

Annual Report

2023 - 2024



modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

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The performance report 2023-24

Overview

The purpose of this section of the performance report is to set out key information on the Trust in relation to its main objectives, strategies and the principal risks it faces. This section includes:

- A foreword from the chair and chief executive
- An overview of the Trust, its strategic objectives, organisational structure, services provided and population served
- An update regarding the Hertfordshire and West Essex Integrated Care System and the West Essex Health and Care Partnership
- A statement on adopting Going Concern basis
- A summary of the Trust's performance (covering clinical, operational, financial and people)

Foreword - the chair and the chief executive officer

Welcome to our annual report for 2023-24.

It is an opportunity to reflect on the last 12 months, the improvements to services for our patients and the achievements of colleagues. It is also an opportunity to reflect on progress made against each of our 5 key priorities within our **PAHT 2030** strategy, to enable us to continue our drive to be modern, integrated, and outstanding in all that we do.

We are only able to provide the care we do thanks to the hard work, passion, and compassion of our 4,200 colleagues and volunteers, and our partnership working with primary care, community services, mental health and social care colleagues.

We have seen improvements for our patients in their experiences, outcomes, and the environment in which they are treated, and we have continued to see reductions in key quality indicators including the number of falls and the number of pressure ulcers per 100,000 bed days. Importantly our Hospital Standardised Mortality Ratio (HSMR) has continued to fall and during the year it fell to 'lower than expected' (year to October 2023) for the first time ever, a position that has been maintained since.

We continued to develop services in partnership with health and care colleagues over the year, with the development of virtual ward capacity and virtual outpatient appointments.

Most notably, however, has been the new Integrated Urgent Care and Treatment Centre in partnership with local primary care and community services teams. This now provides high quality, timely, urgent care support for the less acute presentations, to more than 100 patients per day and continues to widen its support for urgent and emergency care. The year ahead will see us build upon our partnerships with health, care and local authority colleagues across the West Essex and East and North Hertfordshire Health and Care Partnerships (HCPs).

The number of local, regional, and national awards won by colleagues in 2023-24 was the highest ever, with doctors, nurses, midwives, AHPs, scientists and non-clinical colleagues all recognised. Our volunteers, Patient Panel and Patient Panel chair have also been recognised for the amazing support they provide for our patients and our people. Thank you to all colleagues for their dedication, passion, and compassion.

During the year we continued to progress our work for a new hospital in conjunction with the national New Hospital Programme team and investment in services and facilities that will support this. There was a very positive and supportive public consultation undertaken for our plans to develop a Community Diagnostic Centre at St Margaret's Hospital, which will expand diagnostic services and facilities and support changes in models of care to enable more comprehensive and timely diagnosis. We have also been central to the expansion of operating theatre capacity for elective services across the Integrated Care System and the modernisation of integrated pathology services for Hertfordshire and West Essex. With the new hospital still several years away, we have continued to invest in current facilities for our patients and our people, including further ward refurbishments, and brand-new Technical Services Unit, used to make chemotherapy medication, and investment in the critical infrastructure.

The constant modernisation of services and service delivery is essential for high quality outstanding patient care and the very end of 2023/24 saw the delivery of our first surgical robot. Technological advancements and the use of digital progressed strongly through the year, most notably with the groundbreaking use of artificial intelligence (AI) in our imaging services and the use of AI to support and speed up some of our administrative processes. The most notable digital enhancement, however, was the approval of a £30m investment in an electronic health record, Alex Health. This is due to go live in November 2024, enabling us to be one of the most digitally mature hospitals in the country. It will transform how our clinicians work, the information and speed of information available to them

and will support more timely and effective clinical decision making. Our patients will benefit from improved experiences, better clinical outcomes, and improved safety, and it will be a solid foundation on which we can implement our ambitious digital transformation.

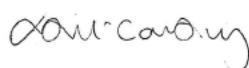
Every year our people are invited to take part in the national NHS Staff Survey. We are pleased that this year we saw the highest response rate ever to the survey and improvements in all seven of the national NHS People Promises and both themes. There was a statistically significant improvement in six of the seven national promises, reflecting the development and enhancement of our people's experience of working at PAHT. Our new online training and learning platform, enhanced leadership development programmes and maturing staff fora, aligned to the 9 protected characteristics, will support colleagues further through 2024-25.

We are both honoured to undertake our roles to lead the Trust and proud of the improvements made to our patients' experiences and outcomes and our people's experiences over the year. Thank you to all our colleagues, volunteers, partners and patients for your commitment to and support for the Trust as we continue our drive to be modern, integrated, and outstanding in all that we do.

Best wishes



Hattie Llewelyn-Davies
Chair



Lance McCarthy
Chief executive

The purpose and activities of the organisation

PAHT is a 414 bedded hospital with a full range of general acute services, including; a 24/7 Accident and Emergency Department (A&E), plus an Intensive Care Unit (ICU), a Maternity Unit (MU) and a Level II Neonatal Intensive Care Unit (NICU).

The Trust serves a core population of around 350,000 and is the natural hospital of choice for people living in West Essex and East Hertfordshire. In addition to the communities of Harlow and Epping, the Trust serves the populations of Bishop's Stortford and Saffron Walden in the north, Loughton and Waltham Abbey in the south, Great Dunmow in the east, and Hoddesdon and Broxbourne in the west. Its extended catchment incorporates a population of up to 500,000.

The Trust owns the main hospital site in Harlow, and also operates outpatient and diagnostic services out of the Herts and Essex Hospital, Bishop's Stortford and St Margaret's Hospital, Epping. The operation of these facilities forms part of the longer term strategy of bringing services closer to where patients live and making services, where appropriate, more accessible and easily available to patients.

The Trust operates different services to meet the needs of its patients (see service portfolio below):

Directory of our services

Children and women's services			
Antenatal and newborn screening	Children's ward including patient at home (23/24 delivered by community provider)	Colposcopy and hysteroscopy services	Community midwifery
Early Pregnancy Unit	Foetal medicine	Gynaecology ambulatory service	Gynaecology including termination of pregnancy services



Infant feeding support	Newborn hearing screening	Neonatal critical care – special care baby unit and neonatal community nurses	Maternity: Antenatal clinics Ultrasound scanning Labour Ward Antenatal Ward Postnatal Ward Maternity Assessment Centre (Maternity Triage and Day Assessment Unit) Birth Centre Community midwifery services Homebirth service
Maternity bereavement services	Obstetrics	Paediatric diabetic Medicine	Paediatrics – inpatients, outpatients, assessment services
Specialist antenatal services	Tongue tie service		
Clinical support services			
Audiology	Blood tests	Breast surgery	Chemotherapy
Clinical haematology	Dermatology	Dietetics	Infection prevention and control services
Interventional radiology	Medical oncology	Mortuary and bereavement services	Neurology
Oncology services	Outpatients	Patient appliances	Pathology: microbiology, cellular pathology, blood sciences, biochemistry
Pharmacy services	Physiotherapy and occupational therapy	Radiology	Speech and language therapy

Tissue viability	Transfusion services		
Medicine			
Cardiology	Diabetic medicine	Endocrinology	General medicine
Genito-urinary medicine	Geriatrics including frailty	Medical inpatient wards	Older people's assessment and liaison (OPAL)
Oncology services relevant to medical care	Patient at home, adult (23/24 delivered by community provider)	Respiratory medicine	Rheumatology
Specialist palliative care and end of life services			
Surgery and critical care			
Day surgery	Colorectal services	Ear, nose and throat	Endoscopy services
Gastro enterology	General surgery	High Dependency Unit	Intensive Care Unit
Maxillo-facial surgery	Ophthalmology	Oral surgery	Perioperative Medicine (Anaesthetics and ICU)
Surgery – inpatients	Trauma and orthopaedics	Urology	Vascular services
Urgent and emergency care			
Adult assessment services incorporating same day emergency care and urgent 'hot' clinics	Integrated Urgent Treatment Centre – in collaboration with Stellar Health, Stort Valleys Federation, Essex Partnership University Trust and Herts Community Trust	Emergency department	Paediatric emergency department

Strategic objectives

Following significant consultation in 2021, we launched our strategy, **PAHT2030**, which we are now delivering through our clinical and management teams.

Our vision

Our vision remains:

To be modern: always using up-to-date treatments, technology and facilities.

To be integrated: working as one to provide joined-up healthcare that always puts patients first.

To be outstanding: delivering healthcare that our patients deserve and that makes us proud.

Our strategic priorities

From 2022, our people and patients have worked together to produce a range of strategies incorporating clinical, corporate and cultural improvements to support the delivery of our **PAHT2030** strategic priorities:

1. Transforming our care

We are developing the most up-to-date and expert care designed to meet the individual needs of the patient, where and when they need it.

We will:

- Work with **health system partners** to **empower patients** to take more control over their care and in monitoring their health
- **Enable our people to work in connected, streamlined ways** to deliver the right care, at the right time, in the right place
- **Drive continuous improvement** using real time data to enable PAHT to be a truly learning organisation

2. Our culture

Our focus is on fostering and nurturing an inclusive environment that champions diversity and equality, and where our people are engaged, supported and helped to learn and grow.

We will:

- **Foster a healthy workplace** where wellbeing is paramount, and staff feel valued, supported and safe to speak up
- **Create new and enhanced ways of working**, with a focus on greater collaboration as well as individual professional development
- Offer great career and development opportunities and **be a model for diversity and inclusion**

3. Digital health

We're harnessing new technology and digital solutions to transform patient care and improve how we work.

We will:

- Rollout our powerful new **electronic health record**
- Use **innovative technologies to capture, share and learn** from the latest patient and clinical data
- Create a **digitally enabled hospital** that will increase efficiency and improve staff experience and patient outcomes

4. Corporate transformation

A focus on continuing to modernise our corporate services to support our clinical teams in providing outstanding care.

We will:

- **Modernise our systems and services** to support better care delivery, making the Trust an amazing place to work and thrive
- **Collaborate with the Integrated Care System** and **Integrated Care Partnership** for greater service integration
- **Build high quality working environments** for greater efficiency and cross departmental working

5. Our new hospital

We're building a world class hospital for the future, providing first rate care for our patients and the best place to work for our people.

We will:

- **Improve outcomes for patients** and future-proof our service delivery through smart, flexible building design
- **Become more sustainable** across everything we do, achieving our target of net zero carbon
- **Exploit our greenfield location** as a place of wellness not illness, for the benefit of staff and patients and local biodiversity

Alongside our **PAHT2030** priorities, our five corporate core objectives: patients; people; performance; places and pounds continue to hold us to account, keeping us grounded in reality and challenging us to keep improving the experience for our patients, visitors and people.

And, throughout everything we do, we are guided at all times by our PAHT values:

- **Patient at heart**
- **Everyday excellence**
- **Creative collaboration**

Delivery of PAHT2030

The Programme Management Office has supported and driven the delivery of the key major projects and programmes of **PAHT2030**.

Transforming our care

A key part of transforming our care is the development and delivery of key clinical strategies covering all major specialities. These strategies outline the transformation required between now and 2030 to enable our services to be modern, integrated and outstanding. There are five key themes arising from our clinical strategies:

1. **Pathway redesign/development/change**
2. **Workforce and training**
3. **The use of technology**
4. **Workforce (recruitment and new roles)**
5. **Workforce (innovative (re)use of existing resources)**

Transforming our care has delivered a number of improvements including the increased use of virtual ward and virtual hospital and non-face to face activity (30% of our outpatient appointments are virtual, including virtual fracture, COPD, heart failure and falls clinics), enhanced training for extended training roles, the optimisation of surgical pathways leading to better outcomes for patients, the launch of the mental health and quality strategies and the embedding of Same Day Emergency Care and Adult Assessment Unit pathways. The programme has also enabled the delivery of the patient safety and incident response framework (PSIRF).

Our culture

Our culture work stream has focused on the patient and staff survey, with feedback to action work undertaken locally and collectively to address identified shortfalls, whilst ensuring areas of good practice are maintained and shared as part of our culture of sharing and giving feedback. The embedding of the Trust's values, establishment of staff networks and protected characteristic groups have helped to engage our people and ensure that their voices are heard. A shared governance framework has been adopted across nursing, midwifery and allied health professionals (AHPs).

There are also increased resources in place to help managers with effective rostering and workforce planning and enhanced support for our people through our accredited staff health and wellbeing team. Work on streamlining our people tools, onboarding process and organisational development offering and access to resources is ongoing through our digital platform including the This is Me System (TIMS) and electronic staff record (ESR) being improved and embedded. The 'Ready to Manage' programme was successfully launched with 21 modules available for our people to access.

The equality, diversity and inclusion strategy and associated action plans have been produced and implemented. The People Strategy 2024-2030 will be launched later this year and will provide details of the next steps in our journey to enhance our culture at PAHT.

Digital health

Digital health has been a fast-moving programme to advance the care and services provided by the Trust using the latest digital technology. At the forefront of digital health is the replacement of our patient administration system with an electronic health record (EHR). This is a significant change and the largest transformation project undertaken at the Trust. This year has seen the completion of the planning and preparation of the new system, with the design and testing undertaken in preparation for go-live in October 2024. Work is underway to ensure that benefit realisation from the EHR implementation takes place and that the benefits identified in the Trust's business case are realised.

Other developments have taken place including the deployment of AI, through the introduction of the CDS i-refer system in radiology, the introduction of robotic surgery in theatres, a reduction in the use of paper and an increase in system integration. Remote healthcare delivery has been adopted across clinical services as well as remote monitoring and use of wearable technologies.

New hospital

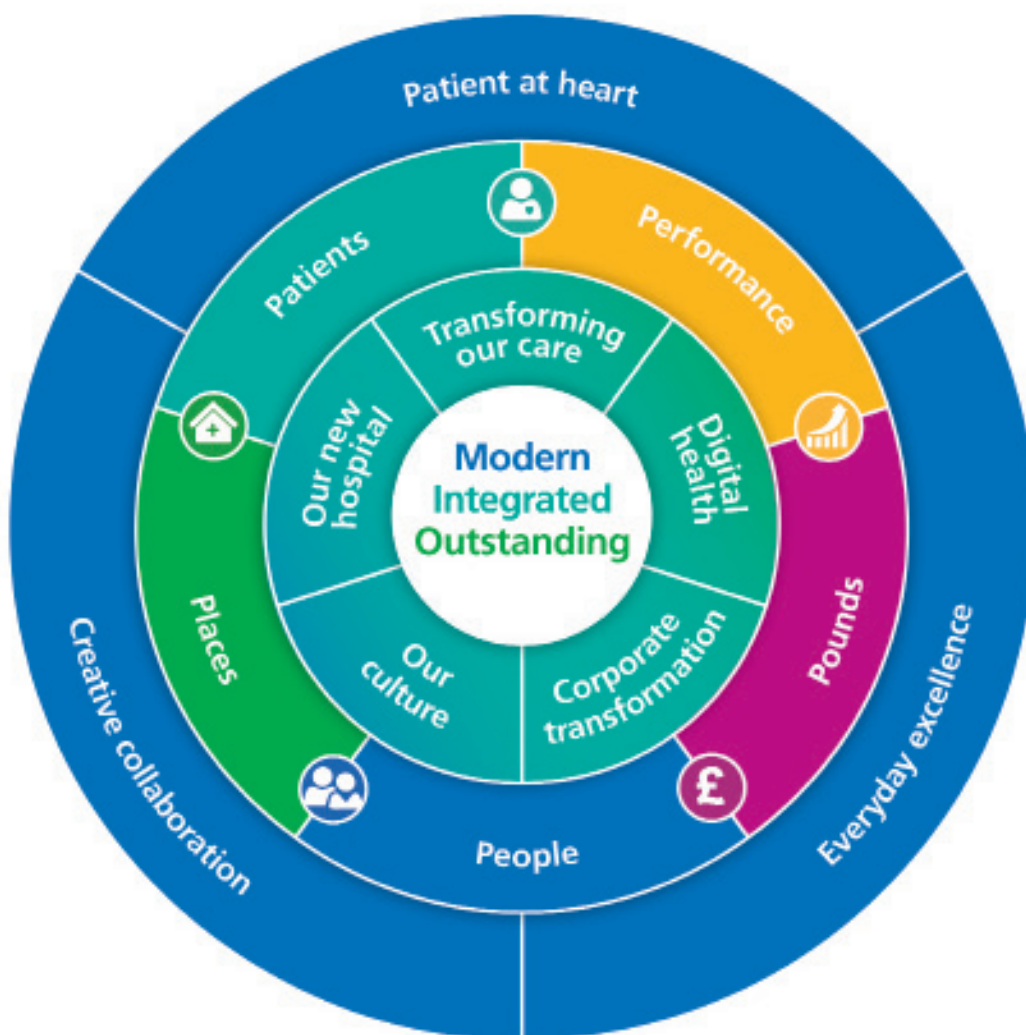
Preparations for the new hospital have continued with work undertaken to revisit and refine the demand and capacity work to ensure that we build a hospital that aligns with the future needs of our patients. The business case is being progressed through the National Hospital Programme (NHP) and the hospital team responsible for the design and delivery of the programme is being recruited into.

Corporate transformation

The corporate transformation programme focused on improving and rationalising some corporate functions to enhance the support provided to clinical and front-line teams. The finance team has achieved level 1 accreditation as part of the FFF programme, with increased automation and a new financial ledger system. We have made improvements in enabling self-service access and functionality for corporate functions to have increased and improved access to information and data. Governance processes have also improved in terms of reporting, planning, budget setting and business planning.

Work has continued to modernise corporate functions including the medical secretariat, where digital dictation is being adopted. The ICS pathology laboratory outsourcing mobilisation is progressing with key improvements expected to be delivered in terms of turnaround times, service provision and costs. New ways of working in our corporate areas following the EHR implementation will see significant change taking place which will generate improvements in both efficiency and productivity.





West Essex Health and Care Partnership

The Trust is a member of the West Essex Health and Care Partnership which brings together provider and commissioning organisations with a common purpose of improving health outcomes for the population of west Essex and parts of east and north Hertfordshire. The partnership works together to take joint action to improve and integrate services, to influence the wider determinants of health and to improve the sustainability of our health and care system.

Core partners include PAHT, Hertfordshire and West Essex Integrated Care Board, Essex Partnership University NHS Foundation Trust (EPUT), Essex County Council, Hertfordshire Community Trust (HCT), Primary Care Networks, Epping Forest, Harlow and Uttlesford District Councils and our voluntary sector.

The partnership has a fast-growing population from commuter towns to rural countryside villages. Our communities have their own identities and vary greatly in demographic and healthcare needs.

Some of the challenges identified by the partnership include:

- Constrained financial resources and increasing demand due to demographic changes
- Recovering from the impact of, and adjusting to living with Covid-19
- The population of west Essex living longer, growing faster and more people with comorbidities needing access to our health and care system
- Marked differences in health experience and outcomes, driven by differences in social determinants of health and variation in service provision
- Multiple entry points for people accessing our services
- While some outcomes are better than average, there is data suggesting these are achieved through a comparatively heavy reliance on hospital care

Achieving health equity and preventing poor health:

The difference in health outcomes across our localities is often related to the wider determinants of health that could influence an individual's or community's choices and their ability to remain healthy. Not addressing the wider causes of ill health denies our patients and residents the tools to optimise their health, causing further ill health and fostering dependence on the NHS and social care services.

The partnership has worked with our Primary Care Networks to achieve the outcomes that are important to our communities. In support of its ambition to achieve health equity and prevent poor health, the partnership has focused on the following programmes of work in 2023-24:

- An Integrated Urgent Treatment Centre offer in Harlow
- Expansion and integration of community capacity and capability – Virtual Ward and falls service
- Whole place system flow programme including Care Coordination Centre
- Integrated Neighbourhood Teams including acute outreach to support our complex frail patients, through an anticipatory care planning approach
- New model for intermediate care
- Local implementation of ECC Adult Social Care Market Shaping Strategy
- Expansion of the Harlow Health Inequalities Project
- Community asset building through developing the health and wellbeing offer of Community Hubs
- Targeted approach for children mental health
- Future skills for health and social care careers with the education sector including apprenticeships and targeted programmes for entry level employment
- Key worker accommodation
- Estate review

Looking ahead to 2024-25, a delivery plan has been developed which focuses on three priorities:

Priority 1: Prevention

Through a “Healthy Places” approach led by our district councils, our plans will address the prevalence of obesity, wellbeing and resilience of children and young people. We will also focus on adults at risk of worsening mental wellbeing.

We will also focus on cardiovascular disease by supporting people to manage their long-term condition and reduce acute inpatient episodes, increasing case finding for hypertension, education and the development of our integrated heart failure pathway.

Priority 2: Frail population, those living with multiple long-term conditions or at end of life

To develop a proactive and preventative model of care that will meet individual needs in the community, to maintain independence and when there is an escalation of need this is managed in the community to prevent emergency department (ED) attendances and inpatient episodes.

Priority 3: Community urgent and emergency care

Improving access to emergency care in the community through the development of urgent care pathways including urgent community response and falls pathways, the increased utilisation of virtual ward and the continued development of the primary care led Integrated Urgent Assessment and Treatment Centre. This will also protect our emergency departments for those people that need access to the specialist urgent and emergency response of our acute hospitals. We will also continue the development of our enabler programmes bringing partners together to address workforce challenges, improve utilisation of our collective estate and support planning for growth and digital innovation.

Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board (ICB) is the local NHS organisation that plans and oversees how NHS money is spent and makes sure health services work well and are of high quality. The ICB was established on 1 July 2022.

Overall, the Hertfordshire and West Essex Integrated Care System (ICS) is designed to:

- improve the general health and wellbeing of Hertfordshire and west Essex residents, and improve health and care services in the area
- tackle the inequalities which affect people's physical and mental health, such as their ability to get the health services they need, and the quality of those services help tackle health and wider inequalities
- get the most out of local health and care services and make sure that they are good value for money
- help the NHS to support social and economic development in west Essex and Hertfordshire.

The Health and Care Partnership delivery plan 2024-25 will support the delivery of the ICB's strategic priorities.

Key risks

The Trust has a Board Assurance Framework (BAF) which provides a mechanism for the Board to monitor risks to delivery of the Trust's strategic objectives. The risks are reviewed monthly and progress is monitored by the relevant board committees and Trust board every other month. Each risk is aligned to one of the strategic objectives.

A summary of the BAF risks is below:

Board assurance framework risks 2023-24

Strategic objective 1: Our patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population.

- **1.1: Clinical outcomes:** Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience
- **1.2: EPR:** The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care
- **1.3: Recovery programme:** Risk of poor outcomes and patient harm due to long waiting times for treatment

Strategic objective 2: Our people – we will support our people to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our Staff Survey results.

- **2.1: GMC enhanced monitoring:** There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services
- **2.2: Workforce:** Inability to recruit, retain and engage our people

Strategic objective 3: Our places –we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an outline business case (OBC) for a new hospital, aligned with the further development of our local Integrated Care Partnership.

