** – positive variation, and a couple of positive variation points also on closed within 60 days, although still an Alert metric for the moment.

To note

- **Diagnostic waiting times** remain below target, with 31.6% of patients waiting over six weeks against a target of 20%.
- **Cancer 62-day performance** remains below the national standard, achieving 60.2% against the 80% target.
- **Four-hour emergency care performance** remains below trajectory, achieving 77.1% against the local target of 82%
- **Productivity and Quality Programme (PQP)** delivery remains below plan, requiring continued focus to achieve the planned savings target.

Supporting Information – what is an SPC Chart?

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

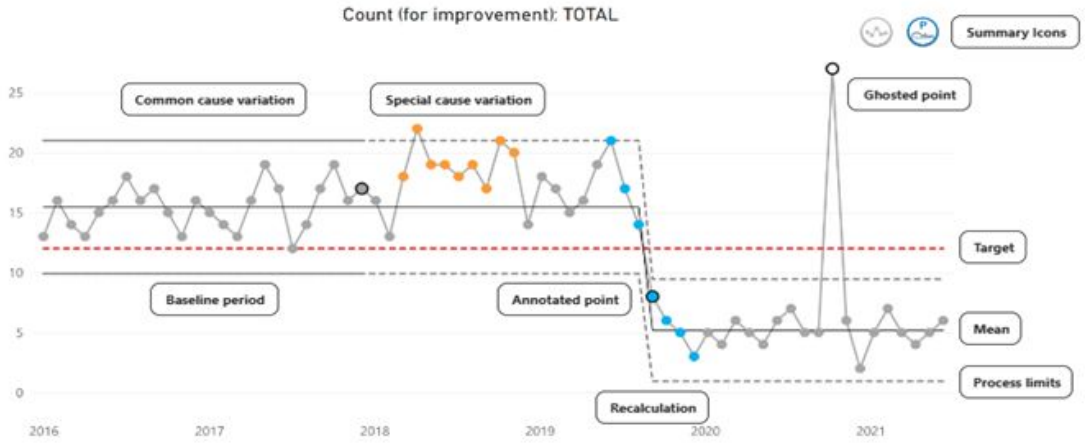
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines
Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

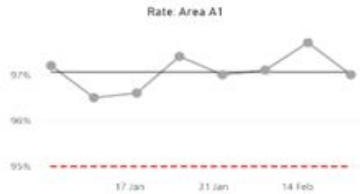
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

Annotations
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.

Purple dots
It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.



Supporting Information – SPC Icons

Variation	Assurance: P	Assurance: ?	Assurance: F
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.
	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.

All Matrix

VARIATION	ASSURANCE: Will consistently pass if nothing changes	ASSURANCE: Neither pass or fail consistently	ASSURANCE: Will consistently fail if nothing changes
H / L	Pts. - MRSA Perf. - Outpatient DNA Rate Pple. - Staff Turnover Voluntary Pple. - Bank Staffing Spend	Pts. - Compliments Pts. - No. of Complaints Closed per Month Pts. - Bed Occupancy excluding GIB, HM, CHAM, LAB, OBS/MID & SAM Pts. - Mortality - HSMR Pts. - Tissue Viability - (Reportable P/U Cat 2,3,4 & Mucosal) per 1000 bed days Pts. - Total Pressure Ulcers Cat 2 & Mucosal per 1000 bed days Pts. - Patients Detained under MHA Pts. - Smoking rates - At Booking Perf. - Percentage of Handovers over 45 Minutes Pple. - Statutory & Mandatory training Popn. - Estates Responsiveness (Priority 2 - Urgent) Pnds. - Variance to Monthly Plan	Pts. - Mortality - SHMI Pts. - Continuity of Carer Perf. - Percent of episodes moved or discharged to patient-initiated outpatient follow-up pathway as an outcome of their attendance Perf. - RTT Incomplete Standard Perf. - RTT over 52 week waiters Perf. - RTT PTL Size Perf. - RTT over 65 week waiters Perf. - Percentage treated within 4 hours in ED Pple. - Appraisals - Non Medical
	Perf. - Outpatient New to Follow-up ratio Pple. - Bank Staffing Spend	★ Pts. - Falls per 1000 bed days Pts. - C-DIFF Hospital onset healthcare associated Pts. - Hand Hygiene Pts. - Klebsiella Pts. - Pseudomonas Pts. - MSSA Pts. - Complaints - New Pts. - Complaints per 1000 bed days Pts. - Percentage of complaints where an extension has been agreed Pts. - PALS Pts. - Percentage Complaints Closed in Month under 60 Working Days Pts. - Friends and Family Test (FFT) Recommender Score Pts. - Percentage of Patients Completing Friends and Family Test (FFT)	Pts. - Number of Complaints closed within 60 day Target Perf. - Percentage waiting for a diagnostic test or procedure over 6 weeks
H / L	Perf. - Outpatient New to Follow-up ratio Perf. - RTT Percentage Under 18 Weeks Waiting for a 1st OPA Perf. - Non elective LOS – acute Perf. - Overnight total general and acute bed occupancy %	Pts. - Falls - Total of Minor, Moderate & Severe Pts. - Falls with Harm per 1000 Bed Days Pts. - E Coli Pts. - Number of Complaints Open at Month End Pple. - Sickness Absence Pnds. - Cost Improvement Plan - Variance to Plan Pnds. - Capital Spend - Variance to Plan Pts. - Mixed Sex Accommodation breach	Perf. - Cancer 62 Day

★
Pts. - Tissue Viability - (Pressure Ulcers Grade 3 & 4) per 1000 Bed Days
Pts. - Patient Safety Incident Investigations
Pts. - Mental Health Patients PAH
Pts. - Breast feeding rates - At delivery (NOT including mixed feeding)
Pts. - Smoking rates - At Delivery
Pts. - Births
Pts. - Still Births per 1000 Births
Pts. - Triage Initial Assessment within 15 min
Perf. - Cancer 28 Day
Perf. - Cancer 31 Day
Perf. - Over 12Hrs ED
Perf. - Average Ambulance handover time
Perf. - Percentage of Handovers over 15 Minutes
Pple. - Agency Staffing Spend
Pple. - Vacancy Rate
Popn. - Domestic Services (Cleaning) Very Risk High
Popn. - Domestic Services (Cleaning) High Risk
Popn. - Difference in days from RTT (Male:Female)
Popn. - Difference in days from RTT (BAME:White)
Popn. - Difference in days from RTT (IMD 1-3:IMD 8-10)
Pnds. - Bank Spend - Variance to Plan
Pnds. - Agency Spend - Variance to Plan
Pnds. - Cash Balance - Variance to Plan

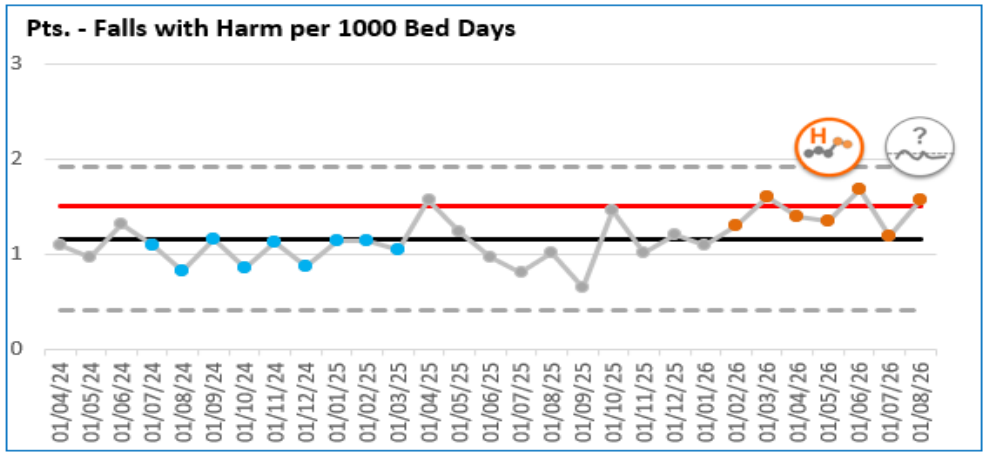
Pts. = Patients Pillar
Perf. = Performance Pillar
Pple. = People Pillar
Popn. = Population Pillar
Pnds. = Pounds Pillar

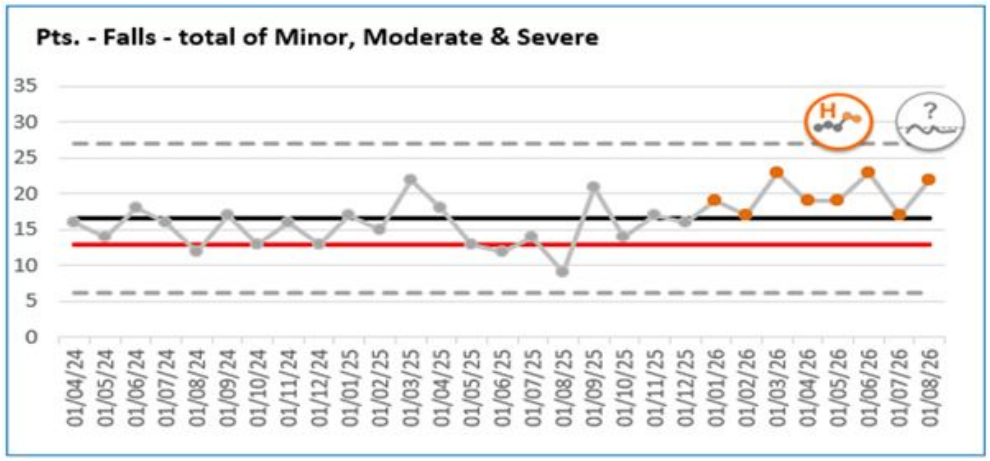
PATIENTS

Integrated Performance Report

Patient Pillar – Exception SPC

RISE: Standards





Narrative:
Lead: Andy Dixon/Sharon Cruse

Issue: Falls with harm per 1,000 bed days remain above the SPC mean and target. The increase is predominantly driven by falls resulting in minor harm, rather than moderate or severe harm, providing important context to the current deterioration in the overall harm rate.

Actions / next steps: Falls with harm continue to be reviewed through SWARM and thematic analysis to identify recurring themes and areas of concern. Targeted ward support and scrutiny of key falls prevention measures will continue, with learning from post-fall reviews shared through established governance routes.

Timeline: Harm rates and severity will continue to be monitored monthly through the Improving Essential Care – Falls Group, with quarterly reporting to Patient Safety Group. The expected trajectory is a sustained reduction in falls with harm towards the SPC mean and target.

Narrative:
Lead: Andy Dixon/Sharon Cruse

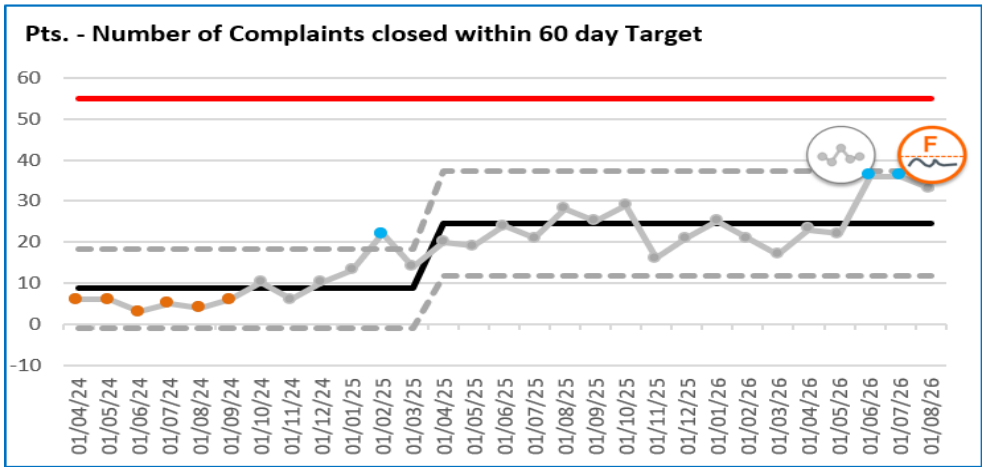
Issue: Total falls remain above the long-term SPC mean, indicating a sustained increase in incidents. Review of harm severity indicates that the increase is predominantly attributable to falls resulting in minor harm, rather than moderate or severe harm.

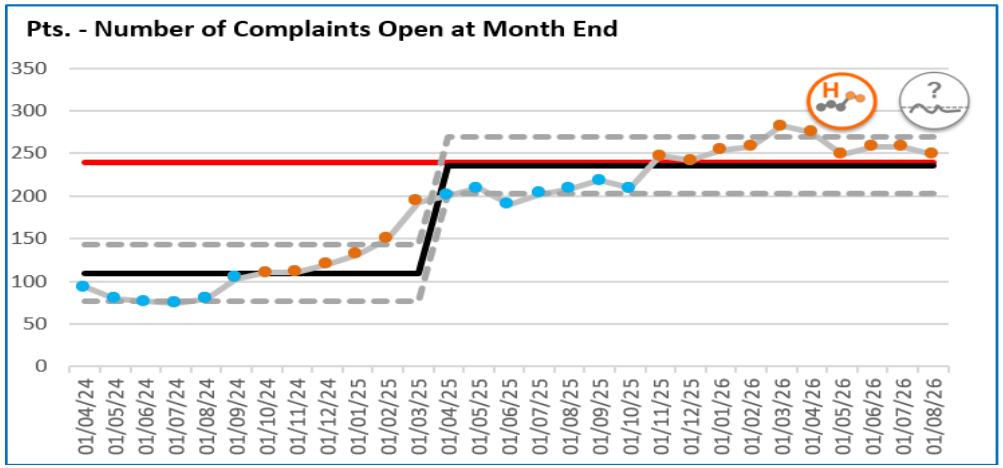
Actions / next steps: SWARM and thematic review of areas of concern continues to identify recurring contributory factors and patients at greatest risk. Targeted support is being provided to wards with higher rates, with scrutiny of risk assessment compliance, personalised falls prevention interventions and learning from post-fall reviews.

Timeline: Performance and delivery of improvement actions will continue to be monitored monthly through the Improving Essential Care – Falls Group, with quarterly reporting to Patient Safety Group. Improvement will be evidenced by a sustained reduction in total falls towards the SPC mean and target

Patient Pillar – Exception SPC

RISE: Standards





Narrative:
Lead: **Shahid Sardar**

Actions / next steps: Clear evidence of continuing improvements in number of complaints closed within 60DT. Process improvements on track to achieve required level.

Issue: Continuing increase in volume of complaints per calendar month. AI generated complaints.

Timeline: March 2027

Narrative:
Lead: **Shahid Sardar**

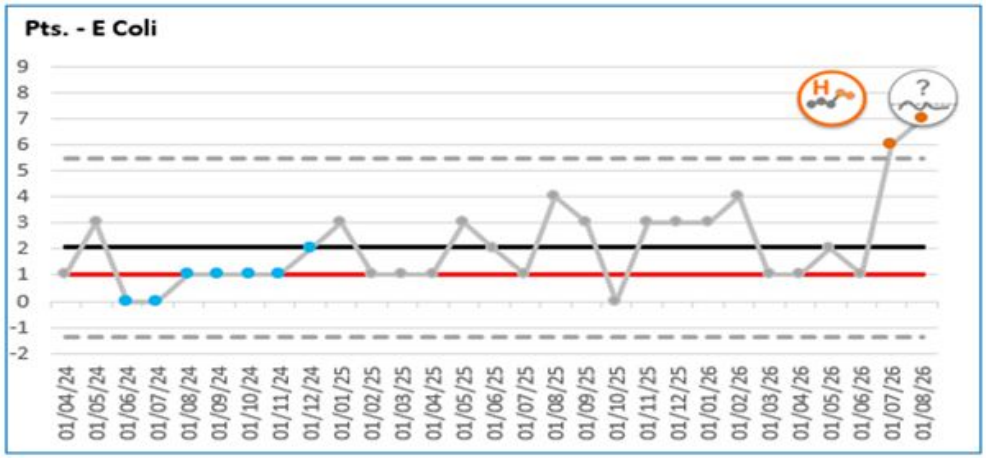
Actions / next steps: Continue to implement planned changes for process improvements, work planned with PPD.

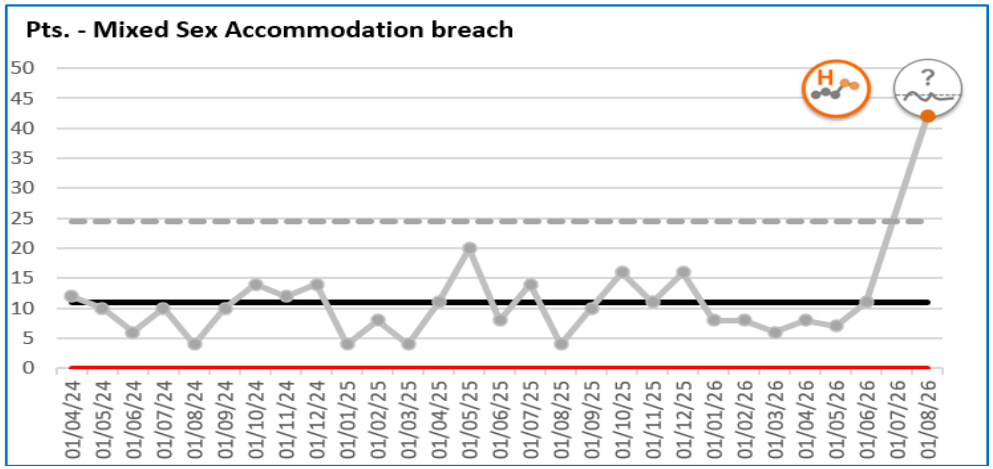
Issue: Increase in volume has not yet settled.

Timeline: October 2026.

Patient Pillar – Exception SPC

RISE: Standards





Narrative:
Lead: Jenny Kirsh

Actions / next steps:
Some bacteraemia cases in last year have occurred post prostate biopsy, need to carefully study if increasing anti-microbial resistance is contributing to prophylactic antibiotics given prior to biopsy being ineffective.
Issue:
E-coli bacteraemia numbers increased from 1 base in June (unusually low), to 6 cases in July and 7 cases in August. Case numbers so far for September is just 1 case, which is encouraging. Cumulative rate YTD is 85.41, compared to East of England 139.87.
Timeline:
We are looking at possible delays in surgery for renal stones and gall stones being a reason for patients presenting with bacteraemia. Analyse July & August in detail, however above risk factors are ongoing and have not suddenly changed in last 2 months. Also need to see effect of all the QMLR data being entered by 6th Oct, which is an omission from the lab, and being corrected.

Narrative: George Hopcroft
Lead: Polly Read

Actions / next steps:

Issue: There was an incredible rise in MSA breaches for the month of August 2026. I believe this is due to the fact that ICU is currently being refurbished, which started midway through August, and we are only using HDU and F-Bay in Henry Moore which has made it a lot more difficult to avoid breaches with the limited number of beds we have.

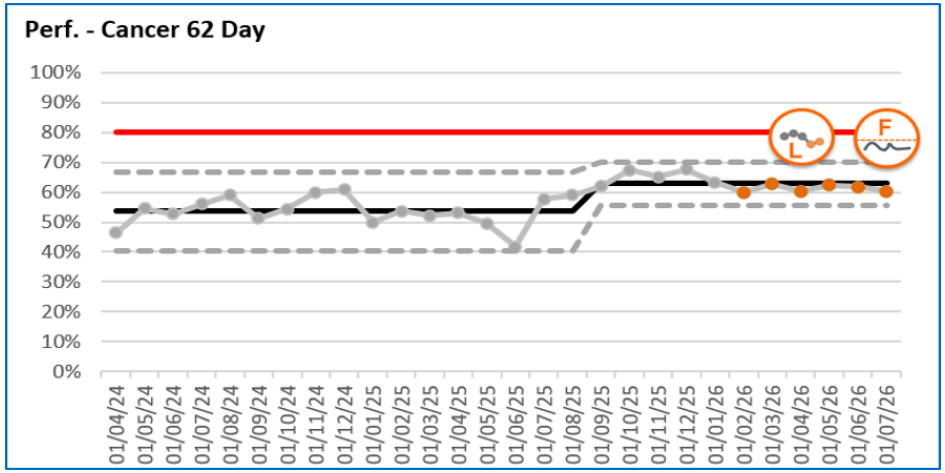
Timeline:

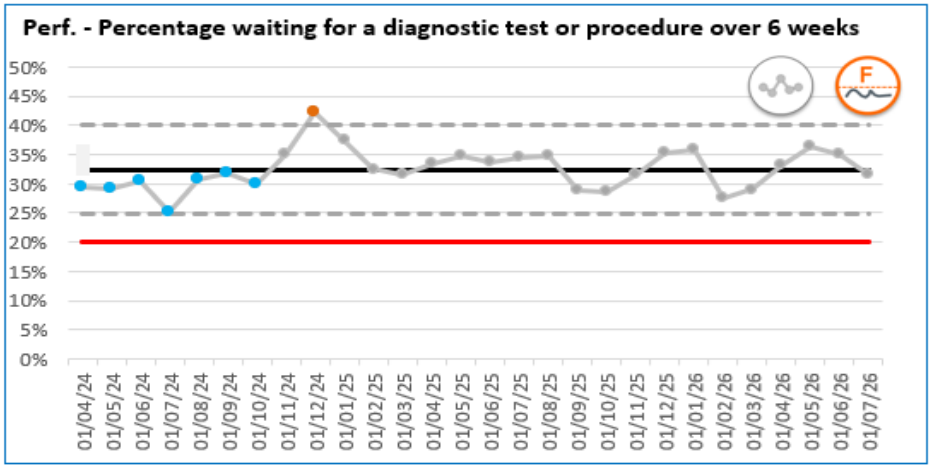
PERFORMANCE

Integrated Performance Report

Performance Pillar – Exception SPC

RISE: Standards





Narrative

Lead: Anna Jebb /Rebecca Gildea

Actions / next steps: 62-day performance remains below trajectory, and delivery forecasts have been revised to reflect current performance. Recovery actions in Breast are beginning to deliver improvement, with performance increasing by 4.5% between Month 2 and Month 3. The principal risks to delivery remain Urology and Dermatology. In Urology, executive approval has been secured for an insourcing recovery model with Xyla. The haematuria pathway is planned to go live on 12 September, with the prostate pathway expected to mobilise in October. In Dermatology, a recovery trajectory is being finalised, incorporating weekend insourcing for minor operations and additional weekday capacity within the existing workforce.

Issue: Recovery plans for Breast, Urology and Dermatology have been incorporated into a revised Trust 62-day forecast following performance below plan. Based on the current recovery assumptions, the Trust remains forecast to achieve the national 62-day standard of 80% by March 2027. An accelerated recovery trajectory for Dermatology is currently being developed and, subject to agreement, will be reflected in a future forecast update.

Timeline: Achievement of the national 62-day standard (80%) by March 2027.

Narrative

Lead: Anna Jebb /Rebecca Gildea

Actions / next steps: Improved performance in Endoscopy modalities due to comprehensive waiting list validation and data cleansing exercise alongside maximised utilisation of both weekday and weekend insourcing capacity. Further improvements are anticipated in Audiology following validation activity and mutual aid which is expected to be reflected in future reporting periods.