- **3.1: Estates and infrastructure:** Concerns about potential failure of the Trust's estate and infrastructure and consequences for service delivery.
- **3.2: System pressures:** Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system
- **3.3: New hospital:** There is a risk that the new hospital will not be delivered to time and within the available capital funding

Strategic objective 4: Our performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators.

- **4.1: Seasonal pressures:** Risk that the Trust will be unable to sustain and deliver safe, high quality care during seasonal periods due to the increased demand on its services
- **4.2: Emergency department (ED) performance:** Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience
- **4.3: Industrial action:** There is a risk that the ongoing industrial action creates deteriorated operational performance in both elective and urgent care

Strategic objective 5: Our pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.

- **5.1: Revenue:** Risk that the Trust will fail to meet the financial plan

Going concern

The Trust Board has assessed the Trust's ability to continue for the foreseeable future in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual. Consequently, as in previous years, the Trust has prepared its 2023-24 Annual Accounts on a going concern basis.

In approving the Trust's annual accounts, the board of directors has satisfied itself that the Trust has prepared the accounts on the basis of a going concern.

The directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS has published its Medium-Term Financial Plan for the period 2024/25 - 2027/28 and this plan includes the continued provision of services by the Trust. The Trust is one of 3 acute providers within the ICS and key to the delivery of the future healthcare provision for Herts and West Essex.

The Trust continues to develop and is planning for a new hospital which will be funded directly by the Treasury. The proposal and Strategic Outline Case (SOC) is supported both locally and nationally by a range of stakeholders.

There are no known factors or circumstances identified that would cause the directors to doubt that The Princess Alexandra Hospital NHS Trust will continue to provide healthcare services into 2024-25.

For the 2023-24 financial year, the Trust delivered a system performance deficit of £6.1m against the system breakeven plan. Income from our local Integrated Care Board (ICBs) was largely under the NHS Payment Scheme (NHSPS) which

replaced the National Tariff Payment System on 1 April 2023 and this provided relative certainty regarding our income and cash flow with the majority of income that the Trust receives based on 'fixed/block contracts' rather than being linked to cost and volume; the Trust ended the financial year with a £28.2m cash balance. The Trust received specific income for Elective Recovery (ERF) and the ongoing Covid-19 costs, although this value was lower than the previous year and continues to reduce in 2024-25.

For 2024-25, we continue with the funding arrangements as a mixture of fixed payment and activity based contracting, with COVID funding as a percentage (0.1%) of the contract embedded.

The Trust's income is predominantly made up from commissioner contracts uplifted for inflation and growth, with an allocation for Covid support and Elective Recovery (ERF) to reduce the longer wait elective patients.

The financial requirement for the year will be reducing the Trust's underlying cost base and delivering efficiencies to achieve a deficit plan of £25.4m. This position includes a £18.5m Patient, Quality and Performance (PQP) efficiency target and an agreement with the ICS to deliver efficiencies across the provision of healthcare across the system which have been collectively agreed as an ICS.

The Trust has prepared a 12 month rolling cash forecast, incorporating the planned £25.4m deficit, during the going concern period to 30 June 2025. The cash forecast shows sufficient operating liquidity for the Trust to continue during 2024-25. The Trust has access to NHS working capital support and loans should the need for this arise, however, there is no expectation of utilising this facility during 2024/5.

In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Performance analysis

Financial performance

2023-24 has seen the NHS transition from the pandemic financial regime. As part of these arrangements NHS organisations have seen a reduction in top-up and Covid income and targeted investment to tackle and reduce elective and 104 week waits. Whilst the Trust did receive some additional income support for winter and mental health/community discharge challenges, the non-recurrent income seen over the previous 2 financial years has been substantially reduced.

The delivery of the elective recovery and 104-week waits has seen service pressures through higher staffing cost, insourcing to meet capacity challenges and the outsourcing of activity. In addition, continuing temporary staffing expenditure, reduced productivity and higher estates costs reflecting the ageing infrastructure have contributed to the Trust's deficit in 2023-24.

Operating and financial review

The Trust delivered an adjusted financial performance deficit of £6.1m for the financial year 2023-24 (please see note 29 of the accounts). This was an improvement of £6.9m from the deficit achieved in 2022-23, however, the financial environments are not comparable due to changes in the contracting arrangements as the NHS moves out of the pandemic response and towards the Government's 'living with Covid' strategy and the receipt of significant non-recurrent funding in 2023-24.

Cost improvement

The Trust made efficiency savings of £16.7m in 2023-24, of which 48% were non-recurrent. Throughout 2023-24, the Trust used our Patient Quality and Productivity (PQP) programme and putting the patient at the centre of everything we do and making sure we optimise productivity through high quality care. In 2023-24 efficiency savings were delivered utilising the new Trust wide PQP programme.

Capital investment

The Trust invested £29.9m in capital infrastructure and equipment to support the delivery of services in 2023-24 and future years. Key projects included major investment in the development of the electronic health record (EHR), infrastructure upgrades across our estate and ICT to improve the sustainability and resilience of our systems, the Community Diagnostic Centre (CDC), robotic assisted surgery and radiology imaging facilities.

Approximately half of the spend was funded through the Trust's own self-funded capital programme with the other half provided through Public Dividend Capital (PDC) which is provided via DHSC.

The investment in the PAH New Hospital Programme has continued in 2023-24 as the Trust looks towards further developing the business case. The planned capital investments for 2024-25 include:

- Continued investment in EHR, CDC and imaging capacity
- Redevelopment of the ICU corridors to improve flow
- Completion of our demountable training facility
- Estates and ICT infrastructure developments
- The development of our New Hospital Programme

These capital investments support

the Trust to meet our vision to provide high quality care for all patients each day and to demonstrate our focus on Corporate Social Responsibility to the communities we serve. While we plan for a new hospital, we recognise the need to continue to optimise our estate for meeting the short to medium term health needs of our patients. This does however cause funding challenges and is one of the on-going cost pressures we are seeking to balance.

Looking ahead

Looking ahead to 2024-25, the payment mechanism remains the same as 2023-24, utilising an aligned payment and incentive contract (API). It is a blended payment, made up of a variable element which funds the majority of elective care and a fixed element which is a stable, pre-agreed value for activity outside the scope of the variable element. Income contracts with the ICBs will be uplifted for inflationary impacts and offset by an efficiency requirement. The Trust will continue to receive elective recovery investment linked to improvements in

elective performance.

The ICS capital allocation continues to be constrained, the Trust's capital allocation is £14.3m of internally generated resources. Additional external capital funding (in the form of Public Dividend Capital) will be received to support the EHR development, Community Diagnostic Centre and the New Hospital Programme. These major capital investment projects will continue to transform the care that we are able to provide, whilst maintaining the existing hospital. In line with prior years, we anticipate further funding being received in the form of PDC in 2024-25 and may look to bid for some of this funding. We will continue to look at opportunities to further invest in our hospital to provide the best possible care to our local population now and into the future working with the Herts and West Essex system.



Key financial results

The following table shows a range of financial performance values taken from the accounts.

Accounts highlights	2023/24 £000's	2022/23 £000's
Adjusted Financial Performance Deficit	(6,125)	(13,049)
Public Dividend Capital Dividend Payable	(4,357)	(4,014)
Value of Property, Plant and Equipment	179,127	164,432
Right of Use Assets (Leases – IFRS 16)	41,698	31,655
Value of borrowings (Leases - IFRS 16)	(41,620)	(27,943)
Value of borrowings (including loans)	-	-
Cash at 31 March	28,242	39,196
Creditors – trade and other	(51,215)	(51,994)
Debtors – trade and others	14,953	14,408
Revenue from patient care activities	342,014	339,047
Clinical negligence costs	(13,591)	(13,242)
Gross employee benefits	(266,699)	(246,877)



Better payment practice code

The code sets out the following obligations for NHS organisations in respect of the payments it makes to its suppliers (please see note 26 of the accounts) principally:

- payment terms are to be agreed with suppliers before a contract commences
- payment terms are not to be varied without prior agreement with a supplier
- by default, bills are to be settled within 30 days unless other terms have been agreed

During and post the COVID-19 pandemic, the Trust is committed to making supplier payments within 30 days of the invoice date. Where possible and appropriate the Trust will accelerate payments to suppliers recognising its responsibility to support all businesses in sustaining cash flow.

Operational performance

The Trust's operational performance against national and local standards is monitored and reviewed at:

- Regular Divisional Review Meetings between members of the executive team and each division or department
- Urgent Care Board
- Access Board
- Cancer Board
- Senior Management Team meetings
- Performance and Finance Committee
- Trust Board meetings

An Integrated Performance Report is presented to the Performance and Finance Committee, Quality and Safety Committee and Trust Board meetings. Externally, the Trust is held to account for its operational performance by NHS England and its commissioners.

As such performance in 2023-24 was an improvement on 2022-23. We will as part of our enhanced focus on cash management in 2024-25, continue to review our payment performance and policy.

Anti-fraud and bribery

The Trust continues to work to maintain an anti-fraud, bribery and corruption culture and has a range of policies and procedures to minimise risk in this area. The Trust is committed to providing and maintaining an absolute standard of honesty and integrity in dealing with its assets. We are committed to the elimination of fraud, bribery and illegal acts within the Trust and ensure rigorous investigation and disciplinary or other actions as appropriate if allegations are made. The Trust utilises best practice, as recommended by NHS Counter Fraud Authority.

Targets and national standards

Elective performance

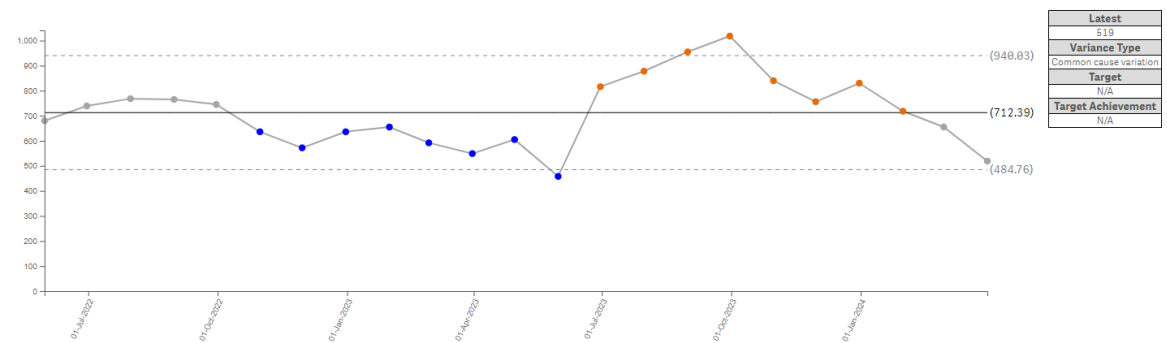
Delivery of national standards has continued to be impacted by the increased elective waiting lists caused by the COVID-19 pandemic, industrial action and high numbers of emergency patients requiring care. The Trust has established infection and prevention processes that minimise bed closures for COVID-19, influenza and norovirus.

The Trust has focused on improving the efficiency of services to ensure that as many patients receive appointments and treatment as possible with the facilities and staff available. Full elective operating was delivered for a second winter period with only a 2 week closure of the orthopaedic ward to support the increased emergency admissions. Critical care capacity has been challenged during 2023-24 with a number of elective critical care cases requiring rescheduling due to emergency

pressures and developments to increase capacity are being developed.

The 18 week Referral to Treatment (RTT) standard has been impacted by the long waiting times for treatment with 48% of our patients waiting over 18 weeks for routine treatment. This standard has remained steady throughout the year as routine patients are treated in chronological order to reduce the longest waiting times. The Trust continues to book patients in clinical priority order with urgent and cancer treatments continuing to be delivered in under 18 weeks.

Referral to Treatment access target – patients waiting over 65 weeks

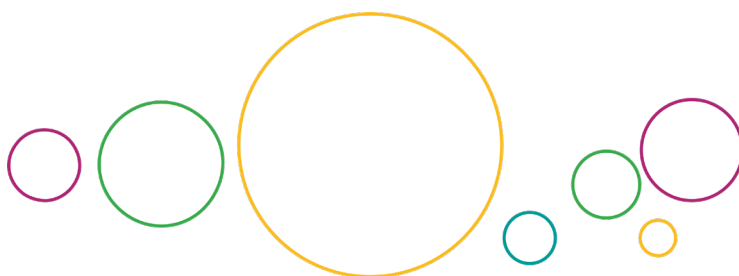


(Statistical Process Control chart – dotted lines show the confidence limits for data points fluctuating through common cause variation)

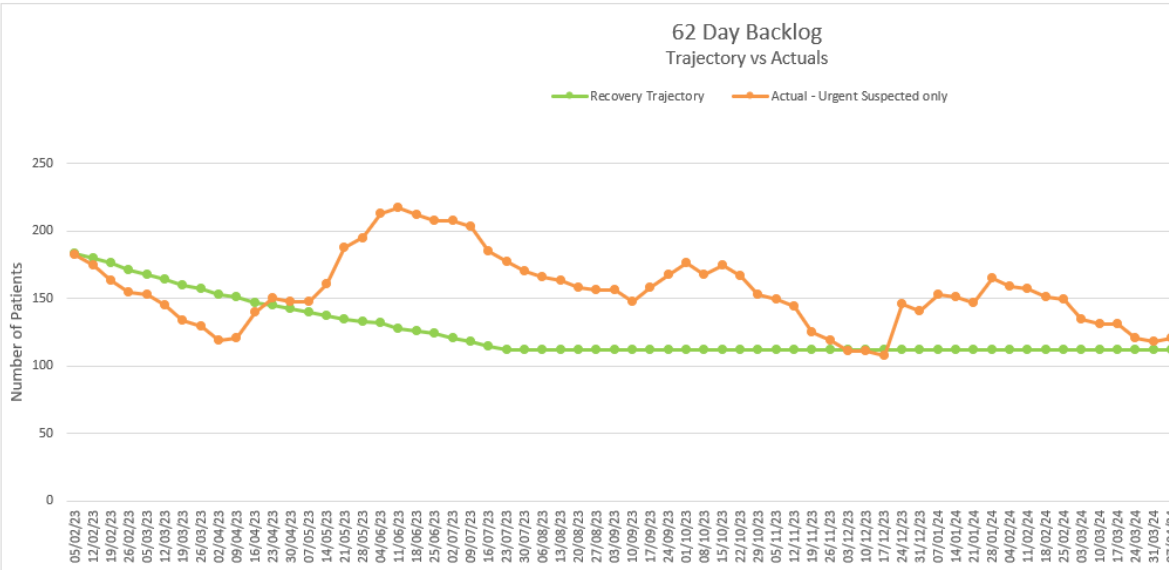
The Trust has also reduced the number of long waiting patients over 78 weeks however the aim to have no patient waiting this long by July 2023 was not achieved due to the impact of industrial action and the requirement to prioritise an increase in cancer and urgent patient treatments. This aim remains a focus for the Trust along with the requirement to have no patients waiting longer than 65 weeks by 30 September 2024. The graph above shows the impact of the industrial action during 2023-24 increasing the number of longest waiting routine patients and the progress made to reduce the number waiting in 2024.

Cancer performance

Delivery of the national cancer standards has continued to be impacted by the number of patients waiting over 62 days for their treatment however significant progress has been made in reducing the long waits. The Trust only slightly missed the target set by the national team for numbers of patients waiting longer than 62 days for treatment.

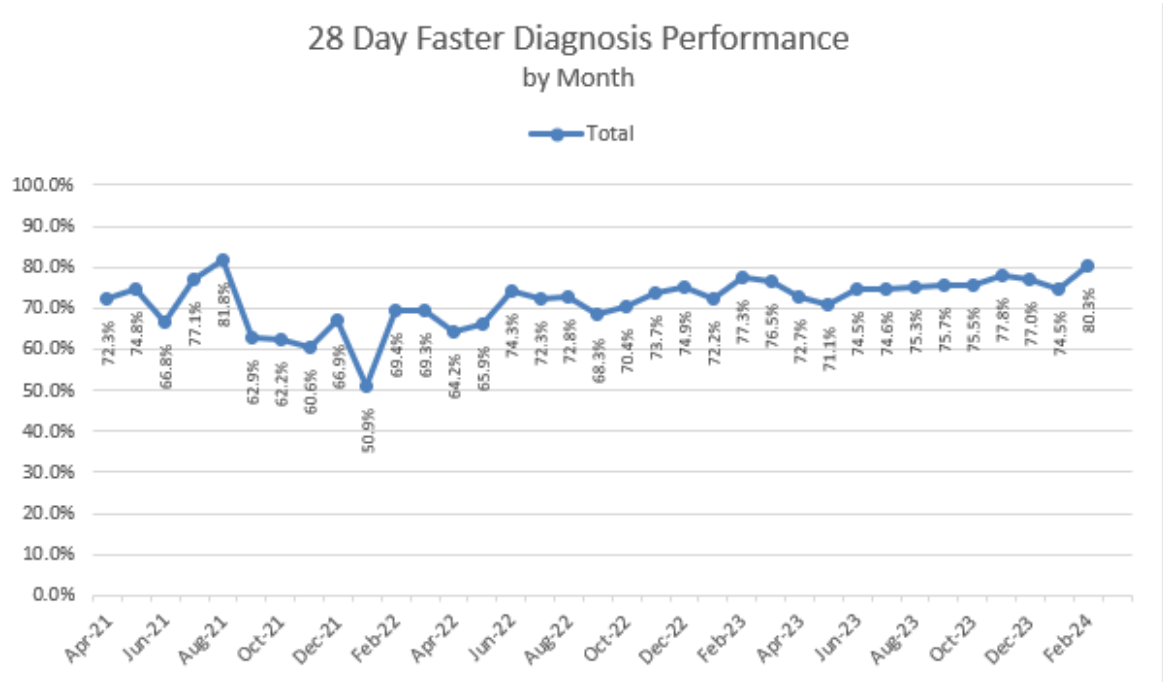


62 Day cancer backlog



The Trust has achieved the national standard of 75% for the 28 day Faster Diagnosis Standard for more than 6 months and is one of the top performing Trusts in the East of England for this clinical safety standard.

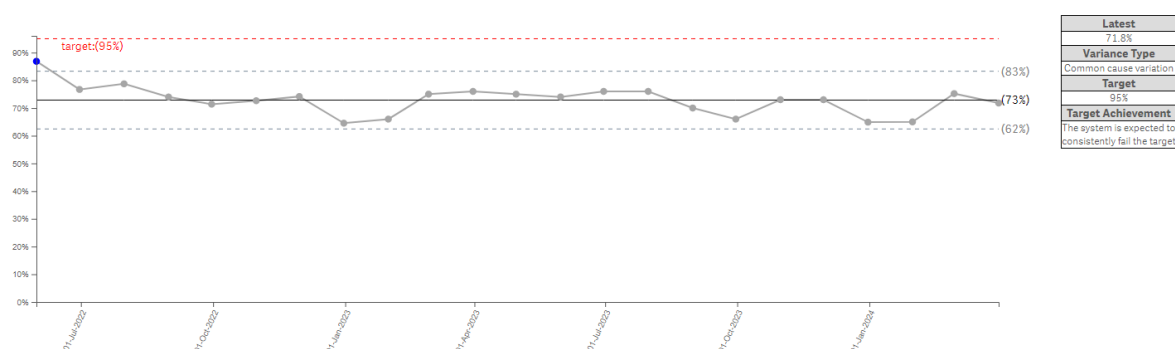
28 Day Faster Diagnosis Standard



Diagnostic performance

Diagnostic performance has also been impacted by backlogs of routine patients waiting longer than 6 weeks for their diagnostics. There has been a significant increase in referrals such as MRI increases of 34% and 18% in ultrasound. The opening of additional capacity at the St Margaret's Hospital site and ongoing additional capacity from temporary diagnostic services has contributed to a steady improvement in the number of patients receiving their radiology diagnostic within 6 weeks. Additional capacity in the audiology service has improved waiting times for patients and the endoscopy service is also delivering additional capacity and has significantly improved performance.

Diagnostic times: Patients seen within 6 weeks

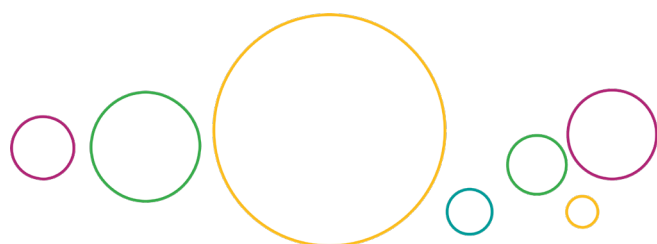


(Statistical Process Control chart – dotted lines show the confidence limits for data points fluctuating through common cause variation).

Urgent and emergency care performance

The proportion of patients treated within 4 hours in the emergency department has remained lower than the national target during the year although increased in March 2024 to 64.9% as the improvement plan started to embed. Demand for urgent care services remained high in 2023-24 and flow through the hospital was challenged impacting on the swift movement of patients to the most appropriate clinical ward and the off-loading of ambulances into the department.

The Trust has implemented a number of improvements to improve transfer to wards such as a larger discharge lounge with longer opening hours, a “golden patient” initiative to expedite morning discharges and a reverse boarding policy. During 2023-24 the Trust has partnered with Stellar Health, Stort Valleys Federation, Essex Partnership University Trust and Herts Community Trust to create an Integrated Urgent Treatment Centre service with pathways from 111 and the emergency department reception triage to offer a more effective service for minor health conditions. In addition, working closely with East of England Ambulance colleagues the Trust has made improvements in hours lost to handover.



Responding in an emergency

The responsibility of the Emergency Preparedness Resilience and Response lead (EPRR) is to ensure that PAHT fulfils its legal obligations as a category 1 responder under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012, amended 2015.

For the reporting year 2023-24 the EPRR lead has focused on ensuring that PAHT meets the required standards which had changed from previous years; developing and commencing the required national operating standards and core standards training.

All business continuity plans are up to date for all the critical services ensuring that if an emergency or business continuity event occurs PAHT is prepared and able to continue its critical services. As required nationally, an assessment against the NHS England emergency preparedness, resilience and response core standards was undertaken and assurance provided to NHS England.

The Covid-19 'command and control' structure remained in place to meet the increases and decreases in demand and respond to changing situations including periods of industrial action. The initial structure comprised a Strategic Command Cell, with tactical cells managing operational response, clinical response, infection prevention and control, supporting our people, communications response and the management of our estate and infrastructure.



Clinical performance

Infection prevention and control

Respiratory viruses including COVID-19

In 2023 - 2024 we saw a reduction in the impact of COVID-19. COVID-19 testing and documented outbreaks reduced throughout the course of the year, with a shift towards managing COVID-19 as part of a wider group of respiratory viruses in line with the UK Health Security Agency (UKHSA) recommendation. In line with national guidance, testing for COVID-19 (in patients as well as health care staff) reduced gradually over the course of the year. Only symptomatic patients were tested for COVID-19, either by lateral flow tests or using rapid diagnostic testing. A total of 32 COVID-19 outbreaks were recorded across our wards in 2023 - 2024, compared to 41 in the previous year.