Issue: July DM01 performance achieved 68.41% representing a 3.34% improvement against June's performance. MRI performance improved considerably to 67.55% (from 55.25%), while CT achieved 88.98% remaining just below trajectory. Ultrasound reported 72.52% a slight decline from 73.72% in June. Performance has improved significantly across all Endoscopy modalities with Colonoscopy achieving 96.74% and both Gastropscopy and Flexible sigmoidoscopy achieved 95.65%. Cystoscopy achieved 50% but remains ahead of trajectory. Audiology continues to show a sustained improvement at 24.23% and remains above trajectory. Echocardiography maintained strong performance at 95.92% contributing positively to the Trust's overall DM01 position.

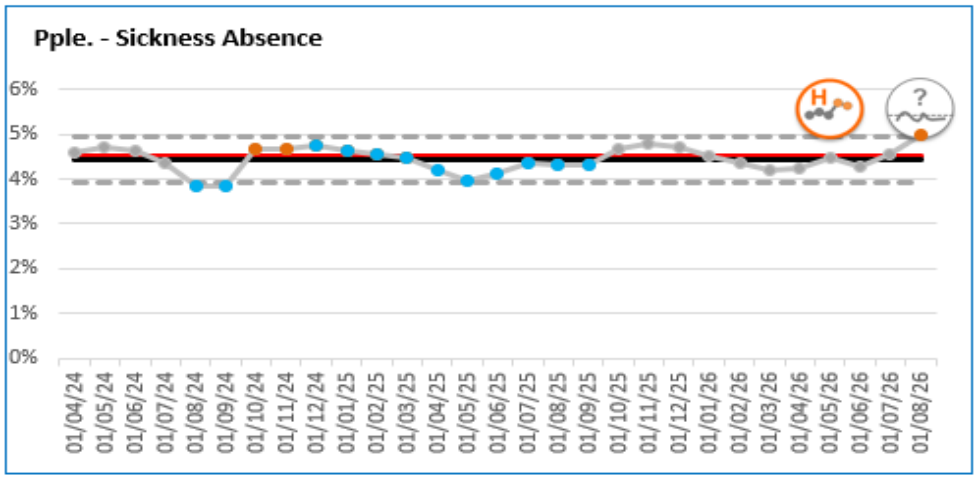
Timeline: Recovery trackers with RAG ratings are in place and monitored weekly against agreed recovery trajectories to identify and address performance deterioration.

PEOPLE

Integrated Performance Report

People Pillar – Exception SPC

RISES Hope



Narrative:
Lead: Ellie Manlove

Actions / next steps:

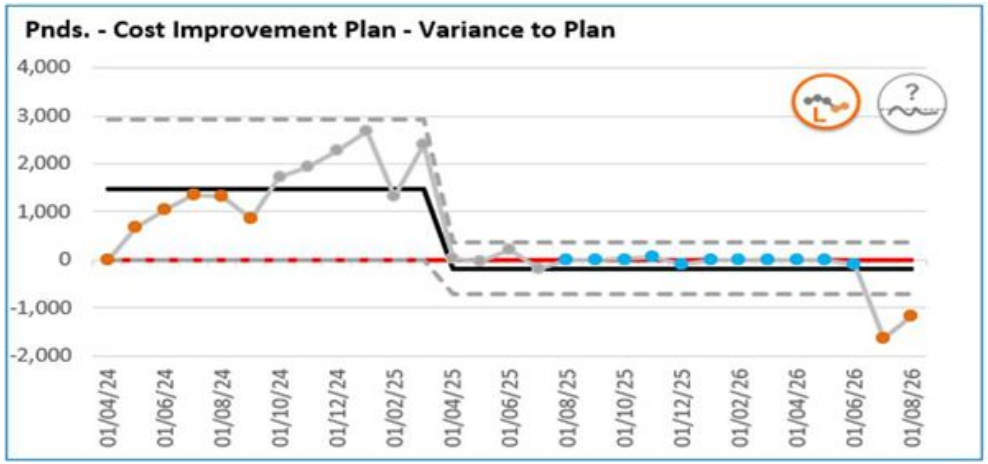
- Current work relating to long term sickness is currently underway. A deep dive has been carried out, and individual managers have been contacted for any staff member that is currently on long term sickness to ensure that this is being managed, and the appropriate referrals are made.
- Sickness clinics are scheduled for some divisions however due to gaps with the employee relations team this will be delayed for all divisions.
- Timely people information is being disused with a view that this is implemented in the coming months

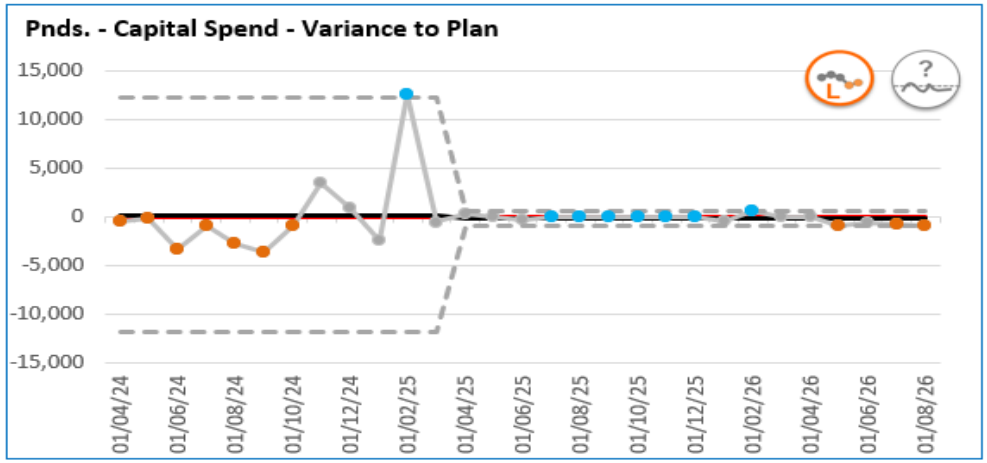
POUNDS

Integrated Performance Report

Pounds Pillar – Exception SPC

RISE: Standards





Narrative
Lead: Bethany Potton

Actions / next steps: Divisions have been asked to produce recovery plans. Continued focus on identification of schemes via PQP sessions.

Issue: Recorded PQP delivery has not delivered to planned levels in M5. The target increased from quarter 2 and a corresponding increase in savings has not been realised. Clinical divisions are currently underperforming against their targets predominantly due to continued costs pressures of which includes spending on delivery of operational performance.

Timeline: 30th September 2026

Narrative
Lead: Bethany Potton

Actions / next steps: Estates have been asked to produce monthly capital forecasts for all projects to understand profiling and risk of slippage. EBME have been provided a rough figure to work to when pulling equipment refresh plans together, with a request to work with divisions to get business cases in as soon as possible.

Issue: Capital spend remains within plan; however additional work needs to be done to refine forecasts at a detailed level.

Timeline: 30th September 2026

POPULATION - No metrics in exception

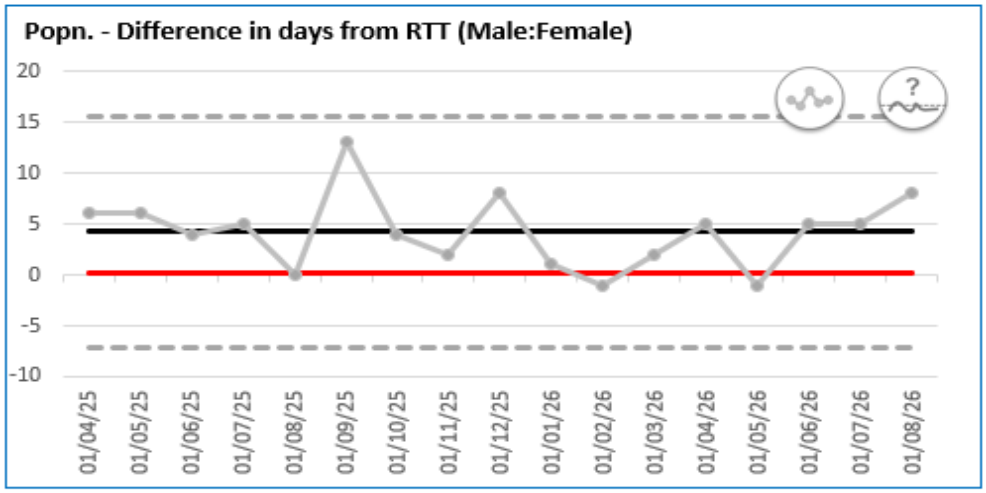
Integrated Performance Report

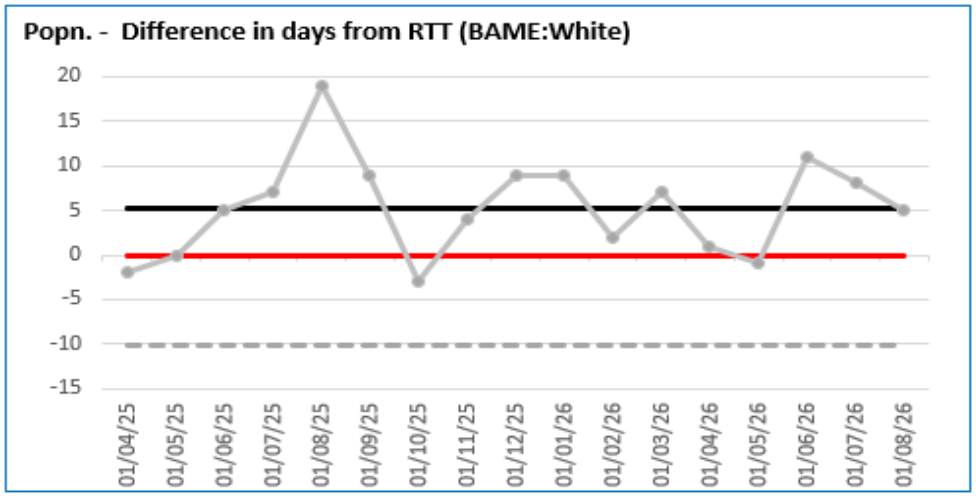
Inequalities

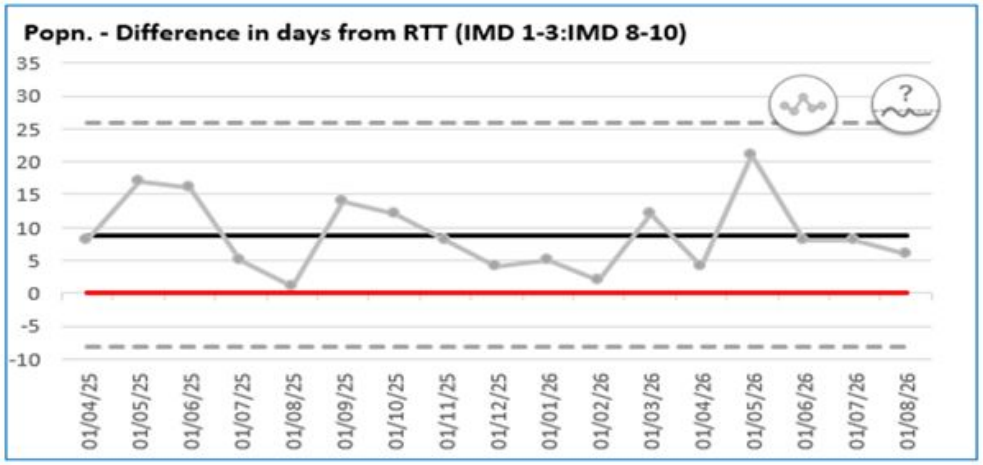
Integrated Performance Report

The Princess Alexandra Hospital NHS Trust | Prepared by Information Team | paht.information@nhs.net | v1.0