Our in-house microbiology laboratory responded to the changing requirements for management of respiratory infections in our patients, and by early 2024 introduced polymerase chain reaction (PCR) testing using a wide respiratory panel. Previously only COVID-19, Influenza A and B and respiratory syncytial virus (RSV) were tested for, in and out of hours.

Point of Care testing helped clinicians adhere to the latest guidance from the Royal College of Paediatrics to isolate children with respiratory viruses appropriately whilst protecting immunocompromised children.

Clostridioides difficile (C.difficile)

A total of 48 hospital and community onset health care associated C. difficile cases were reported during the year 2023-24. Of these, 38 were hospital-onset, health care associated (HOHA), detected three or more days after admission, and 10 were community-onset healthcare associated (COHA), detected in the community, or within two days of admissions, and the patient had been an inpatient in the Trust in the previous four weeks. This compares with a total of 36 cases in 2022-2023, 28 of which were HOHA, and eight were COHA.

There is a link between C.difficile infection and antibiotic use, particularly broad spectrum antibiotics. The total antibiotic consumption in the organisation continues to be high, and the Trust continues to implement its action plan which includes reducing antibiotic burden, reviewing treatment protocols and reducing course lengths, monitoring antibiotic use in hospital and improving medical engagement with the antimicrobial stewardship agenda. We look forward to sharing our work with the NHS England regional team in May 2024.



Meticillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia Infections

There was one case of HOHA MRSA bacteraemia this year, and no COHA cases.

This was the first HOHA MRSA bacteraemia case that the Trust has had in 18 months. PAHT is below the East of England (EoE) regional average rate per 100,000 occupied bed days (0.70 for the Trust, compared to 1.57 for the EoE region), and also has the lowest rate of the three acute Trusts in the ICS for MRSA bacteraemia cases.

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia Infections

Unlike some other alert organisms, there is no trajectory in place for MSSA bacteraemia, however, the Trust has continued to closely monitor and review its cases. PAHT previously had low rates of MSSA bacteraemia cases, however, over the last few years there has been an increase. This is reflective of national data, with some infections significantly increasing during the COVID-19 pandemic.

This year, we had a total of 11 HOHA cases and one COHA case. In comparison to the region, the Trust is considerably below the EoE average rate per 100,000 occupied bed days (8.39 for the Trust, and 13.95 for the EoE region), and also has the lowest rate of the three acute Trusts in the

Integrated Care System (ICS)

Gram Negative Blood Stream Infections (GNBSIs)

In line with the ambition to reduce the incidence of gram-negative bloodstream infections (GNBSI) in England, the IPC team has been monitoring trends in GNBSIs throughout the year. Our local data matches national trends except we report more respiratory source infections. The IPC team plan to review respiratory source infections in 2024 – 2025, and monitor this trend.

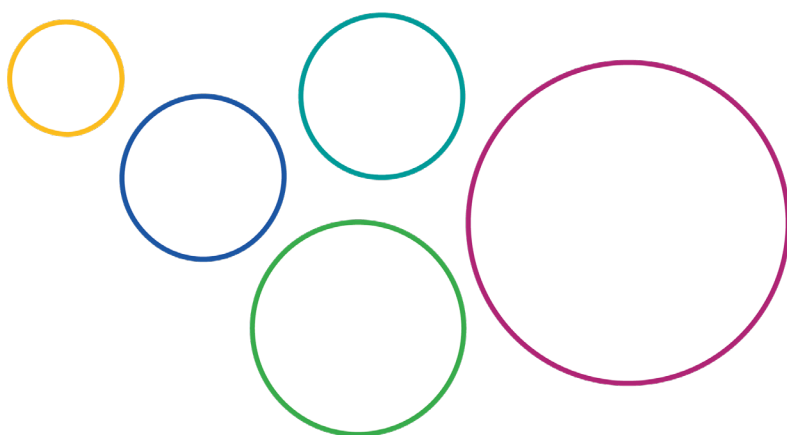
Infection incidents and outbreaks

Norovirus

Norovirus is a common cause of diarrhoea and vomiting outbreaks in hospitals (and other close contact settings) during the winter months. There were four outbreaks of confirmed norovirus in the Trust during 2023-2024.

Measles

An increase in cases of measles is currently a public health concern, and the UKHSA issued several briefing notes on actions required to avert a measles resurgence. Towards the end of 2023-2024, the EoE started to see a rise in cases, and the Trust had two confirmed cases admitted (one adult and one paediatric case, both unvaccinated) in total for 2023-2024.



The Trust has reviewed its processes against the actions set out in the briefing notes, and the IPC team have taken a number of measures, including:

- Ensuring the provision of oral fluid test kits are in place (or alternative viral swabs)
- Development of a measles admission pathway
- Working with staff health and well-being (SHaW) team to ensure there is knowledge of staff vaccination against measles in high risk areas
- IPC progressing development of a measles policy
- Ensuring clinical areas are aware of changes to guidance in the IPC national manual which states staff

must be fit tested and wear FFP3 mask

- Working with the emergency department team to ensure prompt recognition of cases and supporting reception staff to identify potential cases
- Incident review meetings are held for suspected/confirmed cases

In 2024-2025, the Trust will continue its improvement plans for the reduction of C.difficile cases and provision of antimicrobial stewardship leadership. We will also focus on reducing the number of avoidable bloodstream infections for MRSA and MSSA and for Gram Negative BSI.

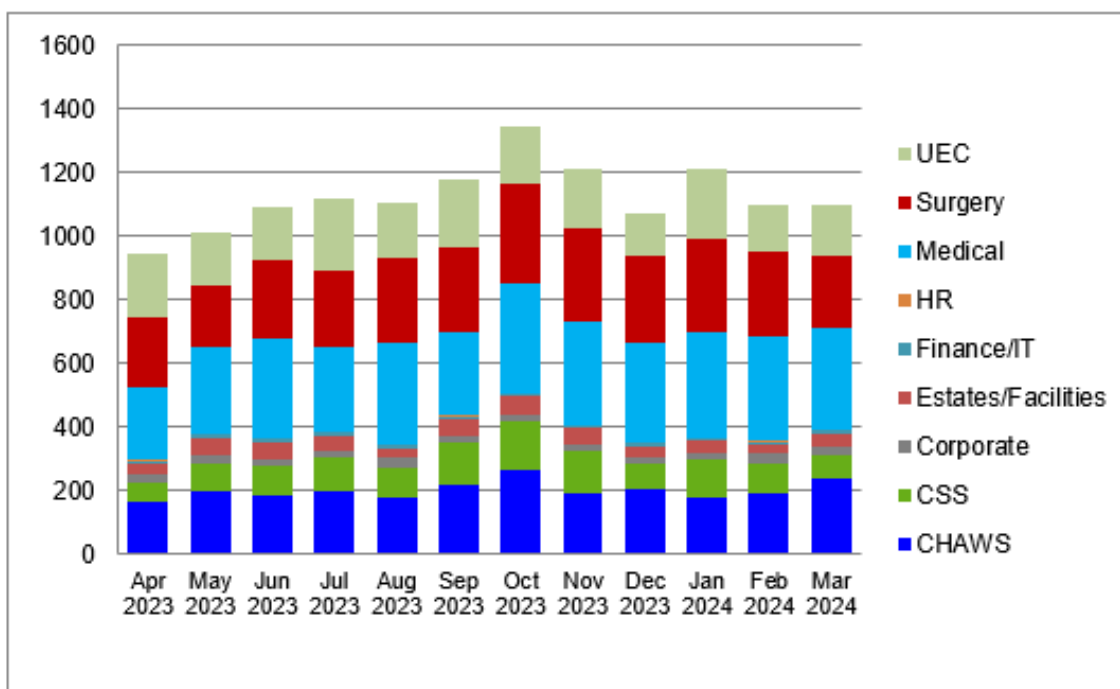
Learning from patient safety incidents

Patient safety is a priority and we continuously work to ensure that incidents are managed effectively, promptly and most importantly, that we learn from them and share the improvements arising with relevant staff members.

A patient safety incident or adverse incident is defined as ‘any unintended or unexpected incident which could have, or did lead to harm for one or more patients receiving NHS funded care’. This includes all terms such as adverse incidents, adverse events and near misses, where an incident was recognised and averted.

For the year 1 April 2023 to 31 March 2024, 13,496 incidents were reported on the Trust’s Datix incident management system; this is comparative to the previous year’s reporting. The spread of incidents across our divisions is reflected below.

Incident reporting data for period 1 April 2023 – 31 March 2024



Category of non-patient safety incidents

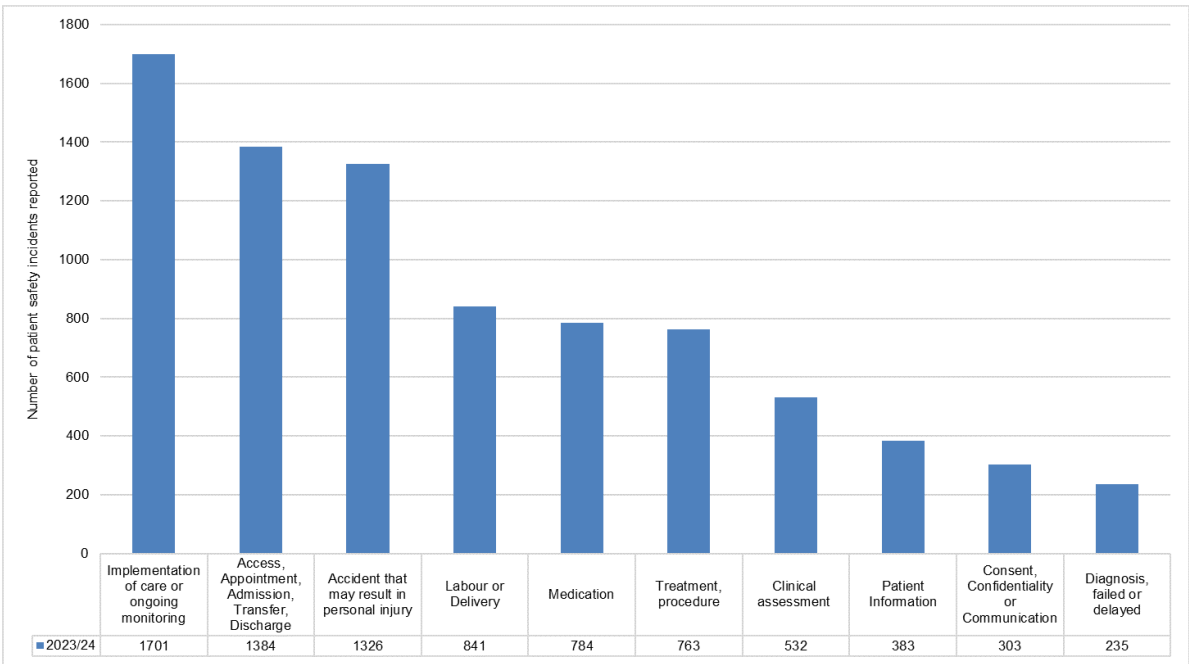
A large proportion of our incidents are not about patient safety and these are detailed below:

Incident category	Number of incidents reported
Patient safety incident	8546 (63%)
Monitoring	1599 (12%)
Staff incident	1055 (8%)
Staff shortage	725 (5%)
Equipment incident	588 (4%)
Security incident	539 (4%)
Environmental incident	353 (3%)
Visitor incident	91 (1%)

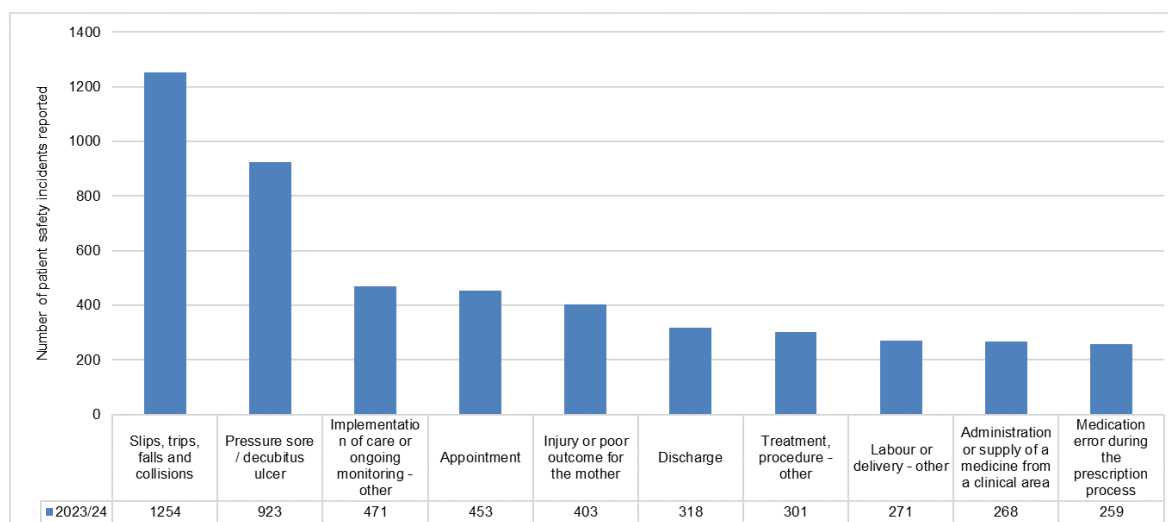
Top 10 patient safety incidents

The top 10 categories of patient safety incidents reported in this financial year are summarised below along with themes of care incidents. These are reported to the National Reporting and Learning System (NRLS) to enable learning and comparison with similar sized organisations across the country to occur.

Top 10 categories of patient safety incidents for 1 April – 31 March 2024



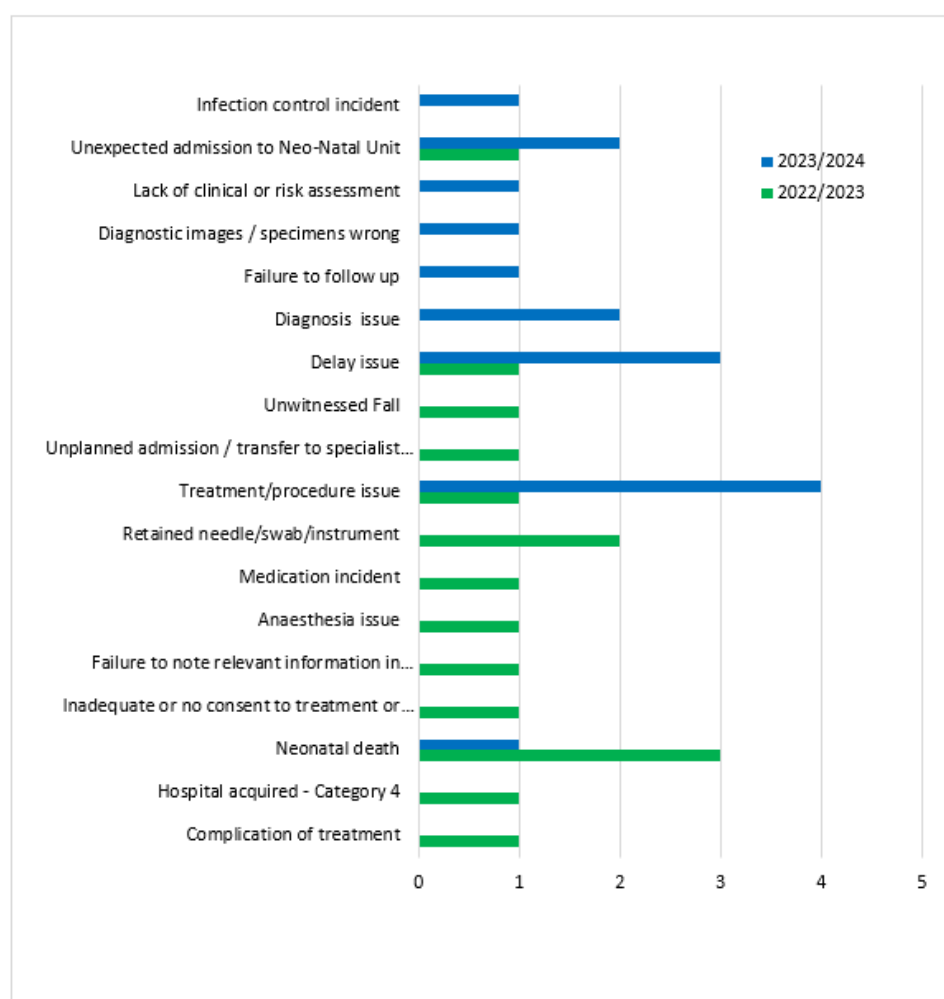
Top 10 themes of care in patient safety incidents which were given for 1 April 2023 – 31 March 2024



Serious Incidents

The Trust raised 19 serious incidents (SIs) during the period 1 April 2023 to 31 March 2024. 3 of these incidents have been raised since January 2024 when the trust commenced management of incidents using the national Patient Safety Incident Response Framework; these incidents are now called PSII investigations. A comparison of incidents raised in 2023-4 against those in the previous year is reflected below.

Number of serious incidents reported - a 2-year comparison of data



Once an SI /PSII investigation is concluded, an action plan is developed to capture the learning and recommendations that needs to be undertaken to prevent a reoccurrence. The Trust uses a sharing the learning report to ensure all relevant staff are

- aware of the key issues that occurred in this incident
- the changes to practice either implemented or being completed
- what the learning from the incident is to prevent reoccurrence

This is presented and shared widely within the local teams where the incident occurred and if relevant to other clinical areas with divisions across the Trust. This information is reported in a Trust wide report that is taken to monthly or quarterly quality governance meetings, including the Quality and Safety Committee.

Of the 19 SIs/PSII's raised during 2023/4, three were Never Events. Investigations for two of these incidents have concluded with robust action plans developed and shared. A subsequent audit confirmed that the actions had been embedded into staff practice. The remaining never event investigation is ongoing however, immediate actions were developed and implemented pending conclusion of the investigation.

Examples of changes implemented as part of learning from incidents

Pressure ulcers

Repositioning of patients in a timely manner and accurate maintenance of records supports pressure ulcer prevention. The implementation of a project called 'Care Colour Circles' provides a visual aid to staff that enables prioritisation of patients according to their pressure ulcer risk. This initiative was introduced on 3 inpatient wards. There is now a

plan in place to introduce this to all inpatient wards.

Consent process

E-consent has been implemented which allows clinicians to complete an electronic consent form during virtual clinic appointments, rather than on the day of surgery which has enhanced patient safety.

Neurological observations

Improvement work by the practice development team has taken place to ensure that nursing staff have gained the skills for undertaking and interpreting neurological observations. This is measured through a competency framework.

Peripheral cannulas

Improvement work has been undertaken to improve the accurate recording and monitoring of insertion, removal and ongoing care of invasive devices. A robust training plan has been established and auditing is in place to ensure that this procedure is carried out to the required standard.

High risk drugs

Improvement work had taken place to ensure that female patients of child bearing age receive the correct information and counselling to avoid pregnancy whilst taking a drug for a skin condition as the drug is harmful to a baby. The improvement work has involved:

- Training has been provided to ensure that a patient's electronic record shows that a patient is prescribed a high-risk drug
- Pregnancy prevention information and reminder cards have been made available to all clinicians
- A procedure has been implemented to ensure that all female patients on high risk drugs receive pregnancy testing according to national guidance

The year in patient experience

We continued to implement our Patient Safety, Experience and Quality Strategy which was launched in March 2022 with Aidan Fowler, National Director of Patient Safety which will support improvements in:

- **Communication:** Addressing harms related to poor communication and ensuring we develop a culture of learning and psychological safety
- **Technology:** Assessing and mediating the impact of technology on patient experience resulting in a reduction in evidence of concerns raised as a result of implementation of new technologies
- **Kindness:** Developing a culture of kindness and compassion to our patients and people which we can measure

The following projects have continued this year:

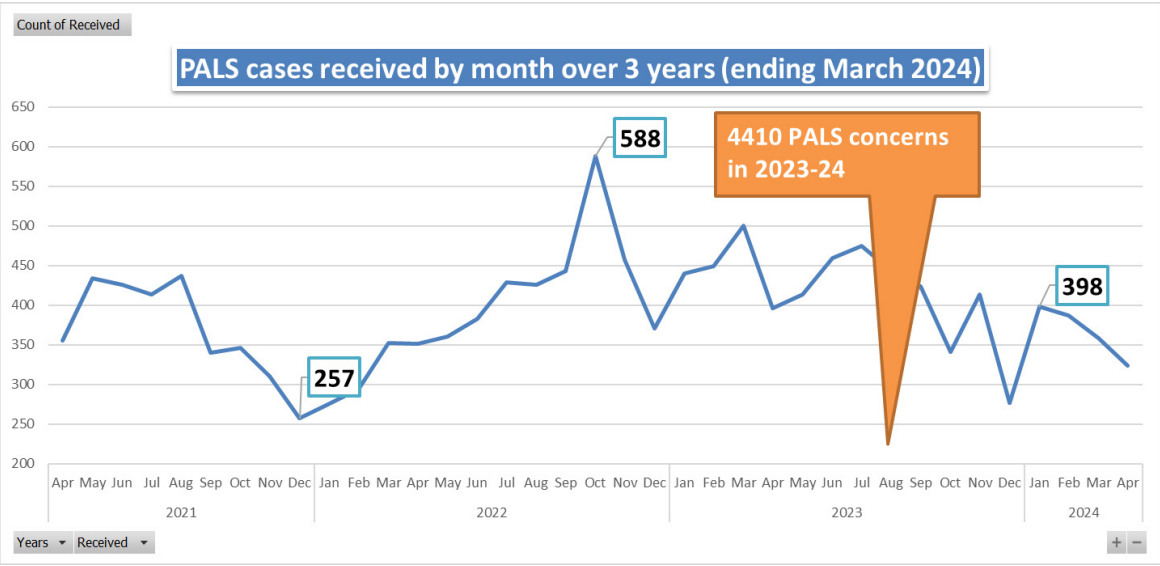
- **Communication skills training:** The highly effective new training programme known as SAGE and THYME has continued
- **Progress:** We have trained 911 staff in this method and have another 460 staff to go, with some evidence of the impact of the training being a one third reduction in the percentage of PALS cases relating to communication and a significant drop in complaints numbers overall.
- **Open visiting:** The recent introduction of extended open visiting which we anticipate will unlock significant improvements in experience for most families and carers
- **Progress:** We know this has had a positive impact on our patients and families and it is believed this has also contributed to reductions in complaints and a smaller increase in PALS cases than in previous years

- **Voluntary services support:** We have increased the number of volunteers on wards using a new support approach known as the compassionate care Namaste volunteer role. The idea of Namaste is to honour the spirit within, a critical concept for patients with dementia whose physical and mental state in hospital may not reflect their normal behaviours
- **Progress:** We continue to build on our Namaste approach with the development of new gardens which complement this work, 16 new volunteers recruited and ongoing plans to develop new members

New projects include:

- The implementation of our new EHR will be a significant change in how we deliver care and we held a workshop event on 21 June 2023 called: 'Electronic Health Record (EHR) and multiple disabilities' from which the patient portal work stream lead and subject matter experts were identified
- We facilitated an event to better understand how we could support our patients with long waiting times for planned care. This was held on 20 July 2023 and that data is now informing the support package patients and their families receive while they are waiting for treatments
- The patient experience team are offering a service at the main reception every morning and we are also working on improving the experience at the front entrance
- The Trust is running communication simulation workshops working with Health Watch Essex Ambassadors and Patient Panel members as well as people with physical and sensory impairments
- Ongoing outreach events have been held in children's centres and the African community working with Maternity Voices Partnership
- Outreach events supported by the Patient Panel, have been held at Bishop's Stortford and Epping.