Inequalities SPC







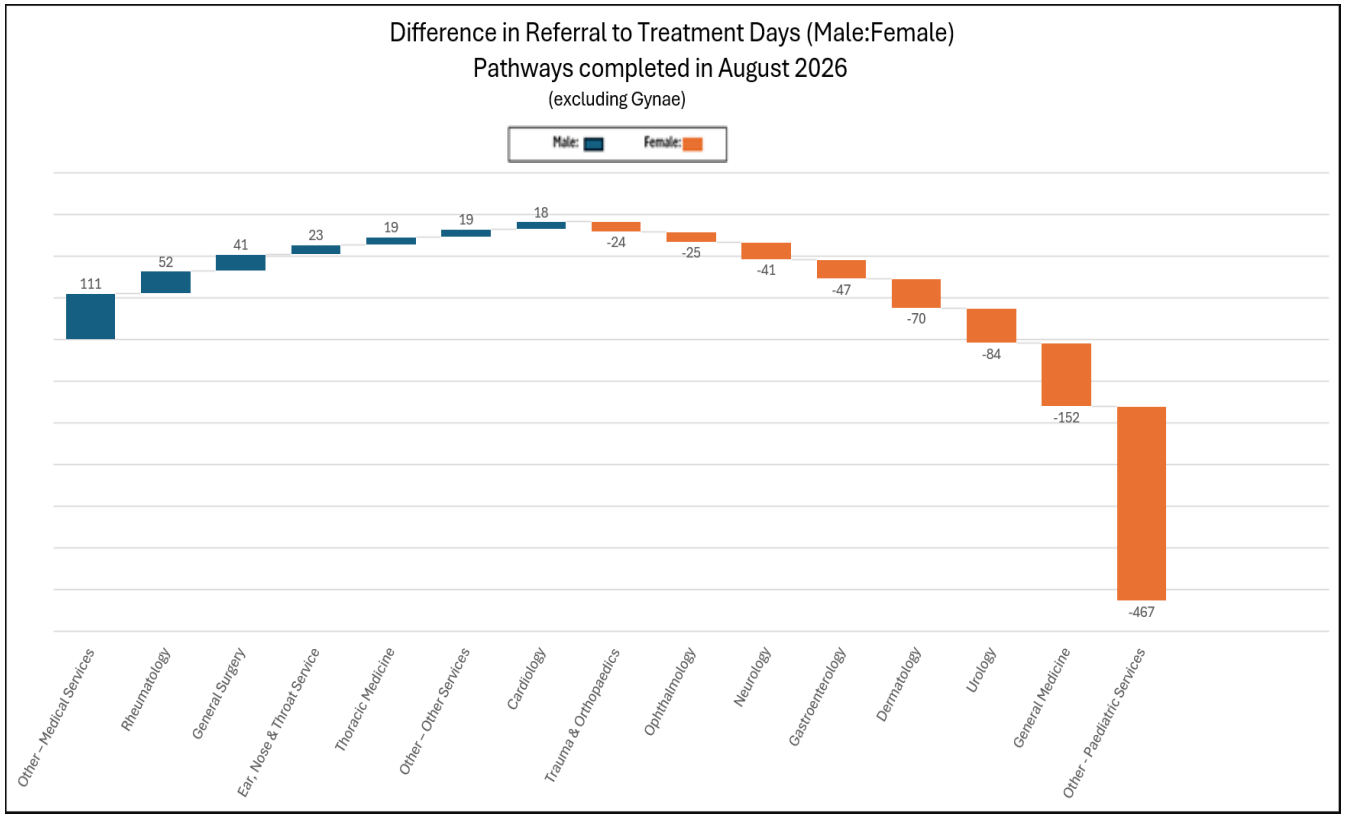
Narrative:
Lead: Anna Jebb

Actions / next steps:
Continue monthly inequalities monitoring.
Undertake specialty deep-dives where variation persists.
Ensure recovery plans consider equality impacts.

Issue:
Variation in RTT waits remains evident across some patient groups and specialties

Timeline
Ongoing monthly review

Inequality Signals – Specialty Split



Male: Female

This chart compares how many days, on average, Male and Female spent on the RTT pathway, highlighting where one group waited longer than the other.

Key: The bars indicate the average difference in Referral to Treatment (RTT) pathway days between Male and Female patients.

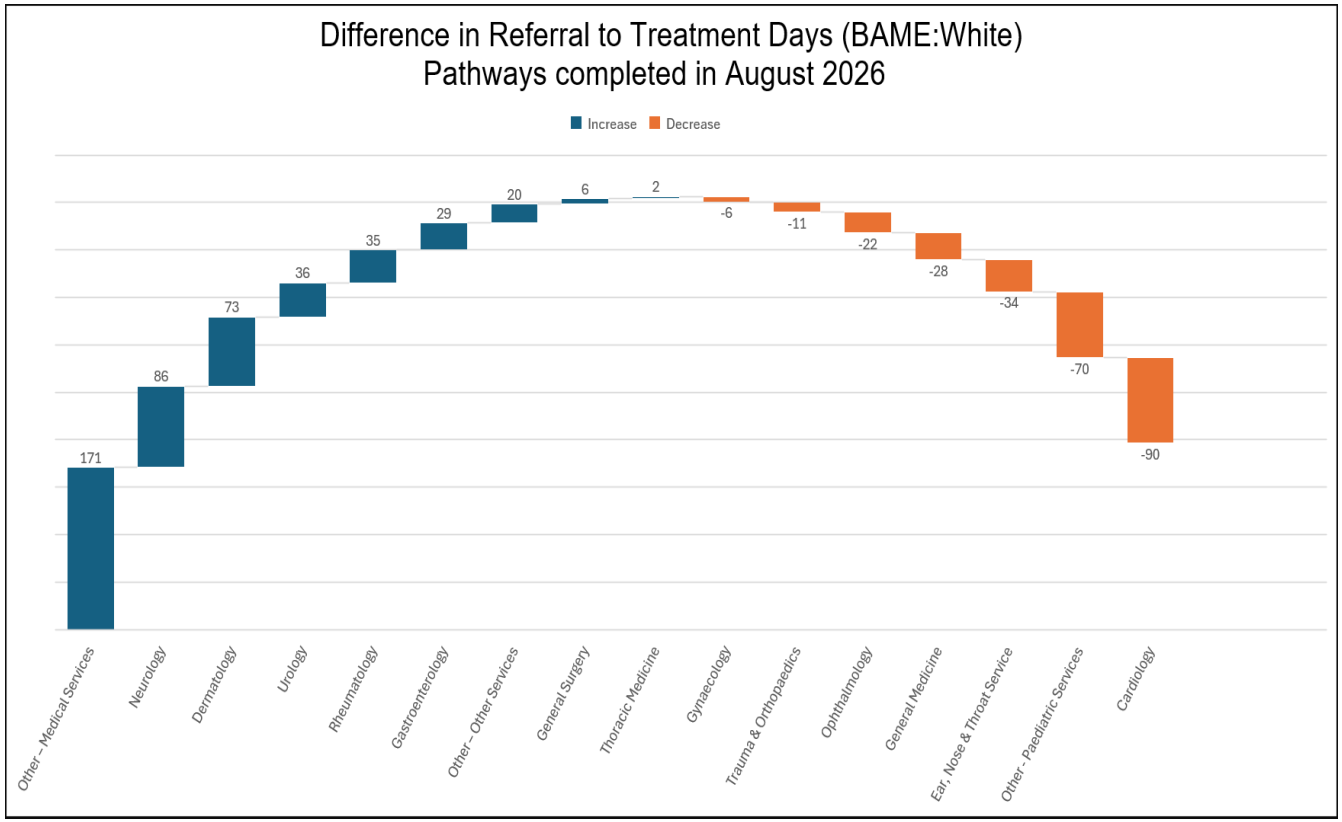
The blue bars indicate specialties where Male patients waited longer on average than Female patients.

The orange bars indicate specialties where Female patients waited longer on average than Male patients.

In August 2026, gender differences in RTT performance varied considerably across specialties. Male patients experienced longer waits in Other Medical Services (+111 days), Rheumatology (+52 days), General Surgery (+41 days), Ear, Nose & Throat Service (+23 days), Thoracic Medicine (+19 days), Other Services (+19 days) and Cardiology (+18 days).
Female patients experienced longer waits in Other Paediatric Services (-467 days), General Medicine (-152 days), Urology (-84 days), Dermatology (-70 days), Gastroenterology (-47 days), Neurology (-41 days), Ophthalmology (-25 days) and Trauma & Orthopaedics (-24 days).

The most pronounced disparities were observed in Other Paediatric Services, where Female patients waited substantially longer than Male patients, and in Other Medical Services, where Male patients experienced the longest waits compared with Female patients.

Inequality Signals – Specialty Split



BAME: White

This chart compares the average number of days that patients from ethnic minority backgrounds and patients from White ethnic groups spent on the Referral to Treatment (RTT) pathway, highlighting variation in waiting times between the two groups.

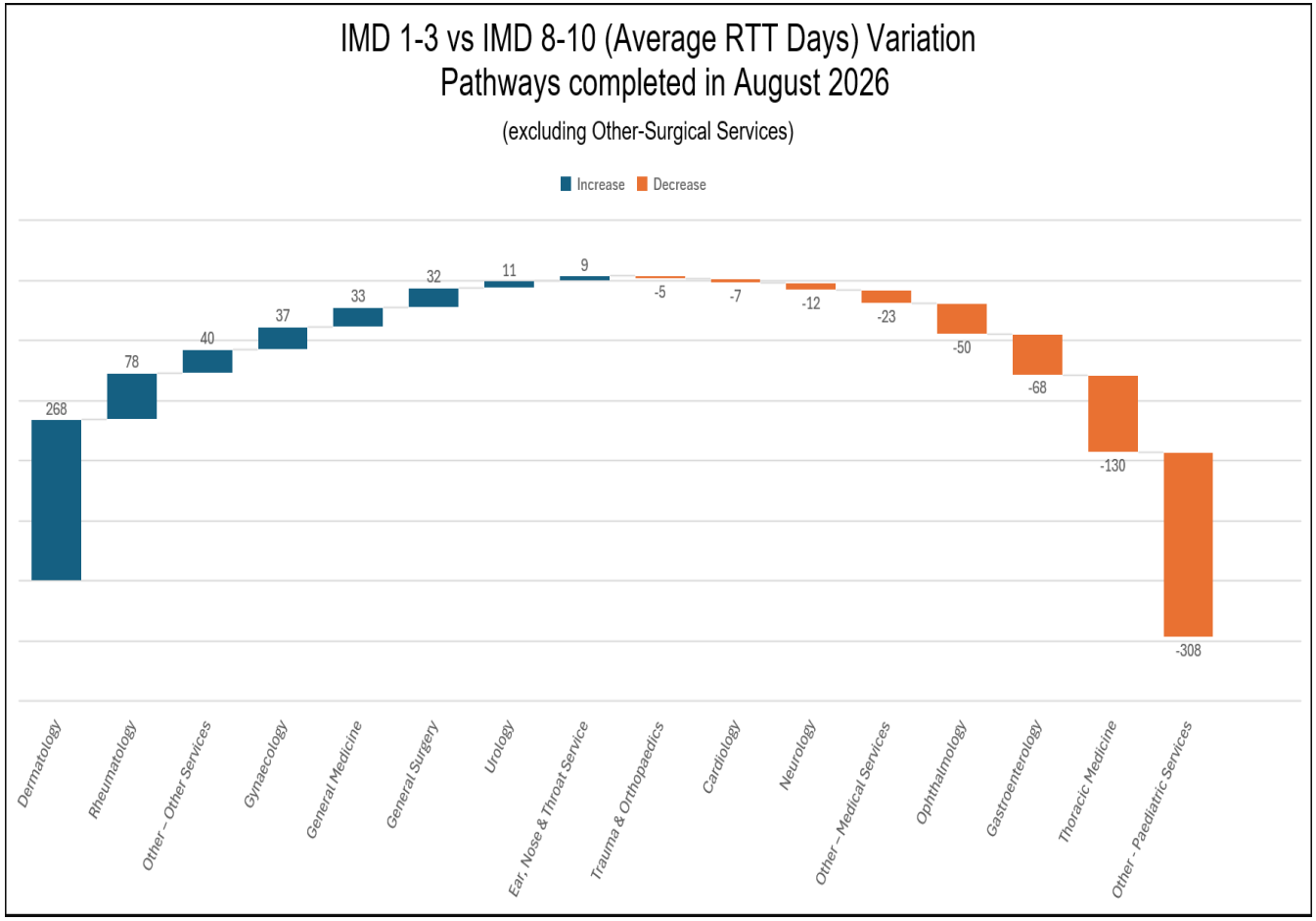
Key: The bars show the average difference in RTT pathway days between patients from ethnic minority backgrounds and patients from White ethnic groups.

Blue bars indicate specialties where patients from ethnic minority backgrounds waited longer on average than patients from White ethnic groups.

Orange bars indicate specialties where patients from White ethnic groups waited longer on average than patients from ethnic minority backgrounds.

In August 2026, differences in RTT waiting times between patients from ethnic minority backgrounds and patients from White ethnic groups varied across specialties. Patients from ethnic minority backgrounds experienced longer average waits in Other Medical Services (+171 days), Neurology (+86 days), Dermatology (+73 days), Urology (+36 days), Rheumatology (+35 days), Gastroenterology (+29 days), Other Services (+20 days), General Surgery (+6 days) and Thoracic Medicine (+2 days).Patients from White ethnic groups experienced longer average waits in Cardiology (-90 days), Other Paediatric Services (-70 days), Ear, Nose and Throat Services (-34 days), General Medicine (-28 days), Ophthalmology (-22 days), Trauma and Orthopaedics (-11 days) and Gynaecology (-6 days).
The largest differences were observed in Other Medical Services, where patients from ethnic minority backgrounds experienced substantially longer waits than patients from White ethnic groups, and in Cardiology, where patients from White ethnic groups experienced longer waits than patients from ethnic minority backgrounds.

Inequality Signals – Specialty Split



IMD 1-3 : IMD 8-10

This chart illustrates the difference in average Referral to Treatment (RTT) pathway days between patients residing in areas of higher deprivation (IMD 1-3) and those residing in areas of lower deprivation (IMD 8-10).

Key: The bars represent the difference in average RTT pathway days between deprivation groups.

Blue bars indicate specialties where patients living in areas of higher deprivation (IMD 1-3) experienced longer average waits than patients living in areas of lower deprivation (IMD 8-10).

Orange bars indicate specialties where patients living in areas of lower deprivation (IMD 8-10) experienced longer average waits than patients living in areas of higher deprivation (IMD 1-3).

In August 2026, variation in average RTT pathway waiting times was observed across specialties. Patients living in areas of higher deprivation (IMD 1-3) experienced longer average waits in: Dermatology (+268 days) | Rheumatology (+78 days) | Other Services (+40 days).

Patients living in areas of lower deprivation (IMD 8-10) experienced longer average waits in:
Other Paediatric Services (-308 days) | Thoracic Medicine (-130 days) | Gastroenterology (-68 days)

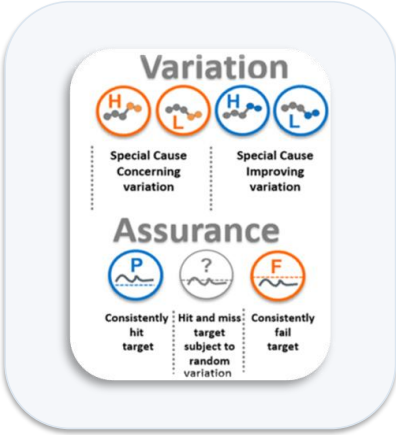
The largest variation was observed in Other Paediatric Services, where average RTT pathway days were higher for patients living in areas of lower deprivation, and in Dermatology, where average RTT pathway days were higher for patients living in areas of higher deprivation. These findings highlight specialty-level variation in RTT waiting times across deprivation groups and support ongoing monitoring of potential health inequalities in access to elective care.

Executive

Integrated Performance Report

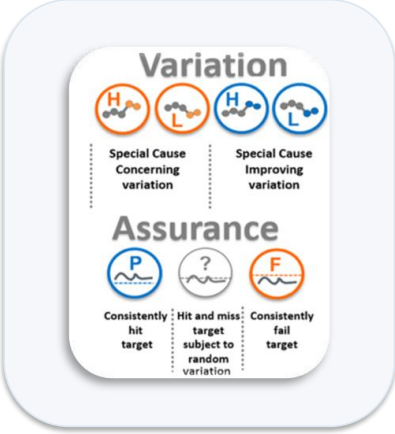
Summary Sheet (1 of 6)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pts. - Falls - total of Minor, Moderate & Severe	Aug 26	22	13	H	?	17	6	27
Pts. - Falls per 1000 bed days	Aug 26	5.8	6.0		?	5.4	3.8	7.0
Pts. - Falls with Harm per 1000 Bed Days	Aug 26	1.6	1.5	H	?	1.2	0.4	1.9
Pts. - C-DIFF Hospital onset healthcare associated	Aug 26	3	2		?	3	-1	8
Pts. - E Coli	Aug 26	7	1	H	?	2	-1	5
Pts. - Hand Hygiene	Jul 26	93.0%	95.0%		?	92.6%	86.8%	98.4%
Pts. - Klebsiella	Aug 26	2	1		?	1	-2	4
Pts. - Pseudomonas	Aug 26	0	1		?	0	-1	2
Pts. - MRSA	Aug 26	0	1	L	P	0	0	1
Pts. - MSSA	Aug 26	4	1		?	1	-2	4
Pts. - Complaints - New	Aug 26	52	56		?	58	24	93
Pts. - Number of Complaints closed within 60 day Targ	Aug 26	33	55		F	24	12	37
Pts. - Number of Complaints Open at Month End	Aug 26	249	240	H	?	236	202	269
Pts. - Complaints per 1000 bed days	Aug 26	4	4		?	4	2	7
Pts. - Percentage of complaints where an extension h	Aug 26	42.0%	50.0%		?	49.6%	36.7%	62.4%
Pts. - PALS	Aug 26	380	350		?	408	280	536
Pts. - Compliments	Aug 26	53	0	H	?	13	-14	41
Pts. - No. of Complaints Closed per Month	Aug 26	64	55	H	?	40	14	65
Pts. - Percentage Complaints Closed in Month under 6	Aug 26	51.6%	52.0%		?	46.0%	14.7%	77.3%
Pts. - Friends and Family Test (FFT) Recommender Sco	Aug 26	83.5%	75.0%		?	81.8%	71.2%	92.5%
Pts. - Percentage of Patients Completing Friends and F	Aug 26	2.8%	3.0%		?	3.1%	2.0%	4.2%
Pts. - Bed Occupancy excluding GIB, HM, CHAM, LAB, OE	Aug 26	88.5%	92.0%	L	?	91.7%	87.5%	95.9%
Pts. - Mixed Sex Accommodation breach	Aug 26	42	0	H	?	11	-2	24
Pts. - Mortality - HSMR	Apr 26	94.7	100.0	L	?	103.2	98.5	108.0
Pts. - Mortality - SHMI	Mar 26	101.9	100.0	L	F	108.2	104.0	112.3



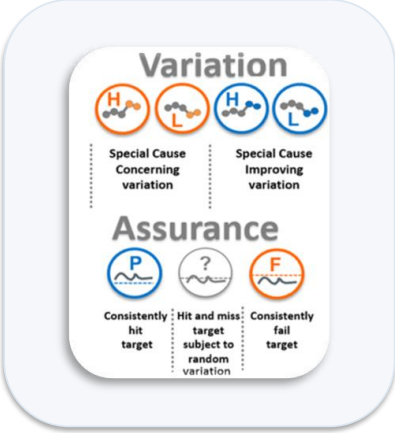
Summary Sheet (2 of 6)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pts. - Tissue Viability - (Pressure Ulcers Grade 3 & 4) per 1000 Bed Days	Aug 26	0.3	1.0		?	0.5	-0.2	1.2
Pts. - Tissue Viability - (Reportable P/U Cat 2,3,4 & Mucosal) per 1000 b	Aug 26	0.8	3.0	L	?	1.9	0.4	3.3
Pts. - Total Pressure Ulcers Cat 2 & Mucosal per 1000 bed days	Aug 26	0	1	L	?	1	0	3
Pts. - Patient Safety Incident Investigations	Jul 26	0	1		?	1	-2	3
Pts. - Patients Detained under MHA	Aug 26	4	7	L	?	5	-2	12
Pts. - Mental Health Patients PAH	Aug 26	16	13		?	17	0	35
Pts. - Breast feeding rates - At delivery (NOT including mixed feeding)	Aug 26	72.2%	80.0%		?	73.3%	64.7%	81.8%
Pts. - Smoking rates - At Booking	Aug 26	5.4%	10.0%	L	?	5.4%	0.7%	10.1%
Pts. - Smoking rates - At Delivery	Aug 26	3.8%	6.0%		?	5.1%	1.0%	9.1%
Pts. - Births	Aug 26	293	300		?	294	249	339
Pts. - Still Births per 1000 Births	Aug 26	0	3		?	3	-5	11
Pts. - Continuity of Carer	Aug 26	11.1%	25.0%	H	F	9.7%	6.0%	13.4%



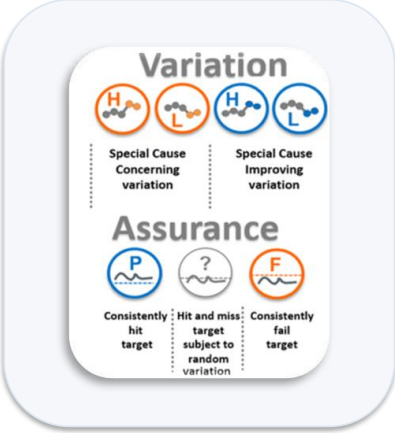
Summary Sheet (3 of 6)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Perf. - Outpatient DNA Rate	Aug 26	4.8%	8.0%	L	P	5.2%	4.3%	6.0%
Perf. - Outpatient New to Follow-up ratio	Aug 26	2	2	H	P	2	2	2
Perf. - Percent of episodes moved or discharged to patient-i	Aug 26	5.4%	4.0%	H	F	3.2%	2.6%	3.8%
Perf. - Cancer 28 Day	Jul 26	70.9%	80.0%		?	74.3%	64.7%	83.9%
Perf. - Cancer 31 Day	Jul 26	95%	94%		?	95%	90%	101%
Perf. - Cancer 62 Day	Jul 26	60.2%	80.0%	L	F	62.9%	55.7%	70.2%
Perf. - RTT Incomplete Standard	Jul 26	68.5%	67.0%	H	F	60.9%	56.7%	65.0%
Perf. - RTT over 52 week waiters	Jul 26	377	0	L	F	1612	1097	2127
Perf. - RTT PTL Size	Jul 26	38992	40200	L	F	45285	41708	48863
Perf. - RTT over 65 week waiters	Jul 26	50	0	L	F	145	41	250
Perf. - RTT Percentage Under 18 Weeks Waiting for a 1st OP	Jul 26	67.7%	67.0%	H	P	57.5%	52.2%	62.9%
Perf. - Percentage treated within 4 hours in ED	Aug 26	77.1%	82.0%	H	F	69.1%	62.1%	76.2%
Perf. - Over 12Hrs ED	Aug 26	771	1009		?	1054	461	1647
Perf. - Average Ambulance handover time	Aug 26	34	38		?	42	15	69
Perf. - Percentage of Handovers over 45 Minutes	Aug 26	19.2%	18.0%	L	?	25.7%	7.4%	43.9%
Perf. - Percentage of Handovers over 15 Minutes	Aug 26	76.8%	69.0%		?	74.6%	63.2%	86.0%
Perf. - Percentage waiting for a diagnostic test or procedure	Jul 26	31.6%	20.0%		F	32.5%	24.7%	40.2%
Perf. - Non elective LOS – acute	Aug 26	7.4	7.3	H	P	4.6	3.9	5.2
Perf. - Overnight total general and acute bed occupancy %	Jun 26	94.8%	95.0%	L	P	96.9%	95.2%	98.7%