We have seen a 3% increase in the number of PALS concerns raised this year; 4410 concerns were raised to the PALS team.



The top themes of the concerns raised to the PALS team related to delays (appointments), communication and cancellations.

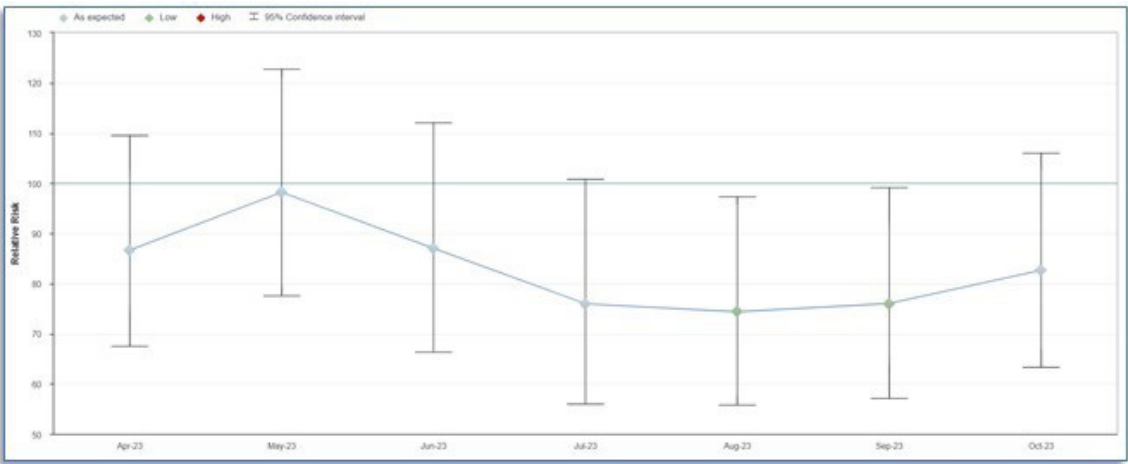
The main themes from the 259 complaints received related to medical care expectations, communication and nursing issues.

These themes, and our focus on hearing the voice of our patients and communities, are included in our strategic priorities and the work detailed above.

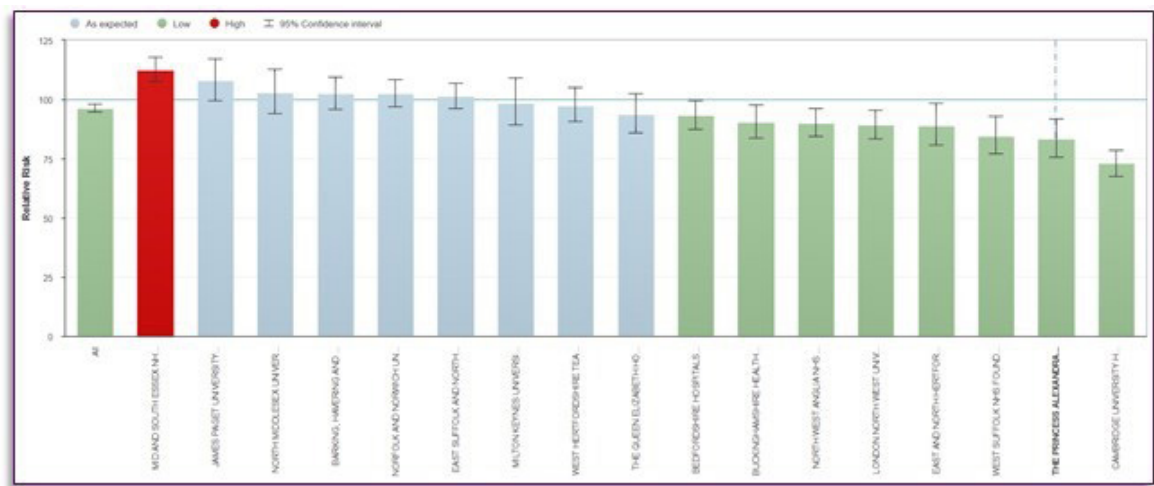
Mortality

The Trust has shown a significant improvement in HSMR, Standardised Mortality ratio (SMR), in the national and regional position in 2023-24.

During the year, the Trust consistently submitted fully coded data on a monthly basis with particular improvements in the capture of co-morbidity reporting and palliative care. Continuous improvements in care for patients and robust reviews of deaths have enabled the Trust return to "as expected" level in historical outlier categories such as sepsis, AKI, COPD, fracture neck of femur and diabetes. HSMR for the period April 2023 to October 2024 is 83.4 and "lower-than-expected" as below:

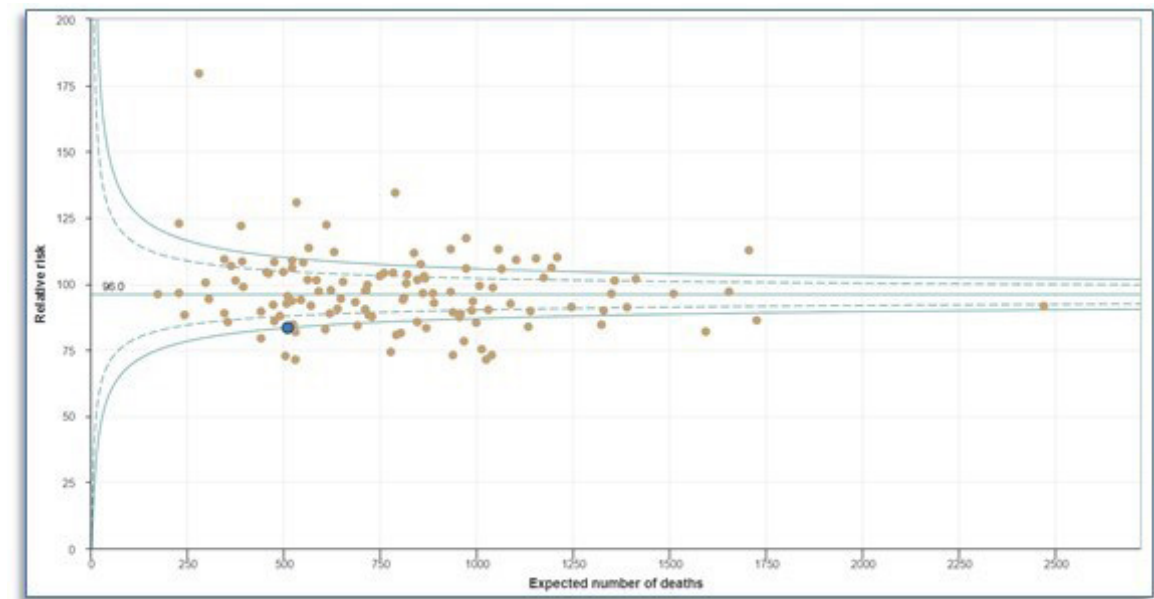


PAHT has the second lowest HSMR value in the region. Regional HSMR is 96.3 and “lower-than-expected”:

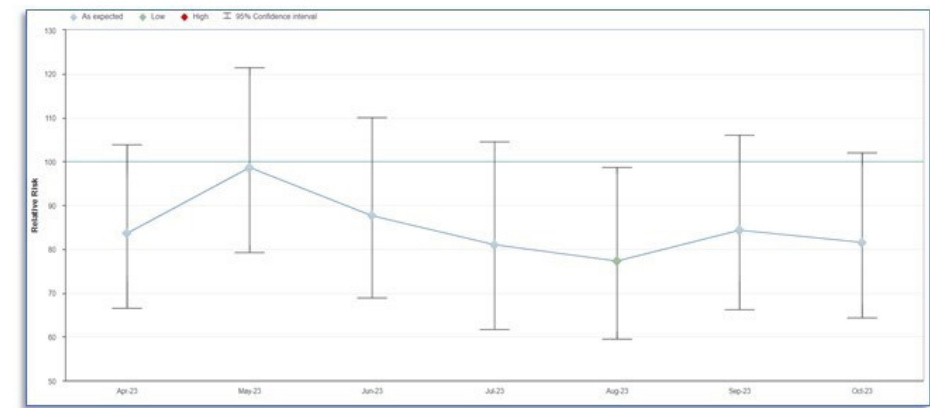


The Trust also remains in a favourable position when compared with national data for similar organisations.

National HSMR for the period April 2023 to October 2023 is 96.0 and “lower-than-expected” (confidence intervals 95.3 – 96.6).



The SMR for the period April 2023 to October 2023 is 85.0 and “lower-than-expected”. SMR for October 2023 is 81.5 and “within expected”.



In summary:

- There has been a significant improvement in the main mortality indices in 2023-24
- Compared to the previous financial year, there has been an improvement in mortality rates and in the position of the historical categories of outliers (sepsis, acute kidney injury (AKI), diabetes and respiratory diseases)
- Since the beginning of the reporting period PAHT has remained in a favourable position compared to peers in the regional and national context

Learning from deaths does not rely solely on the mortality indices. The following processes complement the mortality data:

- The Telstra data set includes diagnosis-specific mortality outliers. All of the patient deaths within each outlier group are reviewed by the clinical specialty leads and the coding leads
- All deaths are scrutinised by the Medical Examiner team
- 25% of deaths are further reviewed using the structured judgement review approach and learning is shared through regular departmental mortality and morbidity meetings
- Any concerns raised through or external to these processes, are scrutinised by the incident management group by reporting using the Trust's Datix system
- Regional networking has commenced, in order to improve learning and benchmarking for national and local processes

The SMART database was implemented in July 2021 and is fully embedded at the Trust.

- This is used for the completion of Medical Examiner independent reviews and the recording of Structured Judgement Reviews
- The database produces a mortality dashboard, which can be filtered to individual specialities or divisions.

This allows teams to review mortality over defined periods of time

- This has proved a useful tool in pulling themes and trends in order to understand the Trust's mortality status and where improvements may be required. It also provides a useful digital platform for the management and standardisation across the Trust of the learning about mortality and morbidity meeting

Next steps:

- The Strategic Learning from Deaths Group continues to support and enable the mortality programme in order to facilitate continued improvement of care of our patients
- The palliative care, coding and mortality teams continue to work closely to deliver training for clinical staff on the importance of accurate documentation and the impact this has on the Trust's clinical data quality
- An associate medical director for mortality and risk was appointed earlier this year and works closely with the mortality matron to oversee the learning from deaths programme
- The Deteriorating Patient Group has been re-established and is working closely with all divisions to improve both early identification and the quality of care delivered to the deteriorating patient across the Trust
- Further implementation of the SMART system will help to standardise and extend the mortality and morbidity program to all services across the Trust
- Enhanced networking with regional peers and primary care will continue to support learning across the system



Quality improvement

The most recent inspection of the Trust completed by the Care Quality Commission (CQC) was an unannounced focused inspection over the summer of 2021, this included a review of the Trust wide Well Led Key Line of Enquiry. The care services inspected were:

- Maternity care
- Medicine (including elderly care)
- Urgent and emergency care (emergency department)

Following this inspection, CQC assigned the urgent and emergency care department (ED) a rating of inadequate in the domains of safe and well led. They issued a Section 31 warning notice that required initially weekly and monthly submission of data to them.

The CQC completed an unannounced focused inspection of the emergency department (ED) in March 2023 to monitor our progress against the



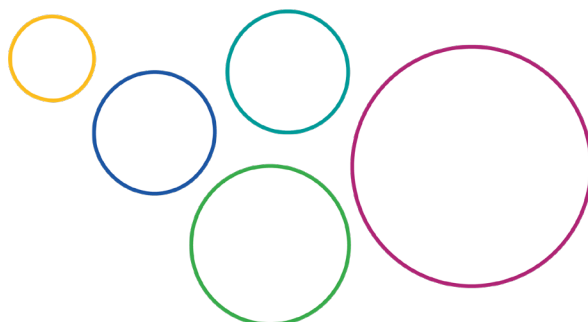
Section 31 action plan and to review our performance against the key lines of enquiry. The report was received in mid-June 2023 and we were pleased to note that the grading for our urgent care and emergency department (ED) had improved.

The CQC noted that the following improvements had taken place in the department:

- Delivery of safe care to patients and the department meeting the standards for leadership under the Well Led framework
- The CQC stated that the department delivers outstanding practice for the provision of care to patients who are in a mental health crisis

Our overall Trust rating

Overall trust quality rating	Requires Improvement ●
Are services safe?	Requires Improvement ●
Are services effective?	Requires Improvement ●
Are services caring?	Good ●
Are services responsive?	Requires Improvement ●
Are services well-led?	Requires Improvement ●



Our overall ratings by service

Figure 2: Our overall ratings by service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Outstanding	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Maternity	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Health and safety

The Health and Safety Committee has oversight of organisational compliance with statutory health and safety requirements and specific NHS duties. In this way, compliance with external organisational requirements such as the HSE, NHS Resolution (formerly the NHSLA), Department of Health, CQC etc. are managed. The director of strategy and estates chairs the Health and Safety Committee, being the director with delegated responsibility for health and safety within The Princess Alexandra Hospital.

The Health and Safety Committee is accountable to the Performance and Finance Committee (PAF) which is in turn, responsible to the Trust Board. The Health and Safety Committee is tasked with monitoring the development, implementation, audit and delivery of health and safety organisational management throughout all working aspects of the Trust's diverse activities. The health and safety team continues to provide advice and guidance in the implementation of statutory risk assessments through the various subgroups. To support the risk assessment programme, the patient safety and risk management team deliver local and open risk assessment training promoting best practice in the completion of a Trust risk assessment

and the principles of effective risk management within departments and in the wider organisation. Specialist risk assessments are being completed by the health and safety team upon request.

Throughout 2023/4 the team has worked hard to continue with their audit programme. These continue to be received well by the organisation. The team have also worked with the divisions and departments on several additional initiatives.

The team has continued to promote positive health and safety working practices with the production of a managers' training module.



Quality improvement

At The Princess Alexandra Hospital NHS Trust (PAHT) we define quality improvement as: 'Working together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.'

The Quality First team are a team based at The Princess Alexandra Hospital that includes both the quality improvement team and the Programme Management Office.

Quality improvement (QI) team

We inspire our people to put quality first for the benefit of our patients, staff and wider community. We achieve this by developing capability, strengthening confidence and enabling capacity to support and guide the organisation through continuous improvement and to achieve our strategic priorities, namely **PAHT2030**.

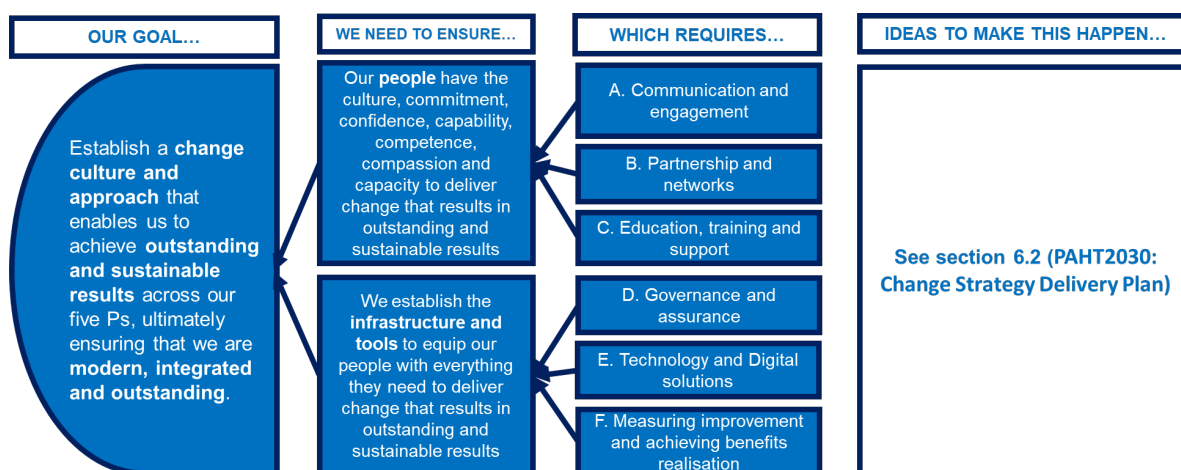
PAHT2030 Change Strategy

NHS Impact is the new, single, shared NHS improvement approach. NHS Impact has been launched to support

all NHS organisations, systems and providers at every level, including NHS England, to have the skills and techniques to deliver continuous improvement. There are five components forming the 'DNA' of all evidence-based improvement methods and underpin a systematic approach to continuous improvement:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

Part of our (PAHT) response to 'building a shared purpose and vision' is the development of our **PAHT2030** Change Strategy. The goal for this strategy is 'deliver a change approach that enables us to achieve outstanding and sustainable results across our five Ps, ultimately ensuring that we are modern, integrated and outstanding'. The strategic driver diagram below outlines the key elements of the strategy:



Modern, integrated, outstanding

Outlined below are key elements of what it means to achieve modern, integrated and outstanding change:

Modern

- Digital first put into practice and lived in the delivery of change
- Fully adopting our digital project management system (PM3) to ensure optimal use and associated benefits realised
- Access to high quality data, information and supporting analysis to provide an evidence base to inform decision making and provide assurance for delivery. Utilising self-service (QlikSense) where possible

Integrated

- Put our value of 'creative collaboration' into practice ensuring effective working between internal and external team (wider health and care system)
- Develop common approaches and methodology for change across the ICS as a whole
- Continuously improve our approach to achieving co-production as an enabler for achieving 'patient at heart'

Outstanding

- Our people having the intrinsic motivation (change agency) to lead and deliver change using a consistent methodology and common language, from board to ward
- Achieve a culture 'fostering and nurturing an environment where our people are engaged, listened to, supported and helped to grow' (PAHT2030)
- Our people having the capacity, capability and confidence to deliver and lead change
- Change that enables sustainable and outstanding results across our five Ps (patients, people, performance, places and pounds)
- Benefits realisation effectively

tracked and delivered

- We celebrate, learn and share in our efforts to have a growth mindset as a learning organisation
- Compassionate leadership, which starts with listening with fascination and encourages change
- Locally, nationally and internationally recognised for leading and delivering change successfully establishing a best practice approach for others to follow
- National staff engagement survey results evidence that our people believe we deliver and manage change well

Improvement partnership

A core part of our **PAHT2030** Change Strategy is strengthening our approach to building capability and capacity at PAHT for quality improvement and transformation.

Ahead of the development of our change strategy, we undertook a review of our current training offers, benchmarking ourselves against other NHS Trusts and identified a need to strength our training, particularly around QI methodology. This has led to a newly launched training offer, 'QI Fundamentals'. This is comprised of two half day modules designed to equip individuals with the essential QI knowledge and skills to support improvement work. To date, two sessions have been delivered with positive feedback, our plan for the next financial year is to continue to grow the volume of individuals that undertake this training and work with divisions and corporate teams to develop a long-term training plan to meet strategic needs.

Our Delivering Change training which covers the human aspects of change has merged with the organisational development (OD) team's change training to strengthen and provide a more holistic training offer. The Delivering Projects training which

provides beginner project management training is now being delivered by the PMO team to enable alignment with PM3 training.

We have successfully designed and delivered a six-month QI accreditation programme in partnership with an external OD provider. All of the QI Practitioners on the course have successfully led improvement projects that have demonstrated measurable impact against their project aim.

2023-24 Programme Highlights

The quality improvement team has supported the following projects this year:

- Improving patient outcomes (mortality improvement)
- Patient initiated follow up (PIFU)
- Long term condition – patient managed pathway
- Referral optimisation
- Urgent and emergency care improvement programme
- Nervecentre ED module
- Patient and clinical administration
- General Medical Council (GMC) enhanced monitoring improvement programme
- Integrated musculoskeletal (MSK) service
- Theatres optimisation
- Electronic health record (Alex Health)



People performance

In 2023-2024 our people worked in challenging circumstances to meet the demands of recovery backlogs, industrial action as well as business as usual. The key workforce indicators for the year are reflected in the table below:

People KPI	2023/24 target	Year to date performance
Vacancy rate	8%	7.47%
Sickness absence	3.7%	4.23%
Voluntary turnover	12%	11.63%
Statutory and mandatory training	90%	81%
Appraisal	90%	74%
Time to hire	42 days	64 days

The five key pillars of the people strategy are:

- **Culture, health and wellbeing**
- **Workforce resourcing and planning**
- **Learning, leadership and team development**
- **New service and workforce models**
- **Optimising technology**

Our NHS people plan focus is:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

Which is underpinned by:



Culture, health and wellbeing

During 2023-2024 the staff health and wellbeing team continued to support people through Covid-19. Along with providing in house occupational health services, the team continued to support the mental health first aiders and the health and wellbeing champions as well as the following services:.

- Financial wellbeing offer
- Self-referrals and management referrals
- Outbreak monitoring
- NHS health checks
- Travel immunisations
- Access to Physiomed (physiotherapy services)
- Referrals to physiological support services
- Support to staff networks
- Flu vaccinations
- Change of employee assistance provider with greater access to podcasts, blogs and a wide range of self-help CBT workbooks
- Nutrition and hydration steering group with a focus on staff

The team achieved the gold level for the Essex Working Well accreditation.

This recognises our robust health and wellbeing strategy and commitment to providing a varied programme to support and develop our people further.



This is Us Week in June 2023 included the following health and wellbeing activities:

- Smoothie bikes
- Schwartz Rounds
- Launch of health checks
- People division stand showcasing the range of the services and ability for our people to meet the teams
- Promotion of staff health and wellbeing services to all sites

Schwartz Rounds continue to run in

the Trust. These provide an opportunity for our people from all disciplines across the organisation to reflect on the emotional aspects of their work. Feedback from the rounds continues to be very positive.



Workforce resourcing and planning

The Trust has continued to recruit both from the UK and overseas with an overall vacancy rate of 7.47% at the end of March 2024 with a qualified nursing (excluding midwives) vacancy rate of 5.69%. Allied health professionals continue to be a challenging role to recruit to locally and nationally with a vacancy rate of 20.75%. We have successfully recruited internationally to some of these roles and in the last quarter held an open day to recruit locally into some positions as part of our 'grow our own' programme.

The recruitment team has worked closely with local organisations such as Harlow Job Centre and Harlow College and supported careers events at schools/colleges. We launched a volunteer to career (Project Search) programme with 10 young people taking part in the programme and then applying for substantive posts with the Trust. A second cohort of young people will join the programme in 2024-25.

To encourage local workforce supply the resourcing team attended local supermarkets showcasing vacancies and opportunities available within our Trust. Future open days are planned to fill vacancies for posts that are hard to recruit to.