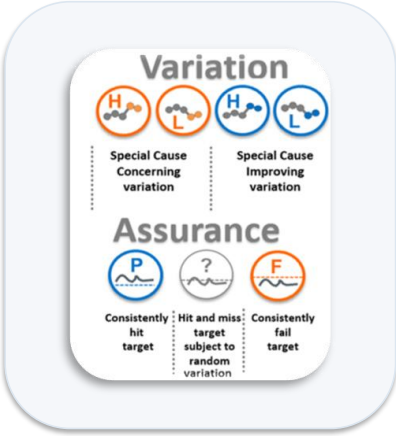
Summary Sheet (4 of 6)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pple. - Sickness Absence	Aug 26	5.0%	4.5%	H	?	4.4%	3.9%	4.9%
Pple. - Staff Turnover Voluntary	Aug 26	6.6%	12.0%	L	P	7.6%	7.0%	8.2%
Pple. - Agency Staffing Spend	Aug 26	1.6%	3.0%		?	1.7%	0.1%	3.4%
Pple. - Bank Staffing Spend	Aug 26	9.6%	15.0%	L	P	10.0%	6.4%	13.7%
Pple. - Vacancy Rate	Aug 26	8.7%	9.0%		?	9.4%	8.4%	10.4%
Pple. - Appraisals - Non Medical	Aug 26	77.7%	90.0%	H	F	72.7%	64.9%	80.4%
Pple. - Statutory & Mandatory training	Aug 26	91.2%	90.0%	H	?	88.3%	85.8%	90.7%



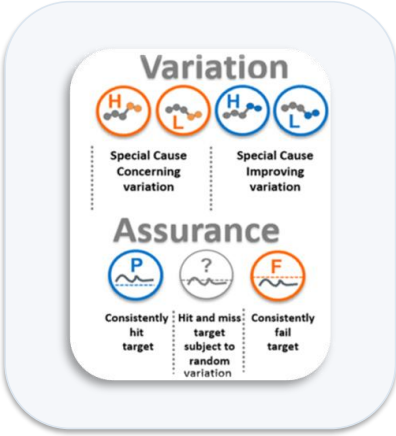
Summary Sheet (5 of 6)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Popn. - Estates Responsiveness (Priority 2 - Urgent)	Jul 26	94.0%	95.0%	H	?	89.5%	69.4%	109.7%
Popn. - Domestic Services (Cleaning) Very Risk High	Aug 26	98.3%	98.0%		?	98.3%	97.7%	99.0%
Popn. - Domestic Services (Cleaning) High Risk	Aug 26	95.6%	95.0%		?	95.2%	93.2%	97.2%
Popn. - Difference in days from RTT (Male:Female)	Aug 26	8	0		?	4	-7	16
Popn. - Difference in days from RTT (BAME:White)	Aug 26	5	0		?	5	-10	21
Popn. - Difference in days from RTT (IMD 1-3:IMD 8-10)	Aug 26	6	0		?	9	-8	26



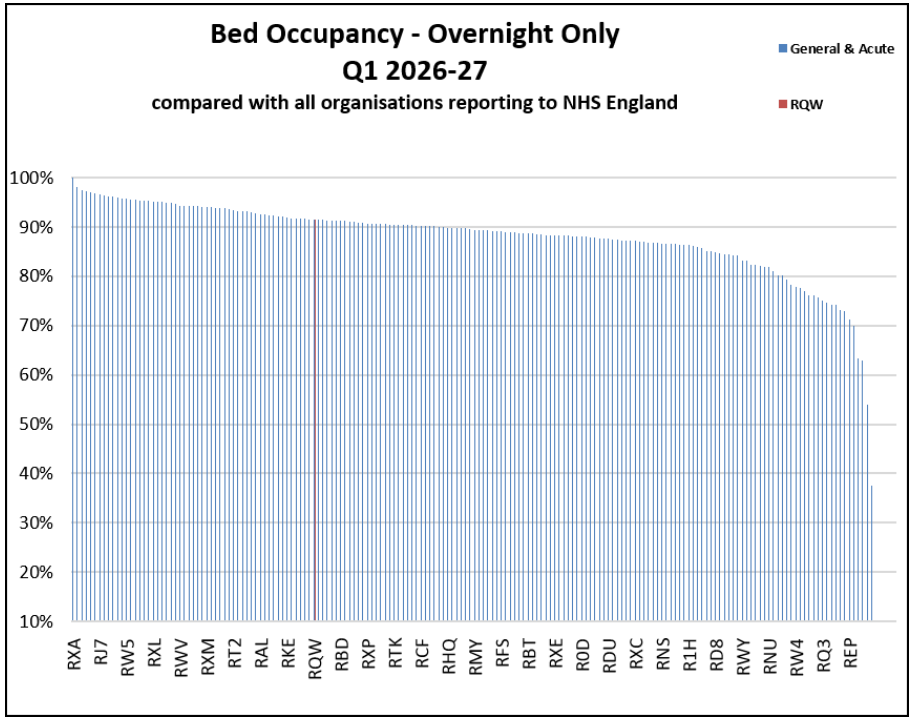
Summary Sheet (6 of 6)

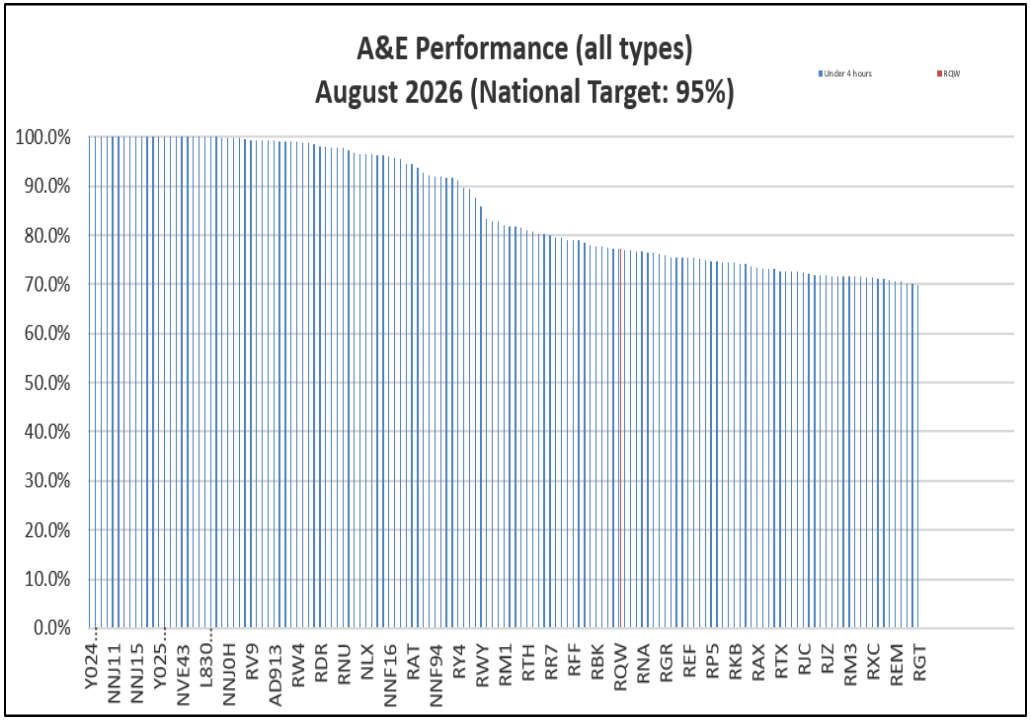
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pnds. - Variance to Monthly Plan	Aug 26	-2218	0			-302	-1098	494
Pnds. - Bank Spend - Variance to Plan	Aug 26	-314	0			-135	-499	229
Pnds. - Agency Spend - Variance to Plan	Aug 26	-122	0			52	-322	426
Pnds. - Cost Improvement Plan - Variance to Plan	Aug 26	-1181	0			-171	-720	377
Pnds. - Cash Balance - Variance to Plan	Aug 26	-4330	0			187	-12086	12460
Pnds. - Capital Spend - Variance to Plan	Aug 26	-952	0			-202	-947	543



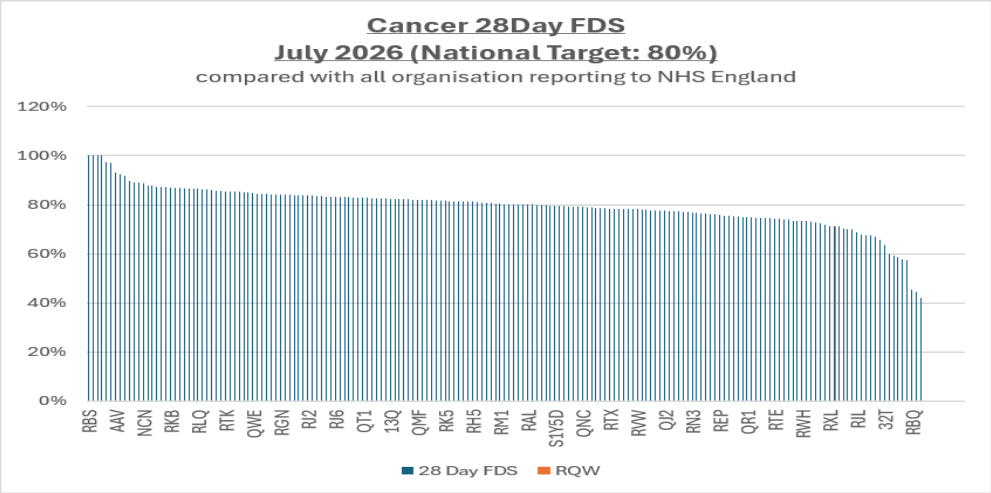
Executive – National Benchmarking

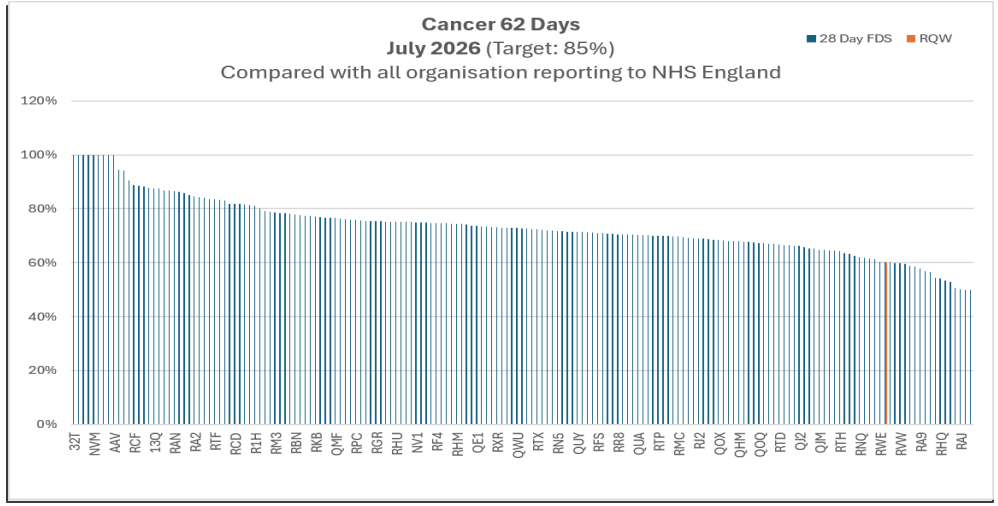
National Benchmarking

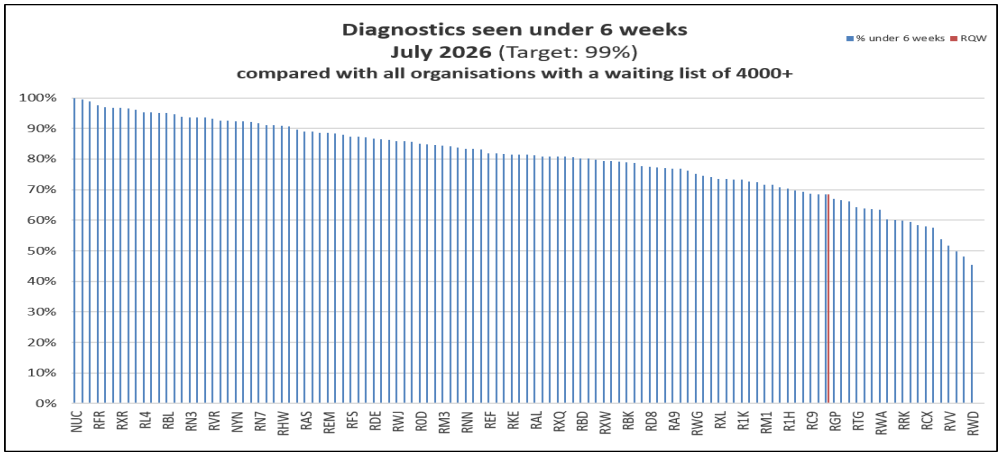


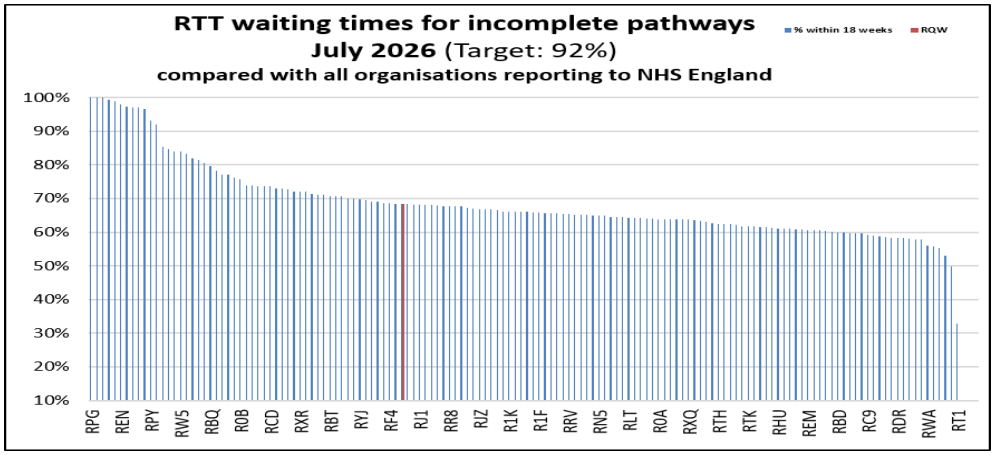


Executive – National Benchmarking









Executive – Pillar & Metric leads

Performance

Rising Standards

Pillar Lead: Anna Jebb

METRIC_NAME	National Target	Local Target
Outpatient DNA Rate	8%	8%
Outpatient New to Follow-up ratio	2.3	2.3
% of Patient treated within 4 hours in ED	95%	78%
Over 12Hrs ED	921	921
Average handover time (No of handovers (ED and non-ED)	37	37
% of Handovers over 45 Minutes	0	0
% of Handovers over 15 Minutes	69.47%	69.47%
Bed Occupancy excluding GIB, HM, CHAM, LAB, OBS/MID & SAM	85%	85%

Metric Lead: Gail De Souza

METRIC_NAME	National Target	Local Target
Diagnostic times - Patients seen within 6 weeks	95%	95%
Cancer 2 week waits	93%	93%
Cancer 28 Day Faster Diagnosis	80%	80%
Cancer 31 Day First	94%	94%
Cancer 62 Day - Shared treatment alloc rules	80%	80%
RTT Incomplete Standard	92%	65%
RTT over 52-week waiters	865	865
RTT PTL Size	36483	36483
% Patients Under 18 Weeks Waiting for a 1st OPA	72%	72%
Non elective LOS – acute	0	7.32
% of episodes moved or discharged to patient (PIFU)	5%	4%
Overnight total general and acute bed occupancy	N/A	97.83%

Metric Lead: Rebecca Gildea

Executive – Pillar & Metric leads

Patients

Rising Standards

Pillar Lead: Joanne Ward

METRIC_NAME	National Target	Local Target
Number of Still births	3.22	3.22
Births	300	300
Continuity of Carer	25%	25%
Smoking rates - At Booking	12.5%	12.5%
Smoking rates - At Delivery	6%	6%
Breast feeding rates - At delivery (NOT including mixed feeding)	74%	74%

Metric Lead: Linda Machakaire

METRIC_NAME	National Target	Local Target
Falls per 1000 bed days	6	6
Falls - total of Minor, Moderate & Severe	13	13
Falls with Harm per 1000 Bed Days	1.5	1.5
Mixed Sex Accommodation breach	0	0

Metric Lead: Polly Read

METRIC_NAME	National Target	Local Target
Tissue Viability - (Pressure Ulcers) per 1000 bed days	3	3
Total grade 3, 4 & unstageable pressure Ulcers	3	3
Tissue Viability - (Pressure Ulcers Grade 3 or Above) per 1000 Bed Days	3	3
Pressure Ulcers (All Grades, Inpatient Wards Only) per 1000 Bed Days	3	3

Metric Lead: Polly Read

METRIC_NAME	National Target	Local Target
Healthcare Associated MRSA Bloodstream Infections	0	0
C-DIFF Total (Inc Community)	2	2
C-DIFF Hospital onset healthcare associated	0	0
Healthcare Associated MSSA Bloodstream Infections -Rate	0	0
Healthcare Associated MSSA Bloodstream Infections	0	0
E Coli	100%	100%
Hand Hygiene	95%	95%
Klebsiella	100%	100%
Pseudomonas	100%	100%

Metric Lead: Jenny Kirsh

METRIC_NAME	National Target	Local Target
Complaints - New	25	25
Compliments	0	0
PALS	405	405
Friends and Family Test (FFT) Recommender Score	0.75	0.75
Percentage of Patients Completing Friends and Family Test (FFT)	0.75	0.75

Metric Lead: Finola Devaney

Executive – Pillar & Metric leads

Pounds | **Rising Standards**

Pillar Lead: Tom Burton

METRIC_NAME	National Target	Local Target
Surplus/Deficit	£-414	£-414
Bank Spend	£-242	£-242
Agency Spend	£-626	£-626
Cost Improvement Plan (now known as PQP)	£1216	£1216
Cash Balance	£28923	£28923
Capital Spend	£2891	£2891
Elective Recovery Funding (this is a new one)	£0	£0
Income	£0	£0
OP Expenditure	£0	£0

Metric Lead: Bethany Potton

People | **Rising Hope**

Pillar Lead: Catrin Asbrey

METRIC_NAME	National Target	Local Target
Sickness Absence	4.5%	4.5%
Staff Turnover Voluntary	12%	12%
Agency Staffing Spend	32%	32%
Bank Staffing Spend	15%	15%
Vacancy Rate	9%	9%
Appraisals - Non-Medical	9%	9%
Statutory & Mandatory training	9%	9%

Metric Lead: Sam Gooden

Population | **Rising Community**

Pillar Lead: Catrin Asbrey

METRIC_NAME	National Target	Local Target
Estates Responsiveness (Priority 2 - Urgent)	95%	95%
Domestic Services (Cleaning) Very Risk High	98%	98%
Domestic Services (Cleaning) High Risk	95%	95%
Catering Food Waste	4%	4%

Metric Lead: Hardev Sagoo & Tracey Burgess

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board – Public 1 October 2026 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

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

DATE OF COMMITTEE MEETING: 14 September 2026

Agenda Item:	**Level of assurance**			**Further work Y/N**	**Referral elsewhere Y/N**	**Recommendation to Board**
	Full	**Partial**	**Limited**			
1.6 Annual Committee Effectiveness Review 25/26 and Terms of Reference 26/27	✓			N	N	The Committee reviewed its annual effectiveness assessment and was assured that it continues to operate effectively, with positive feedback regarding governance, oversight and management of actions. Members supported exploring one face-to-face meeting annually to strengthen relationships and discussion. The Committee approved the Audit Committee Terms of Reference for 2026/27 and recommended them to the Board for approval.
2.1 External Audit Update	✓			N	N	The Committee received assurance from external auditors that the 2025/26 audit had concluded with an unmodified opinion and that strong working relationships had been established during the first year of appointment. Planning for the 2026/27 audit has commenced and a detailed audit plan will be presented later in the year.
3.1 Internal Audit Progress Report including: •Access Policy •Data Security & Protection Toolkit		✓		Y	N	The Committee received positive assurance on delivery of the Internal Audit Plan and noted good progress across the programme. Moderate assurance was provided on the Access Policy review, with management actions in place to strengthen policy compliance and staff awareness.

BOARD OF DIRECTORS: Trust Board – Public 1 October 2026 **AGENDA ITEM: 7.1**

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DATE OF COMMITTEE MEETING: 14 September 2026

Agenda Item:	**Level of assurance**			**Further work Y/N**	**Referral elsewhere Y/N**	**Recommendation to Board**
	Full	**Partial**	**Limited**			
•Global Risk Landscape Report •Internal Audit Standards Essential Conditions						The annual DSPT review achieved a Low Risk/High Confidence outcome with no recommendations, providing strong assurance regarding information governance and cyber controls. The Committee also reviewed emerging risks through the Global Risk Landscape report and received assurance regarding compliance with Internal Audit Standards.
3.2 Internal Audit Follow Up Report		✓		Y	N	The Committee noted a significantly improved position regarding implementation of internal audit recommendations, with all recommendations from 2023/24 now complete and only one overdue recommendation remaining. Members welcomed strengthened oversight arrangements through the Executive Cabinet and recognised the substantial progress made in reducing overdue actions.
3.3 Counter Fraud Progress Report		✓		Y	N	The Committee received assurance regarding the effectiveness of counter fraud arrangements, ongoing investigations, proactive fraud prevention work and development of the Trust's Counter Fraud Risk Assessment. Members discussed challenges associated with evidential requirements for complex investigations, including

BOARD OF DIRECTORS: Trust Board – Public 1 October 2026 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

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

DATE OF COMMITTEE MEETING: 14 September 2026

Agenda Item:	**Level of assurance**			**Further work Y/N**	**Referral elsewhere Y/N**	**Recommendation to Board**
	Full	**Partial**	**Limited**			
						dual employment cases, and received assurance that alternative routes such as HR processes and NHS counter fraud intelligence networks are utilised where criminal thresholds are not met.
3.4 Counter Fraud Annual Report & CFFSR Submission	✓			Y	N	The Committee noted that the Trust achieved an overall Green rating against the NHS Counter Fraud Functional Standards, maintaining performance from the previous year. One standard relating to mandatory counter fraud training remained Amber, with work underway to incorporate training into the Trust's mandatory training programme.
4.1 Waivers, Losses, Special Payments and Debt Write Offs including •Sole Supplier Deep Dive	✓			N	N	The Committee received assurance regarding the management of waivers, losses, special payments and debt write-offs. Members welcomed the finding that there had been three consecutive quarters with no non-compliant waivers. A detailed review of sole supplier waivers provided assurance that classifications remained appropriate and that controls were operating effectively. Annual reporting of sole supplier activity was requested to maintain oversight.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board – Public 1 October 2026 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Audit Committee

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

DATE OF COMMITTEE MEETING: 14 September 2026

Agenda Item:	**Level of assurance**			**Further work Y/N**	**Referral elsewhere Y/N**	**Recommendation to Board**
	Full	**Partial**	**Limited**			
4.2 CQC Compliance Report	✓			N	N	The Committee received an update on progress against historic and current CQC actions and noted that all regulatory actions are being managed through a consolidated improvement programme. Members were advised that the Trust's overall Well-Led rating remains Requires Improvement, although the Effectiveness domain has improved to Good. Oversight of delivery remains with the Quality and Safety Committee, with periodic updates to Audit Committee.