We have developed our workforce plan aligned to finance and activity for 2024-25. The plan aims to reduce bank and

agency spend along with recruiting into vacant posts.

Learning, leadership and team development

Our Feedback to Action programme was our approach to acting upon the insights and feedback from the Staff Survey. The programme ran between March and August 2023 (6 months) and encouraged team development and actions to improve staff satisfaction.

Activities included:

- 14 programme sponsors who were overall accountable for programme implementation within their division
- 33 facilitators were trained to support the divisions
- 100 group members were confirmed at the beginning of the programme
- All groups continued with their plans and adopted full, condensed or localised approaches to the programme

All divisions and corporate areas committed to plans at the beginning of the programme and submitted summaries at the close of the programme.

The activities included in feedback to action plans were linked to the Trust-wide Staff Survey improvement priorities which were:

- Health and wellbeing,
- Learning and safety culture and psychological safety
- Management and leadership
- Effective staffing

Some of the activities within divisions and corporate areas included:

- Listening events with key stakeholder groups
- Caring and co-working in a culture of diversity
- Inter-department shadowing
- 'A Day in the Life Of' was extended

to all staff giving a holistic understanding of interlinking departments and activities

- Suggestion boxes were implemented
- This is Us Week had multiple nominations for stands to celebrate and showcase work
- Employee of the month nominations

Achievements of the Feedback to Action plan are reflected in the positive outcomes of the national NHS Staff Survey benchmark report for 2023.

We continued to build on our existing learning, leadership and team development offerings, and have introduced many new initiatives. For example, we have:

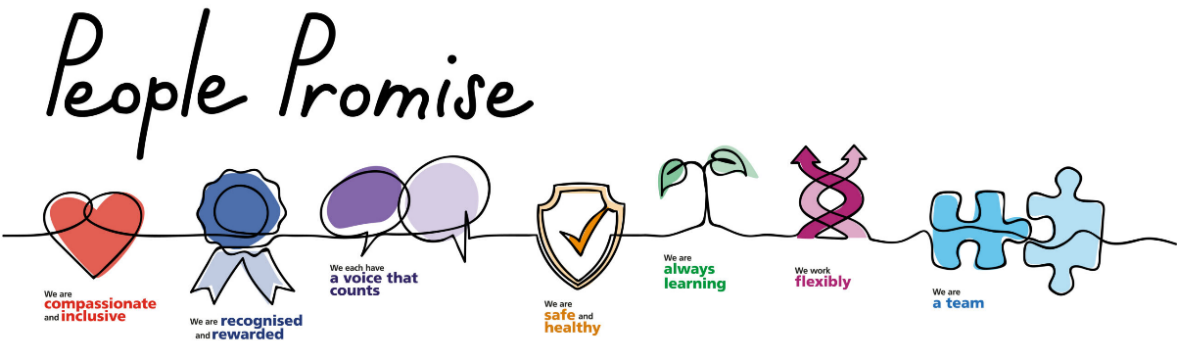
- Introduced an on-line learning management system (LMS) which gives access to learning to all staff. This year our focus was on transitioning our statutory, NHS Core Skills Framework and mandatory training onto the LMS
- Reviewed all staff training profiles in a collaborative multi-disciplinary effort to ensure standardisation and consistency of role specific training needs
- Increased the provision of e-learning opportunities to complement the face to face learning delivery and increase accessibility
- Added managers' induction as part of our revised onboarding programme
- Supported 49 new apprentices this year
- Celebrated 17 apprenticeship completions
- Funded 4,310 places on continuous professional development opportunities for staff in all divisions and corporate areas
- Provided a variety of personal development opportunities focusing on interpersonal skills, building relationships, and leadership, as well as developing a healthy mindset, resilience and mediation training

We continue to be successful in being allocated NHS graduates through the National Graduate Management Training Scheme (GMTS), taking on 3 more trainees in 2023.

Staff Survey

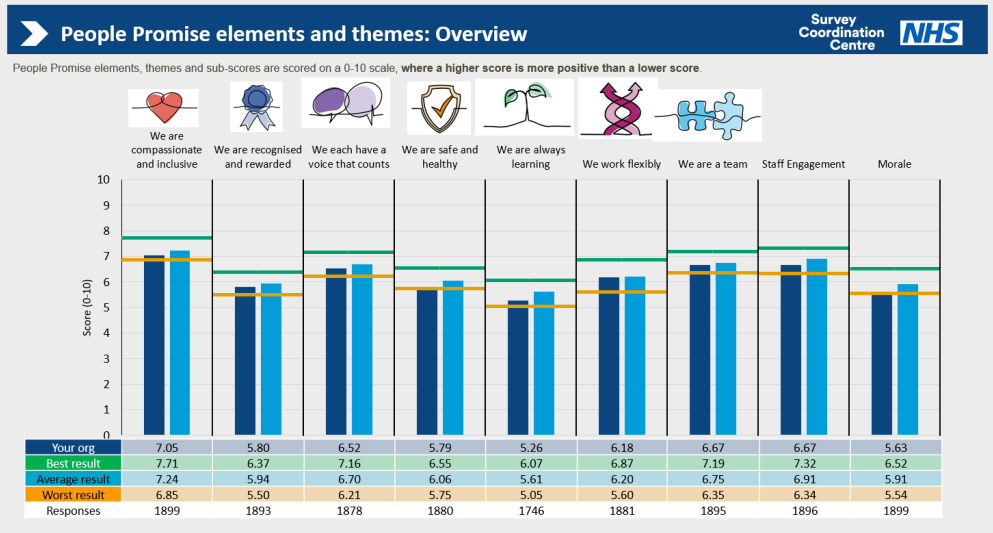
The annual NHS National Staff Survey (NSS) is recognised as an important tool for ensuring that the views of people working in the NHS are used to help inform local improvements. The feedback is useful in helping highlight strengths and improvements that will make PAHT a better place to both work and be treated.

The NHS Annual Staff Survey 2023 results are benchmarked nationally and show our results against the national average. The questions are aligned to the NHS People Promise which are the seven elements that would most improve working life as chosen by NHS employees.



1,953 employees completed the National Staff Survey in 2023. This was a 50% response rate, a record high for PAHT, and a 5% increase on the comparable median rate, again higher than the previous year. 26% of respondents shared a free-text comment, which offered further insights about specific issues important to our people. Significantly, we achieved an improvement on the previous National Staff Survey results across all People Promise elements, staff engagement and morale.

The Princess Alexandra Hospital NHS Trust Benchmark report, page 12



Critically, two important questions for the trust improved this year:

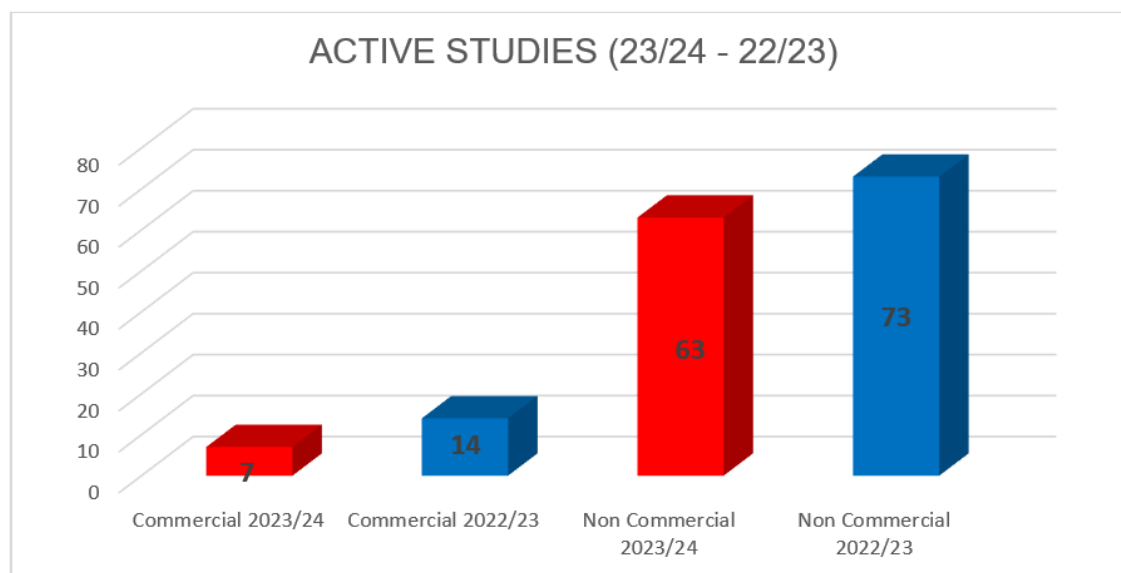
1. Would you recommend PAHT as a place to work? This achieved 50%, which is a 6% increase on last year (44%).
2. Would you be happy with the standard of care if a friend or relative needed treatment at PAHT? This achieved 47%, which is a 5% increase on last year (42%).

Achievements of the Feedback to Action Plan are reflected in the positive outcomes of the national NHS Staff Survey Benchmark Report for 2023. Building on this success, a 'Feedback to Action 2.0' programme was developed for each division to fully review the findings and commence the development of Staff Survey improvement plans. The divisional engagement plans align to three priority improvement actions identified by the Trust and continue to build on the momentum achieved up to October 2023:

- People Promise: We are always learning
- People Promise: We are safe and healthy
- This is Us management practices and leadership promise in our ways of working

The NHS People Promise continues to be important as we strive to deliver care in line with our values and our quality and patient safety strategy.

Research, development and innovation at PAHT

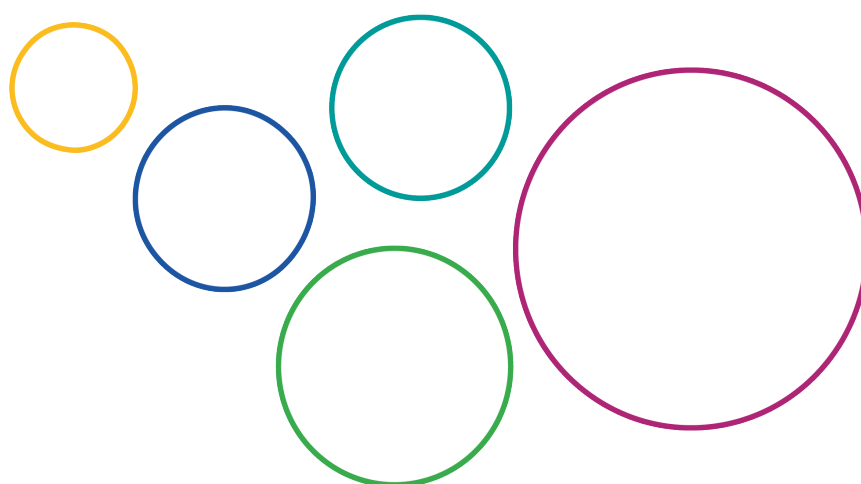


There were 7 commercial portfolio studies 63 non-commercial studies open for 2023-24.



Recruitment per speciality

Recruitment	Speciality	Division	Type
50	Critical Care	Surgery	Non-Commercial
184	Cancer	CSS	Non-Commercial
2	Cancer	CSS	Commercial
39	Gastro	Surgery	Non-Commercial
25	Ophthalmology	Surgery	Non-Commercial
5	Respiratory	Medicine	Commercial
3	Respiratory	Medicine	Non-Commercial
1	Rheumatology	Surgery	Commercial
33	Rheumatology	Surgery	Non-Commercial
313	Obstetrics/ Maternity	FAWS	Non-Commercial
123	T&O	Surgery	Non-Commercial
2	General Surgery	Surgery	Non-Commercial
88	Anaesthetics	Surgery	Non-Commercial
308	Audiology	Surgery	Non-Commercial



Improving our estate

To be a modern, integrated and outstanding hospital, our estate requires significant ongoing investment to enable us to provide the best services possible.

During the last year we have significantly invested in the estate, transforming a number of key sites that have since brought significant improvements to our operations.

This is not just about investing in spaces and places, it is about investing in our people and our patients; listening to their needs, understanding what we can do better to provide and maintain the very best environment to deliver and receive care.

We have a responsibility to invest to improve the health of the planet too, and during the last year we have introduced a number of initiatives to reduce our environmental impact in line with wider NHS green targets.

In 2023-4, the PAHT estate was remodelled and maintained to improve the experience for everyone in the hospital by:

- improving the management of buildings and engineering systems
- providing excellent and sustainable facilities
- ensuring safety and security at all times

The capital programme for this year was circa £8m, this included a £3.8m investment in backlog maintenance and continued investment in our patients and people.

Our patients have benefited from the following completed schemes:

- New Aseptic Suite (TSU) – now relocated into Arendal House to serve the adjacent Williams Day Unit Chemotherapy Unit

- Creation of a new HV/LV transformer building to Northside with new UKPN supply to provide site resilience and Trust owned connecting switch panel
- Mental health room upgrades in the main emergency department (ED), Adult Assessment Unit (AAU) and paediatric ED
- Upgrade of the main kitchen to meet EHO requirements for serving
- Upgrade of the main Alexandra Restaurant areas for all users
- New medical gas pipework installation into main theatres along with new AVUSs to provide safer and better control and monitoring
- Discharge Lounge 2 area upgrade for flexibility of service needs
- Installation of new external and internal wayfinding across the site for better patient experience accessing the site
- Installation of new ventilation systems to the maternity department for gas and air safe use
- Enabling works for new robot in Theatres 6 suite
- ED – general improvement works to comply with national standards including flooring, wall coverings and ligature safety
- Maternity – general improvement works including flooring and wall coverings
- Creation of a new mental health room in Charnley Ward
- Light refurbishment on 7 clinical wards

1. Installation of a new 4G network system supporting IT

2. Upgrade of the environment in the Urgent Treatment Centre and outpatient department

Our amazing people have benefited from the following completed schemes designed to support their welfare and wellbeing:

1. Upgrade works to Oslo House offices

2. New heating and cooling systems across the site
3. Upgrade of an old safeguarding modular unit for agile working
4. Upgrade of the main kitchen for a more compliant working environment
5. Installation of new ventilation systems to the maternity department for gas and air safe use
6. New turnkey state of the Interventional Suite in the radiology department
7. New extended fridge/freezer units in the main kitchen

In addition to these projects, the following projects were completed in 2023-4:

- Replacement of obsolete electrical switchgears across the organisation
- Fire compartmentation works across the site with upgrades
- New boiler set to serve campus houses and clinical areas
- Replacement of failed flooring to prevent slips, trips and falls
- Various roofing projects where leaks were evident
- Replacement of failed heating parts on infrastructure within the basement
- Emergency water main and pipework repairs
- Various replacement/new heating and cooling systems to clinical and administration areas across the site



Annual Sustainability Report 2023-24

1.0 Background

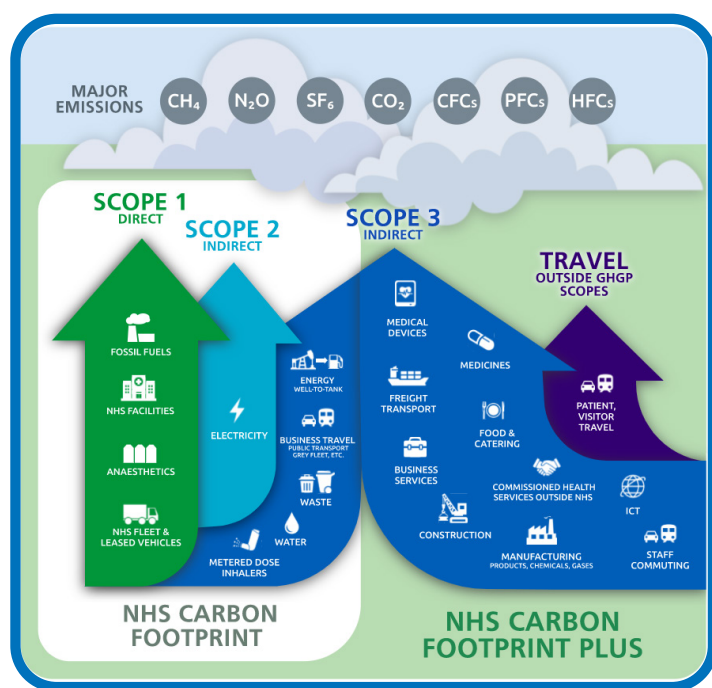
Our planet is currently facing a climate emergency, predominantly driven by our reliance on fossil fuels for heat, power and transport. In response, the UK has set a legally binding target under the Climate Change Act 2008 to reduce its emissions to net zero by 2050.

In 2020, the NHS set out its ambition to be net zero in its “Delivering a Net Zero National Health Service” report. It has committed to be net zero by 2040 for the emissions it can control, known as the NHS Carbon Footprint, with an interim reduction of 80% between 2028

and 2032. The aim is to be net zero by 2045 for the emissions it can influence, known as the NHS Carbon Footprint Plus, with an 80% reduction between 2036 and 2039.

As a part of the NHS, we must contribute toward this level of ambition. As an NHS organisation, and subject to public funding, The Princess Alexandra Hospital NHS Trust (PAHT) has an obligation to have a positive effect on local communities and the environment. By making the most of the social, environmental, and economic assets at our disposal, we can improve health and have a positive impact on the environment both in the immediate, and long term.

Figure 1: GHGP scopes in context of the NHS (Delivering a Net Zero National Health Service, 2020)



In line with the above and to comply with the NHS Standard Contract requirements, the Trust submitted a board-approved three-year Green Plan (2022-2025) to the Integrated Care Board (ICB) in January 2022. Since then, the Trust has been working collaboratively with the ICB and regional Greener NHS teams to deliver the objectives and priority areas in our Green Plan.

2.0 Green Plan 2022 – 2025: Progress

Published in 2022, the Trust's Green Plan identified that carbon emissions for 2020-2021 were 22,068 tCO₂e in which Scope 1 and Scope 2 emissions accounted for 32% and Scope 3 accounted for 68% of the overall carbon footprint. NHS Carbon Footprint Scope 1 emissions from fossil fuels accounted for 16.8% of overall carbon emissions, whereas the NHS Carbon Footprint Plus,

Scope 3, business services, medicines and staff commuting accounted for almost 54%.

Over the past year, the Trust has continued working towards meeting the targets in the Green Plan. Here are some of the achievements made in 2023/24.

Leadership

Goal: To ensure that sustainability is embedded within the Trust's strategies and processes and that we deliver, monitor and report on progress to the board and have a board-level sustainability champion.

Progress made:

- The director of strategy and estates remains the Board-level sustainability champion reporting regularly to the Senior Leadership Team and Board that provides additional support and takes corrective action when necessary
- A sustainability section is included in our Annual Report with transparent reporting on progress
- The Trust is implementing a Sustainable Procurement Strategy in line with the NHS PPN06/20 and PPN06/21 policies on sustainable procurement
- Business cases are being reviewed by the finance team to incorporate a Sustainability Impact Assessment.

Capital projects

Goal: Reduce the environmental impact of construction at the design, refurbishment, build, and operational stages.

Progress made:

- Three buildings were recently refurbished which are now energy-efficient with LEDs, new insulation; and other energy-efficient technologies
- Construction of the Community Diagnostics Centre is set to start in

2024. The Trust aspires to achieve a BREEAM "Excellent" rating throughout all stages of the build from design to completion

Asset management and utilities

Goal: To embed energy and water-efficient technologies and practices throughout our estate and services and deliver year-on-year reductions in consumption.

Progress made:

- The Trust has developed a Heat Decarbonisation Plan outlining a strategy as to how the Trust will replace fossil-fuelled heating systems with low-carbon alternatives
- The target is to reduce electricity consumption by 6% per year. 100% of our electricity is from certified renewable sources from Renewable Energy Guarantees of Origin (REGO)
- In 2023/24, The Trust generated 75,436 kWh of electricity from solar photovoltaic (solar PV), enough power to boil over 3.77 million cups of tea. By doing so, the Trust avoided generating 38.5 tCO₂e.

Sustainable use of resources

Goal: To drive down waste and inefficient use of resources, delivering year-on-year reductions.

Progress made:

- Single-use plastics have been replaced with suitable alternatives in the restaurant
- An in-house furniture reuse scheme is in place that allows for items to be reused elsewhere in the Trust rather than be discarded
- Waste was reduced by 12% since 2022-23, exceeding our year-on-year 5% waste reduction target
- To reduce food waste, patient meals are ordered through the Symbiotix app. More staff meals are now being

cooked from scratch and more plant-based options are on the menu. All food waste is sent for anaerobic digestion rather than to landfill

Carbon emissions

Goal: To measure our emissions, identify opportunities to reduce emissions and take targeted action.

Progress made:

- The Trust was granted £390K through the NHS Energy Efficiency Fund (NEEF) to install almost 3000 LEDs by March 2024. This is expected to yield a reduction of 137.7 tCO₂e, with full measurement and verification being conducted throughout 2024/25
- To improve energy consumption data, upgrades are planned for the Building Management System (BMS) on the connectivity of the platform and the installation of additional submeters. While still at the design stage, the Trust aims to implement an upgraded BMS by the end of 2024.

Sustainable Care Models

Goal: To deliver the best quality of care while being mindful of its social, environmental, and financial impact.

Progress made:

- Desflurane has a very high Global Warming Potential (GWP), which is why NHS England, with the support of the Royal College of Anaesthetists and the Association of Anaesthetists, has announced the decommissioning of desflurane by early 2024, except for exceptional circumstances. The Trust removed the use of desflurane in 2023
- Decommissioning of nitrous oxide manifold is due to be completed by the end of April 2024
- The Trust is taking steps to decrease carbon emissions related to the use of pressurised metered dose inhalers (pMDIs) by following updated guidelines, increasing prescribing of

dry powder inhalers, and reviewing prescriptions of patients classed as high users of pMDIs

Travel and logistics

Goal: To encourage sustainable and active travel and reduce the carbon and air quality impacts of our organisation, and supply chain.

Progress made:

- In November 2023, a Green Travel Plan was published detailing the actions the Trust should undertake to achieve its goals
- A staff car salary sacrifice scheme is being implemented for ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs)
- The Trust fleet of diesel delivery vehicles was switched to ZEVs. This will reduce the Trust's carbon footprint by 34 tCO₂e over the 3-year contract
- Plans are underway to add more electric vehicle chargers. To encourage active travel, there are plans to install more cycle racks and a scooter storage facility

Green space and biodiversity

Goal: To maximise the quality and impact of our green spaces, and to reduce biodiversity loss.

Progress made:

- In 2021, the Trust created a green space for its staff and patients which has been very popular since its inception. There has been an increase in the number of people enjoying this outdoor space

3.0 Energy

3.1 Gas and Electricity

The table below shows gas and electricity consumption and associated carbon emissions.

There has been a 16% increase in electricity* and a 13% decrease in gas usage from the previous year, resulting in an overall rise of 4% in carbon emissions.

Resource	Unit	2022/23	2023/24
Gas	MWh	13,662	11,868
	tCO2e	2,919	2,530
Electricity	MWh	11,341	13,198
	tCO2e	2,966	3,600
Total energy	MWh	25,003	25,066
Total carbon emissions	tCO2e	5,885	6,130

Table 1: Gas and electricity consumption and carbon emissions 2022-23 – 2023-24.

*Due to errors in billing and hence inaccurate electricity consumption data, a three-month average has been used.

The graph below shows gas and electricity consumption between 2022-23 and 2023-24.

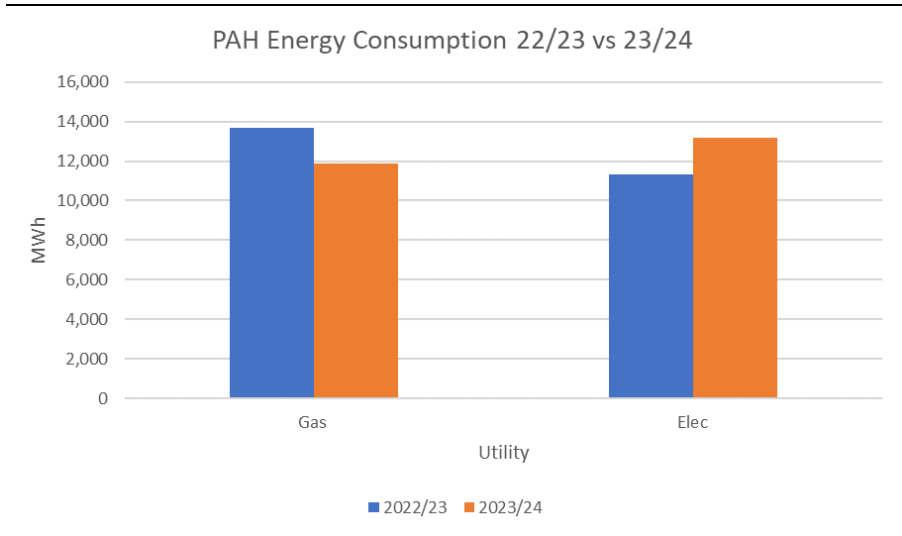


Figure 2: Gas and electricity consumption 2022/23 vs 2023/24

4.0 Waste

The Trust has been recording a comprehensive set of waste types since 2019 and reporting through the Estates Returns Information Collection.

In FY 2023-2024, the Trust produced 1,281 tonnes of waste, a 12% reduction from the previous year.

In 2023, the clinical waste contractor conducted an off-site acceptance waste audit. Many of the bags were found to be contaminated with other waste streams. Therefore, the offensive waste stream was disposed of as hazardous waste. This explains the decrease in clinical non-hazardous waste in 2023/24 and the increase in hazardous waste in 2023-24. The Trust's waste management team is working to improve clinical waste segregation and is collaborating with its clinical waste contractors to resolve the issue.

FY 2022-23 vs FY 2023-24		
Waste Type	22/23	23/24
General	657	569
<i>Recyclables</i>		
- Organic (food)	19	19
- Metals	8	8
- Cardboard	11	11
- Confidential	97	104
- Dry Mixed Recycling (DMR)	1	1
<i>Clinical Waste</i>		
- Clinical - Non-hazardous (offensive waste)	294	22
- Clinical - Hazardous	373	548
Total	1,458	1,281

Table 2: Waste by type 2022-23 vs 2023-24

The graph below illustrates the decrease in waste between 2022/23 vs 2023/24

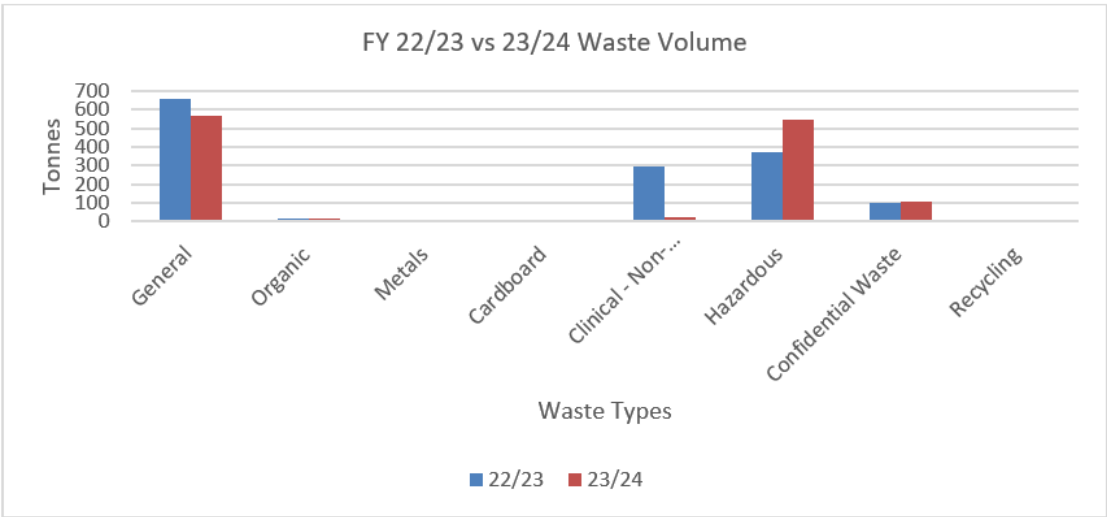


Figure 3: Volume of waste from 2022-23 – 2023-24

The graphs below show the percentage of waste segregation per waste stream. General waste, sent to a waste-to-energy facility, accounts for 80% of waste at the Trust. While waste is segregated, the Trust aims to separate waste further and establish programs to avoid cross-contamination of waste streams.

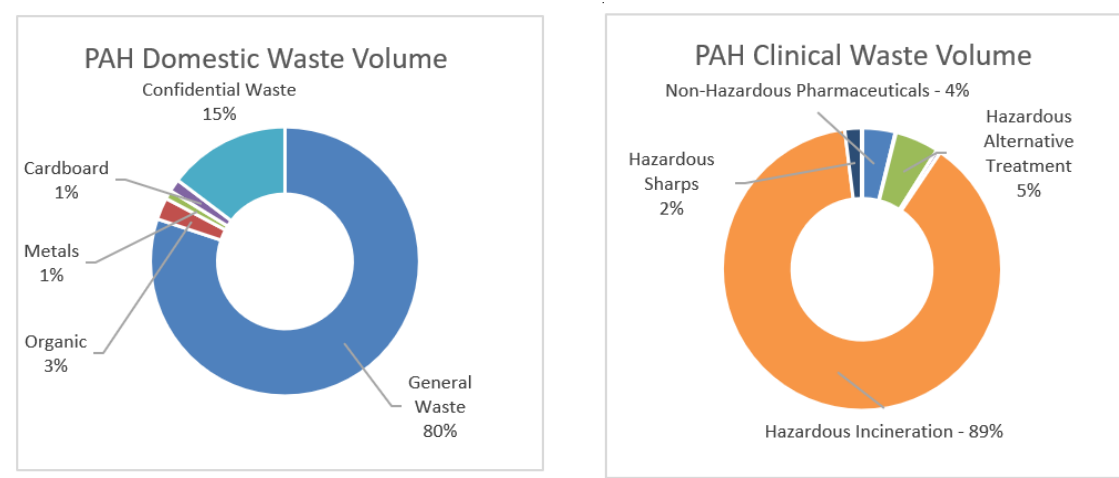


Figure 4: Domestic and clinical waste volumes by percentage for 2023/24

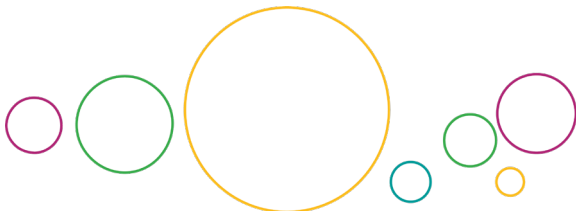
5.0 Water

The Trust used 116m litres of water in 2023/24. The goal set out in the Green Plan is to reduce water consumption by 5% year-on-year. The Trust has reduced water consumption by 33 million litres, a 22% decrease since 2021-22 and 25 million litres, a 17.94% since 2022-23. This has been achieved by installing low-flush toilets and sensor taps in some areas.

The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking. To put the Trust’s water usage and treatment in context, the Model Health System has a water benchmark of 1.2m3/m2/year. The Trust’s water usage is 1.98 m3/m2/year. We aim to investigate technologies that can reduce water use even further.

Table 3: Water usage and carbon emissions 2021 - 2024

Water	Unit	2021 /22	2022/ 23	2023/2 4
Volume	m³	149,484	141,485	116,108
Carbon Emissions	tCO ₂ e	55	52	39



The graph below shows the decrease in water consumption since 2021/22.

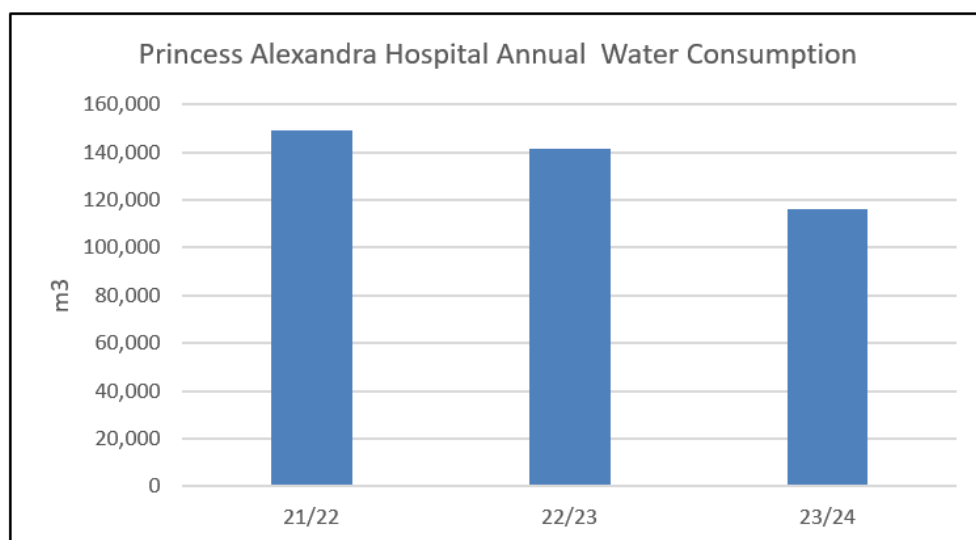


Figure 5: Water usage 2021 - 2024

6.0 Heat Decarbonisation Plan

In line with the NHS Standard Contract which states that a Trust must 'take action to phase out fossil fuels for primary heating and replace them with less polluting alternatives', the Trust has created a Heat Decarbonisation Plan (HDP). The HDP describes the Trust's current energy use, plans for reducing carbon emissions, recommended actions, timescales and intended outcomes.

The HDP will make the Trust ready for the next phase of Public Sector Decarbonisation Scheme grants and will enable the Trust to prioritise backlog maintenance projects that will help reduce its carbon footprint.

7.0 Looking ahead to 2024-25

In the next financial year, the Trust will work to implement the actions in the Green Plan.

While there are many actions to be undertaken in 2024/25, here are a few of the actions that the Trust will focus on:

- The Trust's current Green Plan covers 2022 – 2025. The Trust will review the document and an updated

version will be published in early 2025

- Now that the Heat Decarbonisation Plan has been created, the Trust will work through the goals and actions laid out in the Plan to replace fossil fuel-powered heating
- The Trust will implement the actions laid out in the Green Travel Plan

Climate-Related Financial Disclosures (Crfd)

The influence of climate change on our environment is growing, evident through phenomena such as droughts, floods, storms, and rising temperatures. Consequently, efforts to address the root causes of climate change and adapt to its effects have been instituted at both national and international levels, including through government regulations. The Climate-related Financial Disclosure (CRFD) Regulations, effective as of **6 April 2022**, necessitate the inclusion of disclosures concerning climate change-related risks and opportunities in our Annual Report, as our Trust falls within its scope.

The financial year 2023/24 is the first year that public sector bodies are required to include some of the Task Force on Climate-related Financial

Disclosures (TCFD) in their Annual Reports. Three phases will result in TCFD compliance by 2025/26.

The Trust has taken an active approach to addressing climate and environmental challenges, recognising the need to achieve net zero in its operations, and building climate resilience. We are committed to ensuring our strategies and policies support the national and global requirements to act on the climate crisis.

Since 2022, we have aligned our emissions targets with the NHS target of being net zero carbon by 2045. This is fully documented in our Green Plan published in 2022. This report summarises our Climate-related Financial Disclosures in line with the Climate-related Financial Disclosure Regulations 2022.

The report covers four thematic areas – Governance, Strategy, Risk Management; and Metrics and Targets.

Governance

At The Princess Alexandra Hospital NHS Trust, we recognise that the key to successfully embedding climate-related financial planning is having a leadership team with clear and specific responsibility over climate-related risks and opportunities. A clear governance structure is in place, providing oversight, challenge, and accountability for delivering our carbon emission reduction and sustainability strategy.

The Climate Adaptation process is overseen by the director of strategy and estates and the Performance and Finance Committee, responsible for developing the climate adaptation strategy and CRFD reporting. We have developed strategies and policies to promote cross-organisational action to reduce emissions and adapt to climate change through a Sustainability Steering Group.

Over the next financial year, we will further refine how climate-related issues are considered when developing our organisation's strategy, policies, budgets, and performance.

Strategy

The Trust is currently drafting a Business Impact Assessment which will include fire and flooding plans and details of a scenario analysis to identify the main transition risks and opportunities impacting the Trust. This report is due to be completed by mid-2024. In the coming months, we will continue to develop our Risk Assessment Frameworks.

Risk management

The Trust has robust processes and procedures such as the Risk Assurance Framework for risk management, in which climate-related risks and opportunities are identified, assessed, and logged. Risk assessments are reviewed by the Estates and Facilities Management Board and then reviewed by the Trust Risk Management Group. Climate change risks are then added to the exception report and added as a corporate and Trust-wide risk. It is then added to relevant Health Care Group risk registers.

Metrics and targets

We record Scope 1, 2 and 3 emissions in line with the NHS Carbon Footprint and Carbon Footprint Plus categories. For the financial year 2021/22, we calculated that the carbon footprint of the Trust was 22,068 tCO₂e. The Trust will keep track of its progress, reassess goals and improve data collection across all scopes for more accurate future reporting. Given that collecting accurate data from the supply chain is challenging, we will continue to work with our procurement team to refine our value chain data gathering methods.

Tackling health inequalities

The 2023-24 Operational Planning Guidance required providers and Integrated Care Systems to continue to address health inequalities and prevention of ill-health through their joint forward plans, building on innovation and partnership working, having due regard to the Women's Health Strategy and delivery against NHSE's five strategic priorities for tackling health inequalities.

PAHT works collaboratively with its partners in the West Essex Health and Care Partnership (HCP) and the Hertfordshire and West Essex Integrated Care System (HWE ICS) to analyse health outcomes, data and to design and deliver services that ensure health inequalities are addressed. These partnerships are key to influencing wider social determinants of health and to move away from PAHT just being a healthcare provider. Throughout 2023-24 the HCP and ICS focused on the following 5 priority areas:

- **Priority 1** - Give every child the best start in life
- **Priority 2** - Support our communities and places to be healthy and sustainable
- **Priority 3** - Support our residents to maintain healthy lifestyles
- **Priority 4** - Enable our residents to age well and support people living with dementia
- **Priority 5** - Improve support for people living with lifelong conditions, long term health conditions, physical disabilities, and their families

A number of programmes of work were introduced to support the delivery of these priorities:

- Maternity and obesity project
- Infant feeding project
- School readiness and early years
- Early cancer and screening

education

- Whilst You are Waiting
- Digital inclusion project
- Health checks (EWS)
- Weight management programmes
- Substance misuse projects
- Falls car
- Buddy up project
- Ticket home (UCAN)
- Early cancer and screening education
- Tackling neighbourhood inequalities projects
- Breathe easy project
- Health inequalities trainee GP
- Men's Shed/Fellas
- Suicide prevention work
- Wellbeing hubs

Going forward we will continue to work with system and place partners to:

- Deliver the 5 year forward plan to improve health equity in line with the national NHS Long Term Plan
- Focus on system wide performance in the Core 20 PLUS 5 framework for adults and children and young people. Core 20 PLUS 5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20 PLUS' and identifies '5' focus clinical areas requiring accelerated improvement
- Develop an outcomes framework to show clear performance metrics and tiered outcomes to identify areas where risk factors can be better prevented
- Work in partnership with voluntary, community, faith and social enterprise colleagues to narrow gaps in outcomes and build longevity into actions to ensure they are sustainable and benefit the communities

We continue to improve the collection and recording of ethnicity data. Waiting lists and operational data sets are

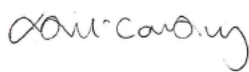
analysed to highlight areas of difference that might indicate inequality or reduced outcomes. This work is then used to adapt service delivery to minimise any potential impacts. PAHT is identifying the lowest quintile of the local population for Core 20, to look at health related outcomes for these patients with regard to the 5 clinical areas and develop interventions to support these patients.

During the year we analysed patient safety incidents by age, gender, ethnicity and Core 20 deprivation data. Themes from this analysis were reported to the Quality and Safety Committee.

The implementation of our new electronic health record will improve digital inclusion and education. We plan to assist our patients to become familiar with using

the NHS App and Patient Portals to increase digital enablement. For patients unable or not wanting to access their appointments, letters and other health related information digitally, access to paper-based information will continue to be available.

The director of strategy and the director of quality improvement are joint executive leads for health inequalities. They are supported by the chief operating officer and chief information officer in relation to the collection and monitoring of performance data.



Lance McCarthy
Chief executive officer



The Accountability Report

2023/24

Corporate governance report

Code of Governance

The Code of Governance sets out a common overarching framework for the corporate governance of Trusts, reflecting development in UK corporate governance and integrated care systems.

NHSE has refreshed its code of governance to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

PAHT is committed to maintaining the highest standards of corporate governance. We endeavour to conduct our business in accordance with NHS values and accepted standards of behaviour in public life, which includes the Nolan Principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The Trust has applied the principles of the NHS Code of Governance on a ‘comply or explain’ basis. A self-assessment has been undertaken against the requirements of the Code and the Trust is compliant with the principles of the Code for the reporting period with the exception of the three areas listed in the table below:

Code section	Summary of compliance
Section B, 2.5 The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	For the 2023/24 year the SID (non-executive director George Wood) was also the Audit Committee Chair. This has been addressed and non-executive director Darshana Bawa was appointed to the SID role with effect from 1 April 2024.
Directors on the Board of Directors and, for foundation trusts, governors on the council of governors should meet the ‘fit and proper’ persons test described in the provider licence. For the purpose of the licence and application criteria, ‘fit and proper’ persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director.	Fit and proper persons checks are carried out prior to appointment and a Fit and Proper Persons policy is in place. An annual refresh is undertaken and Board members’ compliance with the requirements is reviewed during appraisals and documented on appraisal forms.

Code section	Summary of compliance
They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	The Trust's policy and process for complying with the additional requirements in the revised Fit and Proper Persons guidance published in August 2023 is being developed and compliance with the requirements will be reported to the Trust Board in June 2024.
Section D, 2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	This policy is being developed and will be in place by Q2 of 2024-25. The external auditors do not currently supply any non-audit services to the Trust.

Most of the provisions of the Code of Governance requiring a supporting explanation have been disclosed in this section of the Annual Report. The table below provides a reference to the location of statements that appear in other sections of this report:

Code section	Page no.
Section A 2.1	Pages 12-40 and the Annual Governance Statement, from page 75
Section A 2.3	Pages 10, 41 and the Annual Governance Statement, from page 75
Section A 2.8	Pages 12-15 and the Annual Governance Statement, from page 75
Section B 2.6	Included in Corporate Governance section
Section B 2.13	Included in Corporate Governance section
Section C 4.2	Included in Corporate Governance section
Section C 4.7	Annual Governance Statement, from page 75
Section C 4.13	Included in Corporate Governance section
Section D 2.4	Auditors' Report page 84-86

Code section	Page no.
Section D 2.6	In accounts, page 113
Section D 2.7	From page 14-15 and the Annual Governance Statement, from page 75
Section D 2.8	Annual Governance Statement, from page 75
Section D 2.9	Page 16
Section E 2.3	Page 86

Our Trust Board

The Trust Board meets bi-monthly in public. The times and venues are advertised on the hospital's website (www.pah.nhs.uk) and Board papers are published ahead of each meeting.

The role of the Trust Board is to determine strategy and policy for the Trust, to monitor in-year performance against its plans and ensure the Trust is well governed.

The Trust Board formally operates in accordance with its governance manual comprising the standing orders, standing financial instructions and scheme of delegation. All members of the Board have the same legal responsibilities to the Trust and have a collective responsibility to act with a view to promoting the success of the organisation to maximise the benefits for the members of the Trust and the public.

There are comprehensive role descriptions for each of the key roles of chair, chief executive, non-executive director and senior independent director. All of the directors on the Board meet the 'fit and proper' persons test.

Directors declare any potential conflicts of interest as part of the Trust's declaration of interest process. The [register of interests is published on the Trust's website >](#)

Each member of the Board is required to undertake an annual performance review, involving both peer review and self-assessment. The outcomes of the non-executive director appraisals are reported to the Remuneration and Nomination Committee, along with the executive director appraisals.

Objectives for each executive director are set as part of the performance appraisal process and a personal development plan for each is agreed on an annual basis, with mid-year reviews undertaken to monitor progress. For non-executive directors, the Trust follows the national guidance issued by NHSE for the appraisal of Trust chairs and this has been utilised to develop a similar process relevant to non-executive directors.

Committees

The Trust Board has established the following committees to discharge its responsibilities on Board assurance:

Audit Committee

The Audit Committee provides 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. The committee receives an annual report on risk management, clinical audit and CQC compliance.

In addition, the committee oversees the work programmes for external and internal audit and receives assurance of their independence, monitoring the Trust's arrangements for corporate governance.

The Audit Committee encourages frank, open and regular dialogue with the Trust's internal and external auditors. The committee chair meets separately with both the internal and external auditors during the financial year, and the committee's members also meet with the auditors to facilitate an open relationship and effective communication.

Throughout the course of the year, the Audit Committee was assisted in its work by the internal audit function, which undertook detailed scrutiny of the Trust's assurance framework. The Trust's internal audit contract continued to be provided by BDO LLP. The Audit Committee scrutinised the outcomes of all internal audit reviews, with relevant senior management in attendance where appropriate to support its discussions. The committee approves the annual internal audit programme, which is reviewed by the executive team monthly.

The Head of Internal Audit's annual opinion and more detail about the work of internal audit can be found within the Annual Governance Statement.

The Trust's external audit contract was provided by KPMG during 2023-24. KPMG were appointed by the auditor panel in 2021 following a robust procurement exercise. The initial contract term was for a period of 3 years with an option to renew for up to a further 24 months.

KPMG have not undertaken any non-audit work during 2023-24.