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE 2026/27

PURPOSE:

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

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

DUTIES:

The following comprise the Committee's main responsibilities:

7.1

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

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

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

Internal Audit

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

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

External Audit

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

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

Annual Report and Accounts Review

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee shall review the annual report and financial statements before submission to the Board, particularly focusing on:

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.

5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
6. Explanation of estimates or provisions having material effect.
7. The schedule of losses and payments.
8. Any unadjusted (mis)statements.
9. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
10. The letter of representation.

Governance Manual

1. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
2. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
3. Review the schemes of delegation and authority.

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

1. Adequate measures to comply with the Government Functional Standard GovS 013: Counter Fraud.
2. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
3. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions on Fraud and Corruption.

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit

In its capacity as Auditor Panel, the Committee shall:

1. Agree and oversee a robust process for selecting the external auditors in line with the Trust's procurement processes and rules.
2. Advise the Board on the selection and appointment of the External Auditor.
3. Ensure that any conflicts of interest are dealt with effectively.
4. Advise the Board on the maintenance of an independent relationship with the appointed External Auditor.

5. Advise the Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
6. Approve the Trust's policy on the purchase of non-audit services from the appointed external auditor.
7. Advise the Board on any decision about the resignation or removal of the External Auditor.

ACCOUNTABLE TO: Trust Board.

REPORTING ARRANGEMENTS: A regular written report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive. It shall highlight areas of focus from the last meeting and demonstrate progress against the Committee annual work plan.

The Chair of the Auditor Panel shall produce a report from the Panel outlining how it has discharged its duties.

CHAIR Non-Executive Director.

COMPOSITION OF MEMBERSHIP: Members of the Committee shall be appointed from amongst the Non-Executive Directors and shall consist of not less than three members including the Committee Chair, at least one of whom shall have recent and relevant financial experience.

The Trust Chair will not be a member of the Committee.
Members of the Performance & Finance Committee and the Quality & Safety Committee shall be among the members of the Audit Committee.

The Auditor Panel shall comprise the entire membership of the Audit Committee. All members of the Auditor Panel will be independent Non-Executives Directors.

ATTENDANCE Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record will be held for each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.

In addition to the members of the Committee, the following will be invited to attend each Committee meeting:

- Chief Finance and Infrastructure Officer and Operational Director of Finance
- Chief Medical Officer, Executive Lead for Risk Management
- Representatives from Internal Audit, External Audit and the Local Counter Fraud Service.

At least once a year, the Committee shall meet privately with the internal and external auditors.

The Chief Executive shall be invited to attend the Committee at least annually to discuss the process for assurance that supports the Annual Governance Statement. This shall be when the Committee formally considers the annual reports and accounts prior to Board approval.

To ensure appropriate accountability, other Executive Directors and, if required, members of the management team will be invited to attend when the Committee is discussing areas of risk or operation that are their responsibility.

The Chair of the Auditor Panel may invite Executive Directors and others to attend meetings of the Panel. However, these attendees will not be members of the Auditor Panel.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chair, the Audit Committee shall be chaired by one of the Non-Executive Director members of the Committee.

Other deputies may attend but must be suitably briefed and designated and notified in advance, where possible.

QUORUM:

The quorum for any meeting of the Committee shall be the attendance of a minimum of two members. Each member shall have one vote and in the event of votes being equal, the Chair of the Committee shall have the casting vote.

The quorum for any meeting of the Auditor Panel shall be the attendance of a minimum of two members.

DECLARATION OF INTERESTS

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

MEETING FREQUENCY:

There shall be four meetings of the Committee each year with additional meetings where necessary. This includes a meeting to focus on the pre-Board consideration of the Annual Reports and Accounts which will only consider usual business by exception.

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Committee.

MEETING ORGANISATION

Audit Committee

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting shall be closed and not open to the public.
- The Director of Corporate Governance shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.

Auditor Panel

- The meeting shall be closed and not open to the public.
- The Director of Corporate Governance shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.
- The agenda items for discussion by the Auditor Panel shall be clearly distinguished from the items for discussion by the Committee.

- The minutes of the Auditor Panel shall be separate from the minutes of the Committee.

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

AUTHORITY

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

The Committee and the Auditor Panel are authorised by the Board of Directors to investigate any activity within these terms of reference. They are authorised to seek any information they require from any employee, and all employees are directed to co-operate with any request made by the Committee and Auditor Panel.

The Committee and the Auditor Panel are authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if they consider this necessary and to seek advice and support from the Head of Corporate Affairs and external experts as required.

TERMS OF REFERENCE

The terms of reference of the Committee shall be reviewed at least annually and approved by the Trust Board.

DATE APPROVED

By Committee:
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: September 2027

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE MEMBERSHIP

Membership and Those in Attendance	
Members	
Colin McCready	**Non-Executive Director and Committee Chair**
Ben Molyneux	Non-Executive Director
David Baines	Non-Executive Director
In Attendance	
Tom Burton	Chief Finance and Infrastructure Officer
Bethany Potton	Operational Director of Finance
Andrew Kelso	Chief Medical Officer (Executive risk lead)
Thom Lafferty (annually)	Chief Executive Officer
In Attendance (Internal & External Audit)	
James Shortall	BDO (LCFS)
Michael Evans	BDO (LCFS)
Aaron Winter	Partner, BDO (Head of Internal Audit)
Antony Hadjirousos	BDO (Senior Internal Audit Manager)
Charlie Martin	Bishop Fleming (External Audit)
Jonathan Saunders	Bishop Fleming (External Audit)
Secretariat	
Heather Schultz	Director of Corporate Affairs
Becky Aldous	Corporate Governance Officer

7.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 1st October 2026**			**AGENDA ITEM: 7.2**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board**			
REPORT FROM:	**Acting Chair: Richard Boyce**			
DATE OF COMMITTEE MEETING:	**17th September 2026**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
HCP Board Development Session	Y	Y	Y	West Essex partners face increasing expectations to deliver integrated, neighbourhood-based care, improve population health outcomes, reduce health inequalities and support the delivery of Essex ICB strategic objectives. At the same time, reduced system capacity for transformation and programme management means the partnership must adopt a more focused, delivery-oriented approach. Through feedback from partners, a review of the current WEHCP arrangements found that while the partnership remains highly valued and there is strong support for a West Essex place-based model, the HCP must now move beyond relationship-building and governance development towards a clearer focus on purpose, priorities, delivery infrastructure, shared accountability and demonstrable outcomes. In response, a redesigned operating model is proposed that simplifies governance, strengthens accountability, establishes a clear programme portfolio and adopts a matrix approach to transformation support across organisations. This will position the HCP as the primary place-based vehicle for the design, oversight and delivery of integrated care programmes across West Essex, aligning delivery with Essex ICB priorities while maintaining a strong focus on local population needs and neighbourhood-based care. HCP Board Development Session held on the 17th September 2026 agreed to move forward with a focussed set of priority programmes, based upon a place-based outcomes structure, and agreed through a prioritisation framework.

The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS: Trust Board **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Executive Board

REPORT FROM: Tom Burton

DATE OF COMMITTEE MEETING: 16th September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
P1 Business Cases Summary	√			N	Y	The COO presented a summary of all the P1 business cases for Executive Board review/approval. Executive Board approved the following: Tier 4 Anaesthetics business case for onward submission to Trust Board Pharmacy Business case for onward submission to Trust Board assuming income validation Critical Care (ITU) submitted to Trust Board with the recommendation to proceed through to the ICB for their approval process. Executive Board agreed to submit the following cases to the 2027/28 planning round: Respiratory Breast Neurology Histopathology Neonatal Oncology business case was withdrawn by PPD division as funded internally

BOARD OF DIRECTORS: Trust Board **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Executive Board

REPORT FROM: Tom Burton

DATE OF COMMITTEE MEETING: 16th September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
Maternity Triage Baseline		√		Y		Presented to Executive Board for approval. Executive Board requested the previous agreed and mitigations to be included in the report and submitted to the Finance team by Friday 18th September for further review
Ockenden and Amos 10 Point Plan Baseline Assessment	√					Executive Board approved the submission of the Ockenden and Amos 10 Point Plan Baseline Assessment to NHS England. The I-CN is the names Executive Lead for this submission.
Risk Management Group	n/a	n/a	n/a			The CMO requested the report is deferred to a future date to allow a further review of the risk scores. Executive Board approved this request
Finance Update M5	√			N	N	The reported Month 5 position is a £2.2m deficit, which is £2.2m adverse to plan. The YTD position is an £8.0m deficit, £5.2m adverse to plan. The Month 5 variance is driven by under performance against the PQP target, operational performance costs, continuing cost pressures and a prior period income adjustment. The capital plan for 26/27 is £24.2m of which £8.6m relates to PDC funding. YTD expenditure is £5.4m with work ongoing to finalise and prioritise capital programme. Executive Board noted the report

BOARD OF DIRECTORS: Trust Board **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Executive Board

REPORT FROM: Tom Burton

DATE OF COMMITTEE MEETING: 16th September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
New Hospital Programme update	√			N		PAHT and Harlow District Council continue their collaborative relationship, developing proposals that meets the needs of both for Health on the High Street and MSCP to aid the redevelopment of the main hospital site. The Exec Board is asked to note the approval given by Trust Board on 10th September to endorse further development of the Harvey Centre health hub and Wych Elm MSCP as an integrated proposal, without committing to the commercial terms but approving a development fund up to £50K. Executive Board noted the update and report.
Cancer Performance Update		√				Ongoing challenges remain in Dermatology and Urology performance. A dedicated Urology Performance group has been set up to monitor and improve recovery delivery. The COO confirmed the cancer action plan does show signs of recovery especially in Urology. The trajectories are achievable with the cancer teams working in a more agile way to enable support with the PTL. The GP Lead confirmed there is an opportunity to upskill GPs to support with the dermatology recovery and remove patients from the waiting lists. The CMO

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BOARD OF DIRECTORS: Trust Board **AGENDA ITEM: 7.3**

REPORT TO THE BOARD FROM: Executive Board

REPORT FROM: Tom Burton

DATE OF COMMITTEE MEETING: 16th September 2026

Agenda Item:	Level of assurance			Further work	Referral elsewhere	Recommendation to Board
	Full	Partial	Limited	Y/N	Y/N	
						commended the COO for her strong leadership in the cancer recovery action plan.