Remuneration and Nominations Committee

The Remuneration and Nominations Committee determines the remuneration and terms of service of the Trust's directors and senior managers; it also considers the overall skill mix and balance of the Board of Directors. In setting the level of remuneration, consideration is given to the market position of the Trust and its ability to attract and retain the calibre of individuals needed in these key leadership roles. This is achieved by reference to a range of comparator materials, including internal pay scales and external market and sector benchmarking information.

This year the committee also reviewed and evaluated the balance of skills, knowledge, experience and diversity of the Trust's current non-executive directors, as well as the end dates of those directors' terms.

Performance and Finance Committee

The purpose of the Performance and Finance Committee is:

- Consider, challenge and recommend the Trust's operating plan to the Board
- Scrutinise operational and financial performance and monitor

achievement of national and local targets and recommend any re-basing or re-forecasting of operational and financial performance trajectories to the Board

- Assure the Board of Directors that the Trust has robust processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable
- Recommend the Trust's cost improvement programme to the Board and monitor its delivery including investigating reasons for variance from plan and recommend any re-basing or re-forecasting of the plan to the Board
- Monitor the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities
- Review and monitor the management of finance, performance and contracting risks

Quality and Safety Committee

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

In February 2022 a QSC Part II meeting was established to maintain oversight of maternity services. This meeting receives reports on:

- The 3 year maternity and neonatal delivery plan (March 23), incorporating national learning

including the Kirkup and Ockenden Reports

- NHSE three year single oversight plan (and other emerging learning from national and local reports)
- Maternity Incentive Scheme
- Care Quality Commission inspection reports
- Continuity of Carer Implementation
- Maternity Transformation
- Maternity Serious Incidents
- Maternity Dashboard
- Health Education England reports
- National Maternity Surveys
- HSIB learning and reports

People Committee

The purpose of the People Committee is:

- To maintain oversight of the development and design of the workforce and ensure it is aligned with the strategic context within which the Trust is required to operate
- Assure the Trust Board on all aspects of workforce and organisational development and provide leadership and oversight for the Trust on workforce issues that support delivery of the Trust's annual objectives
- Assure the Trust Board that the Trust has adequate staff with the necessary skills and competencies to meet both the current and future needs of the Trust and ensure delivery of efficient services to patients and service users
- Assure the Trust Board that legal and regulatory requirements relating to workforce are met

Strategic Transformation Committee

The Strategic Transformation Committee ("the Committee") is responsible for overseeing the delivery of the Trust's strategy ([PAHT2030](#)) and transformation programmes.

The committee monitors the external strategic environment and developments across the Integrated Care Board and the Health and Care Partnership.

Charitable Funds Committee

The Charitable Funds Committee was established by the Trust Board to make and monitor arrangements for the control and management of the Trust's charitable funds.

Board of Directors

Non-executive directors

Hattie Llewelyn-Davies, chair

Hattie Llewelyn-Davies joined as chair of The Princess Alexandra Hospital NHS Trust in September 2021. Hattie has extensive experience as chair of NHS organisations, having chaired Hertfordshire Partnership Foundation Trust (HPFT) for many years before spending the last seven years as chair at Buckinghamshire Health NHS Trust. She sits on the Board of NHS Providers and the steering group of the Disabled NHS Directors Network (DNDN).



Before joining the NHS, Hattie had a number of chief executive and senior management roles in the housing and homelessness sector; and was awarded an OBE for services to homeless people in 2004. Hattie was also recognised by the *Sunday Times* as Non-Executive of the Year for the Public and Not for Profit Sector in 2019. Hattie chairs Eastlight Community Homes, a housing association based in Essex and works with a wide range of housing organisations on governance, strategy and resident involvement.

Darshana Bawa, non-executive director and senior independent director

Darshana is a finance director, with extensive financial and commercial leadership experience.

She has a background in the delivery of strong financial and commercial information, with a successful track record in organisational change. Working across online retail, e-commerce and third-party logistics, she brings a broad perspective to this role.



Darshana joined the Board in 2021 and is chair of the People Committee and a member of the Audit and Performance and Finance committees.

George Wood, non-executive director

George Wood spent 33 years with Ford Motor Company in their financial services division which included assignments in sales, marketing, strategy, operations and he also worked in South America for five years as vice president responsible for operations in Brazil, Argentina and Venezuela.

He joined BHRUT as a non-executive director and chaired the Finance Committee and latterly became Chairman of the King George's and Queen's Hospital Charity.

George is chair of the Audit Committee and a member of the Performance and Finance Committee. He joined Mid Essex Integrated Care Board in April 2022, and also chairs their Audit Committee.



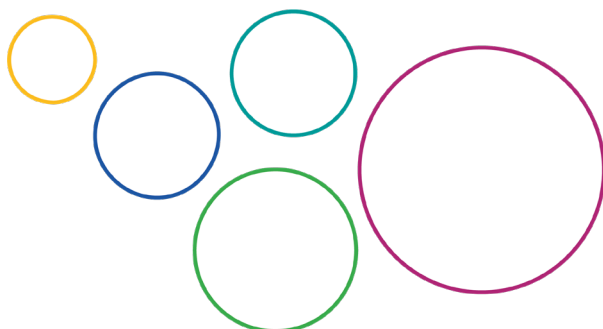
Helen Howe, non-executive director

Helen is a registered pharmacist with a career history in hospital pharmacy. She retired as chief pharmacist at Cambridge University Hospitals. She is a fellow and a faculty fellow of the Royal Pharmaceutical Society and was awarded an honorary professorship of pharmacy by the University of East Anglia for joint working and national input to the profession.

She has contributed to the profession at a national level including working with the Department of Health. She has worked as an inspector with the Care Quality Commission; as a Subject Matter Expert for Deloitte; with the NHS Leadership Academy and the Centre for Pharmacy Postgraduate Education on leadership training.

Helen was chair of the People Committee and a member of the Quality and Safety Committee and Audit Committee.

Helen left the Trust at the end of March 2024; the end of her six year term.



Colin McCready, non-executive director

Colin McCready joined PAHT as a non-executive director in February 2022.

Colin is currently a director of Elysium Healthcare Ltd. Prior to this he held the chief financial officer (CFO) position with NHS Supply Chain and NHS Professionals, where he also held the position of CFO and then interim CEO.

Prior to NHS Professionals, Colin held senior finance director roles at public sector outsourcers Serco and professional services provider Control Risks.

A chartered global management accountant and chartered institute of management accountant, Colin holds a Bachelor of Commerce (Finance Speciality) achieved at Queen's University in Ontario, Canada. Colin is the Chair of the Performance and Finance Committee and a member of the Audit Committee and Strategic Transformation Committee.



Oge Austin-Chukwu, associate non-executive director

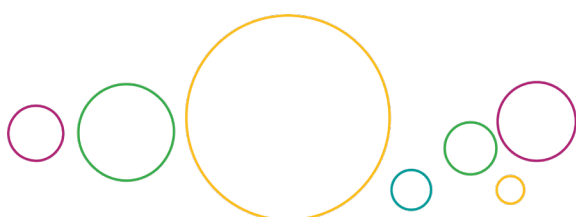
Oge joined the Trust on 4 September 2023 as an associate non-executive director.

Oge brings over 30 years of experience working within the NHS, first in obstetrics and gynaecology and later as a local GP.

During this time, she has held various roles including a senior partner, GP appraiser and medical tutor. As a qualified leadership/executive coach, Oge works with people and organisations to support with clarity on their vision, strategy and performance.

Outside of the NHS and coaching, Oge is co-host of a podcast that provides leadership insights for BAME female leaders, she is the co-founder of a social enterprise that supports leaders and organisations to implement and maintain diversity and inclusion targets, she is also the chair of the charity Freedom 2.

Oge is the Chair of QSCI and a member of the People Committee.



Liz Baker, non-executive director

Liz Baker joined PAHT as an associate non-executive director in February 2022 and was appointed as a non-executive director in April 2024.

She has a wealth of experience from the transportation sector, particularly in the capital delivery of large-scale rail projects such as Crossrail and High Speed 2, and major industry reviews.

Currently a programme sponsor for major railway schemes in the midlands, Liz enjoys sharing learning across the infrastructure and healthcare sectors, whilst contributing her skills to PAHT's strategic transformation programme.

Liz's expertise includes project and programme sponsorship; risk; change; benefits realisation and programme governance. She is a qualified civil engineer, mediator, and construction law professional with a keen interest in collaborative working practices.

Liz is the Chair of the Strategic Transformation Committee.



Anne Wafula-Strike MBE, associate non-executive director

Born in Mihuu, Kenya, Anne was a fit and healthy child before polio struck when she was two years old. After completing A-levels and graduating from Moi University with a Bachelor of Education degree, Anne taught at Machakos Technical College in Kenya.

2004 marked the beginning of an Olympic career when Anne became the first wheelchair racer from Sub-Saharan Africa to compete at the Paralympics in Athens.

In 2006, Anne became a British citizen and joined Team GB. In 2007, she was among the Commonwealth delegates invited to a recognition reception at Buckingham Palace and she was officially recognised with an MBE in 2014 for her services to disability sport and charity work. She is a strong campaigner for diversity, inclusion, and accessible living for disabled people. Anne lives in Harlow and is proud to have taken on the role of associate non-executive director at PAHT, her local hospital, in 2021.

Anne is a member of the Quality and Safety Committee, People Committee and Charitable Funds Committee.



Dr Rob Gerlis, associate non-executive director

Dr Rob Gerlis joined the board as an associate non-executive director in April 2022.

A local GP for more than 30 years, Rob began his career at The Princess Alexandra Hospital, where he completed his postgraduate medical training. He then participated in the West Essex GP vocational training scheme, progressing in his medical career to become a partner at the Ross Practice in Harlow in 1986. Now semi-retired, Rob was the chair of West Essex Clinical Commissioning Group for nine years and has taken on the role of chair of Stellar Healthcare, a GP provider company covering Harlow and Epping Forest.

Rob is the Chair of the QSCII meeting (maternity) and a member of the Strategic Transformation Committee.

Kim Handel – non-executive director

Kim joined the trust in April 2023 as a non-executive director.

With a nursing background spanning over 40 years within the NHS and private sector from independent hospitals, as chief nurse of a large, independent London hospital, to working for the Care Quality Commission as an inspection manager. Beyond the hospital environment, Kim was also a deputy director and listening volunteer for Samaritans, a national charity.

Kim chaired the Quality and Safety Committee and was the trust's maternity safety champion until she sadly passed away in February 2024.

John Keddle, associate non-executive director

John was appointed as an associate non-executive director in July 2019.

John was formerly vice-president at Global Operations for GlaxoSmithKline. He worked internationally for over 25 years managing research and development and business operations in more than 30 countries. A scientist by background, John has a BSc (First Class Hons) in Biology from the University of Newcastle upon Tyne, a PhD from the University of Nottingham and an MBA from the Open University. John was chair of the Harlow Enterprise Zone, chair of Discover Harlow and deputy chair of the London Stansted Cambridge Consortium.

John left the Board in June 2023.



Executive directors

Lance McCarthy, chief executive

Lance joined the trust as chief executive in May 2017, moving from Hinchingsbrooke Hospital where he was the chief executive officer (CEO) for nearly two years. Prior to this, he was the deputy CEO at North Middlesex Hospital for more than four years.

Lance began as an economics graduate and has a wealth of experience within his NHS career, spanning over 25 years. He has worked in acute hospitals in a variety of general, performance and strategic management roles across a range of different hospitals.



Sharon McNally, chief nurse and deputy chief executive

Sharon joined the trust in October 2018, having previously been the deputy chief nurse at Cambridge University Hospitals, a post she held for six years. Her nursing career has spanned over 30 years, working in an acute setting.

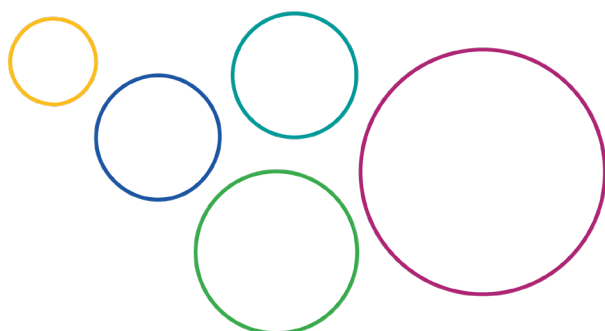
Sharon is passionate about the NHS and The Princess Alexandra Hospital NHS Trust providing high quality, compassionate care for patients. She believes this is achievable through the empowerment and engagement of the trust's greatest asset – our people. Sharon's portfolio includes professional leadership for nurses, midwives and allied health professionals, alongside being the director responsible for infection control, safeguarding, mental health and quality compliance.



Dr Fay Gilder, medical director

Fay joined PAHT from Cambridge University Hospitals NHS Foundation Trust (CUHFT), where she was a consultant anaesthetist and the clinical director for improvement and transformation.

Fay is the Trust's Caldicott Guardian.



Stephanie Lawton, chief operating officer

Stephanie was appointed as chief operating officer in March 2015; she joined the NHS in 1992.

She has a great deal of experience in understanding the complexities of the modern NHS and has many years' experience working in director level roles that have spanned clinical operations, service modernisation, performance improvement, human resources and workforce planning. Stephanie is the trust's accountable officer for emergency planning and preparedness.



Tom Burton, finance director

Tom was appointed as finance director in July 2022, after joining PAHT as interim finance director in May 2022.

He was previously the strategic planning director for the East of England Ambulance Service NHS Trust, a secondment from his role as operational director of finance for the regional NHS England and NHS Improvement team.

He began his career as a mechanical engineer, before becoming an accountant. Tom joined the NHS in 2009 from local government, where he qualified as a public sector accountant (CIPFA). His experience includes financial management roles at organisations including Mid Essex Hospital Services NHS Trust, Bart's Health NHS Trust and Great Ormond Street Hospital.



Ogechi Emeadi, chief people officer

Ogechi joined PAHT in August 2018, having previously worked at Milton Keynes University Hospital NHS Foundation Trust as executive director of workforce. She has over 25 years' experience working in HR in the NHS, during which time she has delivered strategic and operational HR initiatives and on the organisational development agenda. Ogechi is passionate about improving staff health and wellbeing and driving forward staff and leadership development.



Michael Meredith, director of strategy and estates

Michael started at the trust in 2018. He brings a range of experience and expertise to the trust, having started his career as a research scientist with a PhD in immunology and immunogenetics, led a technology development group at the University of Oxford and spent the last fourteen years developing commercial and strategic healthcare services for a wide range of commissioners and providers across the UK and beyond.



Phil Holland, chief information officer

Phil joined PAHT in 2018 as director of operations for medicine and deputy chief operating officer for urgent care; he was promoted to the role of chief information officer in 2021.

Phil brings a wide range of NHS experience in operational, informatics and transformation roles that will underpin the development of information technology at PAHT and support the organisation as it continues its programme of ongoing modernisation.



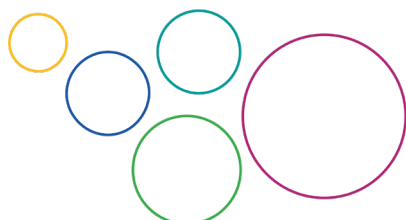
Jim McLeish, director of quality improvement

Jim is a registered nurse with a specialist background in emergency care. He joined the NHS in 1990 where he has held a number of senior clinical and operational roles including director of transformation and director of business delivery before taking up his current post as director of quality improvement.

He has a wide range of operational management, change management, and project management experience.

Jim's role supports the trust to develop and enhance care pathways working alongside our clinical leadership teams to support them in delivering quality and service improvements.

Jim has a diverse portfolio, which includes modernisation and transformation of our clinical support services as well as supporting the delivery of our new system wide transformation programme with colleagues across west Essex.



Attendance at Board of Director Meetings and Committees 2023-24

Attendance at Board of Director Meetings and Committees 2023-24								
Board Member	Trust Board (Public)	Audit Committee	Quality and Safety Committee Part I	Quality and Safety Committee Part II	Performance and Finance Committee	People Committee	Strategic Transformation Committee	Remuneration and Nomination Committee
Non-executive directors		Attendance (actual/possible)						
George Wood	11/11	5/5	N/A	N/A	11/11	N/A	N/A	1/2
Helen Howe	9/11	3/5	9/11	9/10	N/A	5/6	N/A	0/2
Colin McCready*	8/11	4/5	N/A	N/A	11/11	N/A	3/4	2/2
Darshana Bawa	11/11	4/5	N/A	N/A	11/11	6/6	N/A	2/2
Elizabeth Baker *	10/11	N/A	N/A	N/A	N/A	N/A	6/6	2/2
Kim Handel *	8/9	N/A	7/9	7/9	N/A	N/A	N/A	0/1
Board Member	Trust Board (Public and Private)	Audit Committee	Quality and Safety Committee Part I	Quality and Safety Committee Part II	Performance and Finance Committee	People Committee	Strategic Transformation Committee	Remuneration and Nomination Committee

The accountability report

Associate non-executive directors		Attendance (actual/maximum)						
John Keddie *	3/3	N/A	N/A	N/A	3/3	1/1	1/1	1/1
Anne Wafula- Strike	11/11	N/A	7/11	7/10	N/A	5/6	N/A	2/2
Rob Gerlis	11/11	N/A	8/11	7/10	N/A	N/A	1/6	1/2
Oge Austin- Chukwu *	6/7	N/A	6/7	5/6	N/A	N/A	N/A	1/1

- Colin McCready became a member of STC during the year
- Non-executive director Kim Handel was appointed in May 2023 and sadly passed away in February 2024
- John Keddie left the Trust in June 2023
- Associate non-executive director Oge Austin-Chukwu was appointed in September 2023

The accountability report

Board Member	Trust Board (Public)	Audit Committee	Quality and Safety Committee Part I	Quality and Safety Committee Part II	Performance and Finance Committee	People Committee	Strategic Transformation Committee
Executive directors		Attendance (actual/possible)					
Sharon McNally	10/11	N/A	11/11	9/10	N/A	6/6	N/A
Stephanie Lawton	10/11	N/A	7/11	6/10	5/11	3/6	N/A
Fay Gilder	9/11	4/5	11/11	9/10	N/A	N/A	4/6
Tom Burton	11/11	5/5	N/A	N/A	11/11	N/A	4/6
Ogechi Emeadi	10/11	N/A	N/A	10/10	N/A	6/6	N/A
Michael Meredith	9/11	N/A	N/A	N/A	9/11	N/A	5/6
Phil Holland	11/11	N/A	N/A	N/A	9/11	N/A	5/6
Jim McLeish	11/11	N/A	11/11	9/10	N/A	N/A	5/6

The accountability report

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Statement of director’s responsibilities

The full statement of director’s responsibilities is included in the financial statements.

Statement of the chief executive’s responsibilities as the accountable officer of the Trust

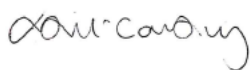
The chief executive of NHS England has designated that the chief executive should be the Accountable Officer of the Trust. The relevant responsibilities of accountable officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust’s auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity’s auditors are aware of that information.

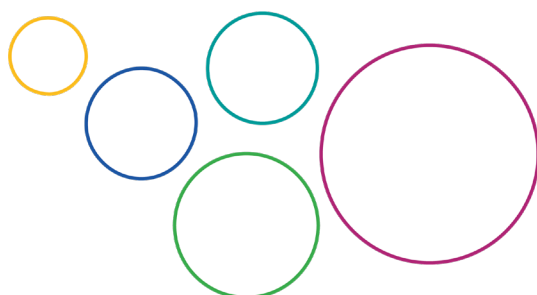
To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed:



Lance McCarthy
Chief executive

Date: 11 July 2024



The Princess Alexandra Hospital Annual Governance Statement 2023-24

My Annual Governance Statement (AGS) has been written describing the governance arrangements in place at the Trust during 2023-24. During the year, we continued to review and strengthen our governance arrangements and took into account the findings of our Care Quality Commission (CQC) inspections together with continuing feedback and support from NHS England.

At the same time, we have taken a full and active role within the Hertfordshire and West Essex Integrated Care Board (ICB) and the West Essex Health and Care Partnership. Delivering high quality, timely and cost effective care to our local community are core components of our strategic objectives, and the ICB gives clear clinically led focus on improving standards, financial stability and adapting services to a growing and changing community across west Essex and Hertfordshire.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a

reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Princess Alexandra Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2024 and up to the date of approval of the Annual Report and Accounts.

The governance framework of the organisation

The Governance Framework describes the structure and systems that are in place for the direction and control of the Trust to fulfil the functions as set out in the Statutory Instrument 1994 No. 3179. These mechanisms include the Trust Board, its Committees, management arrangements, Governance Manual and Risk Management Strategy.

The Trust Board is responsible for making sure we provide safe, effective and compassionate care to our patients at the same time as supporting their families, relatives and carers. It does this by making the key decisions that affect our hospital and setting the values, aims and strategic direction for the Trust. It also reviews performance against our objectives, as well as against national standards and targets. It has overall responsibility for the effective control of the Trust and is accountable, through its chair, to NHS

England and the Secretary of State for Health and Social Care. The Trust Board consists of:

- a chair
- five voting non-executive directors
- four non-voting associate non-executive directors
- five voting executive directors (chief executive officer, director of finance, medical director, chief operating officer and chief nurse/deputy chief executive) and four further executive directors without voting rights; the director of people, organisational development and communications, the director of strategy and estates, the director of quality improvement and the chief information officer

The following non-executive director appointments were made in year:

- Kim Handel was appointed on 1 April 2023 and sadly passed away on 2 February 2024
- John Keddie left the Board in June 2023
- Oge Austin-Chukwu was appointed as an associate non-executive director on 4 September 2023
- Elizabeth Baker, associate non-executive director was appointed as a non-executive director from 1 April 2024
- Helen Howe, non-executive director left the Trust on 31 March 2024

There were no changes to the executive team in year.

Attendance at Board and Committee meetings throughout 2023-24 has been monitored and is recorded in the Annual Report. The Trust Board has established the following committees to discharge its responsibilities in relation to Board assurance:

- Audit Committee
- Quality and Safety Committee (Part I and II, the latter focussing on Maternity)
- Performance and Finance Committee
- People Committee
- Strategic Transformation Committee

- Remuneration and Nominations Committee
- Charitable Funds Committee
- Senior Management Team Meeting

An annual effectiveness review of each committee is undertaken to ensure they continue to meet their terms of reference. The outcomes of the reviews are reported to the Trust Board.

Following each meeting of the committees the committee chairs present written and verbal reports to the next Board meeting. These reports provide a summary of the matters discussed at the meetings, areas of risk or concern as well as areas of good news or positive performance. Progress against the committees' work plans is also included in each committee report to Board.

Capacity to handle risk

As chief executive officer, I am accountable for the overall risk management activity within the Trust. Committed leadership in the area of risk management is essential to maintaining sound systems of internal control required to manage risks associated with the achievement of the corporate goals of the Trust. The Trust's Risk Management Strategy details my overall accountability to the Trust Board for risk management and makes it clear that managing risk is a key responsibility for the Trust and all staff employed by it. The Trust Board receives regular reports that detail quality, financial and operational performance risk, and, where required, the action being taken to reduce identified high-level risks.

I am responsible for ensuring that the Trust is in a position to provide overall assurance that the organisation has in place the necessary controls to manage its risk exposure. In discharging these responsibilities, I was assisted by the following directors during 2023-24:

The director of finance has delegated responsibility for co-ordinating the management of financial and business related risks, the Trust's capital programme and assisted me in ensuring that the Trust's resources were managed efficiently, economically and effectively.

The chief nurse has delegated authority and responsibility for the professional leadership of the nursing, midwifery and allied health professions. The role is also the executive lead for infection prevention and control with the director of infection prevention and control reporting to them. The role has delegated responsibility for reporting to the Trust Board on the delivery of quality and patient experience standards, complaints and claims management and is the Trust's safeguarding lead.

The medical director has overall accountability for operational and clinical risk and incident management. This includes the establishment and monitoring of assurance mechanisms and provision of associated risk reports to the Trust Board. The medical director also has delegated responsibility for co-ordinating and monitoring the Trust's revalidation programme for medical staff in line with the 'Maintaining High Professional Standards' system for the NHS. The medical director is also the Caldicott Guardian for the Trust.

The chief operating officer has delegated authority for managing the Trust's performance delivery both against national operating standards and key performance indicators.

The director of people, organisational development and communications has delegated responsibility for overseeing all people functions across the Trust, including

recruitment, staff training and managing absence as well as embedding the Trust's people strategy, organisational development and culture programme.

The director of quality improvement has delegated responsibility for managing the Trust's transformation and modernisation programme as well as the Quality First team and implementing the quality improvement strategy.

The director of strategy has delegated responsibility for managing the development of the new hospital, health and safety and the implementation of the estates strategy.

The chief information officer has delegated responsibility for ensuring that information governance arrangements at the Trust are suitable, is the Trust's Senior Information Risk Owner (SIRO) and is responsible for the development and implementation of the digital strategy for the Trust and the deployment of the Trust's new electronic health record.

As chief executive, I also hold responsibility for managing the strategic development and leadership of the Trust's quality improvement agenda; ensuring the implementation of the quality management improvement agenda; and ensuring the safety and quality of the care provided to our patients.

All our people receive risk management training at induction and further updates as required. The training covers topics such as risk assessments, health and safety at work, moving and handling, fire safety, incident reporting, information governance as well as infection prevention and control.

In addition to providing staff with skills and knowledge to carry out their work safely, staff are actively encouraged to report incidents and escalate any identified risks in a timely manner. In addition, thematic learning from incidents is shared through newsletters, internal safety alerts, simulation sessions and/or case scenarios through the Trust's Sharing the Learning sessions. We also support a programme of counter fraud training and awareness provided by the local counter fraud specialist team.

The risk and control framework

Overall responsibility for the management of risk within the Trust rests with the Board of Directors. Reporting mechanisms are in place to ensure that the Board of Directors receives timely, accurate and relevant information regarding the management of risks.

The role of the risk and control framework is to identify, evaluate and prioritise clinical and non-clinical risks and gain assurance that these are properly controlled to ensure safe and effective care.

Risks facing the organisation are identified from a number of sources, for example:

- Risks arising out of the delivery of day to day work related tasks or activities
- The review of strategic or operational ambitions
- As a result of an incident or the outcome of investigations
- Following a complaint, claim or patient feedback
- As a result of a health and safety inspection/assessment, external review or audit report
- National requirements and guidance

The identification, assessment and control of risk is delegated to directors, managers, departments, wards and teams within the Trust.

The systems and processes in place for identifying, managing and monitoring risks include:

- A risk management strategy (for the effective management of clinical and non-clinical risk)
- The operational delivery of risk management arrangements is further defined within the Trust's Risk Management Policy
- A Board Committee structure with clear reporting lines to the Trust Board
- A Risk Management Group reporting to the Trust Board via Senior Management Team meetings
- A Corporate Risk Register, Trust wide Risk Register and Board Assurance Framework, all of which are reviewed by the Risk Management Group, Senior Management Team and Trust Board
- Reporting and monitoring systems for incidents and complaints

The risk management strategy, including the risk appetite statement, has been approved by the Board.

Risk is managed at different levels of the organisation. Each division and corporate department has a risk register that is regularly reviewed, ensuring that risk scores are accurate and that risks are appropriately mitigated, managed and escalated. A risk score is obtained by combining estimates of consequence and likelihood using the Trust's 5 x 5 risk assessment matrix, it is calculated by multiplying the consequence (1 - 5) by the likelihood of a risk occurring (1 - 5).

Each risk on the register has a risk owner accountable for that risk.

The Risk Management Group meets on a monthly basis to review risks across all divisions as well as corporate departments.

The Trust has a Board Assurance Framework (BAF) which provides a mechanism for the Board to monitor the risks to delivery of the Trust's strategic objectives as well as the effectiveness of the controls and assurance processes. The risks reflect the Trust's in-year and future risks.

Each risk on the BAF has an executive lead and a designated responsible committee. The risks are reviewed monthly with executive leads and are reviewed by the relevant committees and the Trust Board bi-monthly. The Risk Management Group reviews the BAF by exception.

There are a number of high scoring risks on the BAF:

1.1 Clinical outcomes: Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience, scoring 16.

1.2 EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care, scoring 16.

1.3 Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment, scoring 15.

2.1 GMC enhanced monitoring: Risk that the GMC/HEE will remove the Trust's doctors in training, scoring 20.

2.3 Workforce: Inability to recruit, retain and engage our people, scoring 16.

3.1 Estates and infrastructure: Concerns about potential failure of the Trust's estate and infrastructure and consequences for service delivery, scoring 20.

3.2 System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system, scoring 16.

3.5 New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding, scoring 20.

4.1 Seasonal pressures: Risk that the Trust will be unable to sustain and deliver safe, high quality care during

seasonal periods due to the increased demand on its services, scoring 12.

4.2 ED standard: Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience, scoring 20.

4.3 Industrial action: There is a risk that the ongoing industrial action creates deteriorated operational performance in both elective and urgent care, scoring 20.

5.1 Finance – revenue: Risk that the Trust will fail to meet the financial plan, scoring 16.

In April 2024, the Board approved the addition of a new risk to the Board Assurance Framework to describe the risk relating to a delay in the implementation of the Trust's new electronic health record, scoring 16.

Further detail on these risks and their management is outlined in this Annual Report.

Quality governance arrangements

There is clear accountability at Board level for patient safety and clinical quality outcomes, along with structured reporting of performance against these objectives. Executive oversight of quality improvement is through the chief nurse who, with the medical director, ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. For any transformational change required, they are supported by the Trust's Quality First team. The Quality and Safety Committee has oversight of all key quality indicators including patient safety, patient experience and clinical effectiveness.

Each of the Trust's divisions has a patient safety and quality group where themes and trends from reviews of incidents and complaints and learning are reported. Performance is reviewed at monthly performance review meetings and at the Quality and Safety Committee each division presents a quarterly overview of its performance on

a rolling programme, in line with the Care Quality Commission (CQC) key lines of enquiry. Throughout 2023-24 the Quality and Safety Committee continued to receive updates on progress against the improvement plan developed to address concerns raised by the CQC during their inspection.

Regular 'Sharing the Learning' reports providing an overview of themes, trends and learning arising from incidents, serious incidents and on-going quality improvement initiatives for topics such as falls, dementia and pressure ulcers are also received. In January 2024 the Trust commenced management of incidents using the national Patient Safety Incident Response framework.

Mortality is monitored by the Quality and Safety Committee as well as the Trust Board. The Quality and Safety Committee receives bi-monthly reports on mortality and learning from deaths whilst the Trust Board receives an update at every public Board meeting (held bi-monthly). Medical examiners have been appointed and structured judgement reviews are undertaken. The trust has shown a significant improvement in HSMR and SMR in the 2023-24 year.

The Quality and Safety Committee, People Committee and Trust Board receive reports on nurse and midwifery staffing levels in line with guidance received from NHS England and the Care Quality Commission on the delivery of the 'Hard Truths' commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels.

CEO Assurance Panels have been convened to provide enhanced oversight and assurance where high risk areas have been identified in relation to quality.

Never events

The Trust reported 4 never events in 2023-24; two relating to wrong site surgery and two mis-placed nasogastric tubes. The learning from these cases has been cascaded in line with the Trust's processes for learning from incidents.

Well-led Reviews

The Board commissioned an external review of the Well-led framework in March 2021 and the recommendations were monitored through the relevant committees and the Trust Board.

An assessment against the new Well-led standards is underway and will be reported to the Board in 2024-25.

Compliance with NHS Provider Licence

The Trust is not in breach of the conditions of the licence.

Developing Workforce Safeguards

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which provide assurance to the Trust Board that staffing processes are safe, sustainable and effective. Compliance with the 'Developing Workforce Safeguards' recommendations is demonstrated through the following systems:

- The Integrated Performance Report (IPR) is received at each public Trust Board meeting and details a range of staffing metrics including vacancy rates, recruitment trajectories, sickness absence, turnover, appraisal rates, statutory and mandatory training compliance
- A workforce report is presented to the People Committee bi-monthly where the metrics listed above are scrutinised
- The safer nurse staffing report is presented to the Quality and Safety Committee by exception and bi-monthly to the People Committee and Trust Board; this details

the actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff as well as providing an update on nursing vacancy rates, and in 2023-24, the plans to further reduce the vacancy rate to achieve the target vacancy rate

- In addition to reporting to committees and Trust Board, monthly divisional review meetings take place where a range of performance indicators including vacancy rates, sickness absence, turnover, maternity leave, training and average absence are reviewed
- Freedom to Speak Up Guardians and Guardian of Safe Working reports are presented to the Trust Board and People Committee
- Electronic job planning processes are in place for medical staff
- Bi-annual nursing and midwifery establishment reviews are undertaken and reported to the People Committee, Quality and Safety Committee and the Trust Board. The reviews utilise the Safer Nursing Care Tool (SNCT) for adult ward areas, the Baseline Emergency Staffing Tool (BEST) for the emergency department and Birthrate Plus for the maternity department
- The Trust's workforce plan underpins the Trust's annual operating plan which is reviewed by the Performance and Finance Committee and approved by the Trust Board
- The Trust remains focused on increasing and retaining its core nursing workforce, utilising new roles such as nurse consultants, nursing associates, expanding our clinical nurse practitioners, clinical digital nurses and professional nurse advocates whilst continuing to further develop and embed new workforce models. Working with our Integrated Care System (ICS) partners, we will continue to identify opportunities for joint roles as we identify workforce models that support integrated working and the implementation of our

new models of care

Managing conflicts of interest

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

The Trust's Audit Committee monitors and approves the registers of interest.

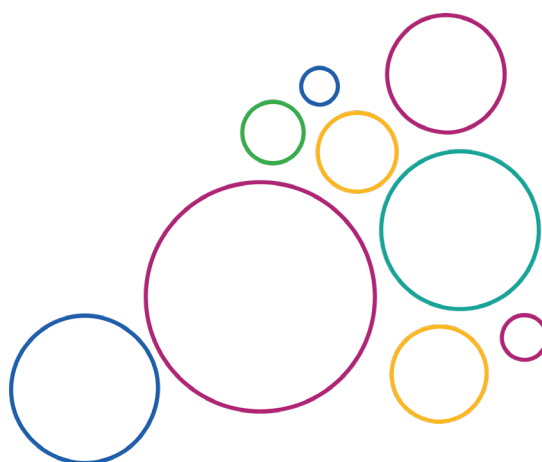
Care Quality Commission

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The most recent inspection of the Trust was completed by the Care Quality Commission (CQC) was an unannounced focused inspection over the summer of 2021, this included a review of Trust wide Well Led Key Line of Enquiry. The care services inspected were:

- Maternity care
- Medicine (including elderly care)
- Urgent and emergency care (emergency department)

In March 2023, the CQC completed an unannounced focused inspection of the emergency department to monitor progress against the Trust's action plan. The report was received in mid-June 2023 and the CQC improved the grading for the urgent and emergency department to Requires Improvement. The Trust's overall quality rating is overleaf.



Overall trust quality rating		Requires Improvement 
Are services safe?		Requires Improvement 
Are services effective?		Requires Improvement 
Are services caring?		Good 
Are services responsive?		Requires Improvement 
Are services well-led?		Requires Improvement 

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Carbon reduction

The trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has a Governance Manual comprising standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of the annual

operating plan, annual budgets for both revenue and capital, reviewing financial performance against budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis.

The Trust has a process for the development of business cases for both capital and revenue expenditure and, depending on the level of investment, these are reviewed by the Senior Management Team, Performance and Finance Committee and Trust Board. The Performance and Finance Committee reviews productivity, operational and financial performance and use of resources both at Trust and Divisional level.

More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in this Annual Report. The Trust's external auditors are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee.

Information governance/data security risks

The Trust reported five Information Governance (IG) data security breaches to the Information Commissioners Office (ICO) during 2023-24.

The first breach related to a letter containing sensitive information sent to an incorrect address.

The second breach related to a letter addressed to a GP which was sent to a personal address in error.

The third breach related to the Trust being notified by a FOI requester that personal and special category deceased patient data, and associated staff names had inadvertently been released via cached information contained in a pivot table linked to an aggregated data response.

The fourth breach related to a patient having received a Subject Access Request (SAR) response in an envelope which had become damaged during the delivery service.

The fifth breach related to a member of staff inappropriately accessing a patient record.

The first four breaches were investigated and closed by the ICO, with no further action taken against the Trust. Learning from these cases has been disseminated locally. The fifth breach is still being investigated.

Data quality and governance

Data quality reports are produced and reviewed at the Data Quality Steering Group. This group reports to the Senior Management Team and quarterly E-health updates are presented to the Performance and Finance Committee (PAF) with escalations to the Trust Board. The Information Governance Steering Group receives a monthly update on data quality.

The Integrated Performance Report is discussed at each of the committees every month and at Trust Board bi-monthly.

The Trust is implementing a new electronic health record and the planned go live date is October 2024. The new system will enable the provision of high quality data.

Elective waiting time data

Patients who have been referred to the Trust on a Cancer Waiting Time or Referral to Treatment (RTT) pathway are managed daily by the clinical and operational teams, in line with the hospital's Access Policy. These pathways are reviewed at weekly Patient Tracker List (PTL) meetings, chaired by the performance manager where pathway trigger points are reviewed and remedial actions taken, if required. The PTL meetings report to the weekly Elective Care Operational Group meetings which are chaired by the head of performance and planning and then to the System Access Board. The System Access Board also reviews RTT Data Quality reports and determines required actions to ensure that processes maintain accurate data recording. Divisions monitor waiting list information at divisional Board meetings.

Quality and Safety Committee

(QSC) receives updates on review lists (overdue un-booked follow-up appointments). Unbooked first appointments due to insufficient capacity (appointment slot issues, ASIs) are also regularly reported to QSC. Both issues are discussed at divisional board meetings and senior management team meetings on a regular basis. Review lists are tracked and monitored through the monthly System Access Board meeting and plans to reduce these unbooked lists are discussed in the Elective Care Operational Group.

In addition, a number of data quality reports are produced to enable the service management teams to monitor patients on non-RTT pathways. These are reviewed through the Data Quality Steering Group. Both the System Access Board and the Data Quality Steering Group report to the Senior Management Team and to Performance and Finance Committee.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, the executive team, managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust has an annual clinical audit programme in place including mandated audits addressing national and local issues, targets and performance.

The Trust's internal auditors provide an opinion on the overall arrangements for gaining assurance as part of the risk-based Annual Internal Audit Plan. During the year, the following internal audit reports received a moderate/limited assurance rating for design and operational effectiveness:

- Mandatory training and appraisals
- Business Continuity and Disaster Recovery

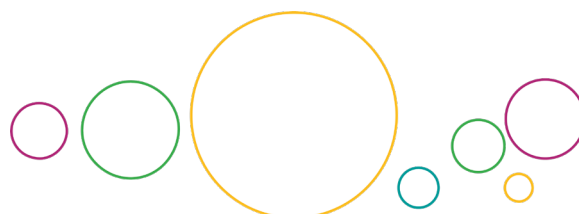
The Head of Internal Audit Opinion (HoIA) on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2024 - report by BDO LLP:

As the internal auditors of The Princess Alexandra Hospital NHS Trust, we are required to provide the

Audit Committee, and the Directors with an opinion on the adequacy and effectiveness of risk management, governance, and internal control processes, as well as arrangements to promote value for money. In giving our opinion it should be noted that assurance can never be absolute. The internal audit service provides The Princess Alexandra Hospital NHS Trust with **Moderate assurance** that there are no major weaknesses in the internal control system for the areas reviewed in 2023/24. Therefore, the statement of assurance is not a guarantee that all aspects of the internal control system are adequate and effective.

The statement of assurance should confirm that, based on the evidence of the audits conducted, there are no signs of material weaknesses in the framework of control. In assessing the level of assurance to be given, we have taken into account:

- All internal audits undertaken by BDO LLP during 2023/24
- Any follow-up action taken in respect of audits from previous periods for these audit areas
- Whether any significant recommendations have not been accepted by management and the consequent risks
- The effects of any significant changes in the organisation's objectives or systems
- Matters arising from previous internal audit reports to The Princess Alexandra Hospital NHS Trust
- Any limitations which may have been placed on the scope of internal audit – no restrictions were placed on our work



Significant issues

The following is a summary of three significant issues which were and will continue to be the focus of the Trust Board's attention and direct the Trust's management efforts during 2024 (and beyond); these issues are also reflected on the Board Assurance Framework:

Urgent and emergency care

The Trust has struggled to deliver against the Emergency Department Standard throughout the year. The Urgent Care Improvement Board maintains oversight of actions being taken to improve performance against all the emergency care standards. Recovery plans remain in place to address performance issues both internally and across the health and social care system.

Elective recovery programme: 78 weeks and cancer waits

The Trust has reduced the number of long waiting patients over 78 weeks. However, the aim to have zero patients waiting over 78 weeks by July 2023 was not achieved due to the impact of industrial action and the requirement to prioritise an increased number of cancer and urgent patient treatments. The Trust continues to focus on this aim along with the requirement to have no patients waiting longer than 65 weeks by 30 September 2024.

Delivery of the national cancer standards has continued to be impacted by the number of patients waiting over 62 days for their treatment however significant progress has been made in reducing the long waits.

Finance

The Trust achieved its revised 2023-24 forecast outturn position of a £6.1m deficit. This was achieved through a number of non-recurrent measures. The planned position for 2024-25 is a deficit of £25.4m which includes delivering a cost efficiency programme of £18.5m. The movement between the 2023-24

outturn position and the 2024-25 plan is related to the non-recurrent funding and measures deployed in 2023-24 which will not be available in 2024-25. The scale of the financial challenge for 2024-25 is a risk to the Trust.

Estate

The quality and safety of the estate remains a significant challenge for us at a time of financial constraint. It has been well communicated that the current hospital estate has reached its limit in terms of capacity and development. Our ability to keep up with the changing clinical landscape, technological advances and delivery of new models of care is limited by our current estate. In addition, the estates and facilities team has faced significant leadership and staffing challenges in 2023-24 and a sustainable long term solution is being developed.

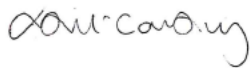
These key risks and concerns drive our long-term estate strategy which includes building a new hospital to address these challenges and enable the Trust to be successful in delivering integrated care. However we still need to deliver high quality, efficient services from the current estate as we continue to progress the new hospital plans in line with the national New Hospital Programme.

Conclusion

As Accountable Officer, I receive information and assurance from a wide range of sources about the Trust's internal control systems and structures in place to ensure the effective operation of the Trust. These facilitate the identification of strengths and areas in need of attention enabling appropriate action plans to be established and acted on.

Although significant issues have been identified as above, my review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and

objectives and statutory duties. I and the Trust Board remain committed to achieving continuous improvement and enhancement of the systems of internal control.



Lance McCarthy
Chief executive

11 July 2024

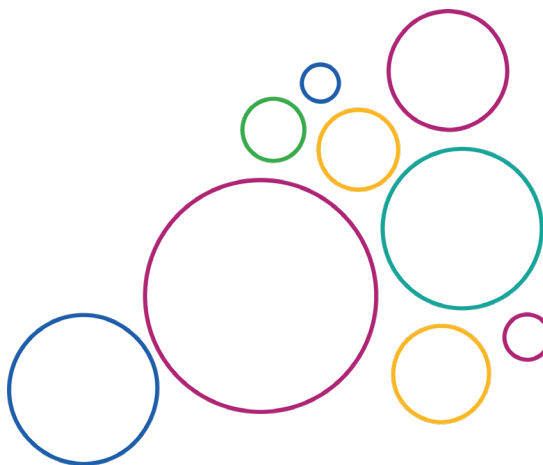
Remuneration and staff report

Remuneration report

Background

This report includes details regarding “senior managers” remuneration in accordance with paragraphs 3.69 to 3.127 of the DHSC (Department of Health and Social Care) Group Accounting Manual 2023/24. Most of the remuneration report set out below is subject to audit by our external auditors.

The Trust has established a Remuneration and Nominations Committee to advise and assist the Board in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the chief executive officer, executive directors and very senior managers. The Remuneration Committee is chaired by the Trust’s chairman and meets at least annually. Membership of the committee consists of Trust chairman and all non-executive directors with the director of people and others in attendance. The chief executive officer and executive directors’ remuneration is determined on the basis of reports to the Remuneration and Nominations Committee taking account of any independent evaluation of the post, national guidance on pay rates and market rates. Pay rates for the chair



and non-executive directors of the Trust are determined in accordance with national guidance.

The Trust does not operate any system of performance related pay and no proportion of remuneration is dependent on performance conditions. The performance of non-executive directors is appraised by the chair. The performance of the chief executive officer is appraised by the chair. The performance of Trust executive directors is appraised by the chief executive officer. Annual pay increases are implemented in accordance with national pay awards for all other NHS staff.

Staff report

Pay multiples

Reporting bodies are required to disclose 4 key indicators between years:

- Percentage change in salary and allowances for highest paid director from previous year
- Percentage change in performance pay and bonuses for highest paid director from the previous year
- Percentage change in average salary and allowances for employees of the entity as a whole, and
- Percentage change in average performance pay and bonuses for employees of the entity as a whole

For PAHT for 2023/24 (and 2022/23), these were:

2023/24			2022/23	
	Highest paid director	Employee average	Highest paid director	Employee average
Salary and allowances	4.1%	6.8%	0.9%	3.7%
Performance pay and bonuses	0.0%	0.0%	0.0%	0.0%

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation’s workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The 25th percentile movement from prior year is as a result of pay uplift for agenda for change staff especially for the band 2 to 3 who had a significant increase in their bandings. The banded remuneration of the highest paid director/member in PAHT in the financial year 2023-24 was £215k (2022-23, £204k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2023/24	25th Percentile	Median	75th Percentile
Total remuneration	20,162	29,629	44,629
Salary component of total remuneration	20,162	29,629	44,629
Pay ratio information	11:1	7:1	5:1

2022/23	25th Percentile	Median	75th Percentile
Total remuneration	21,658	29,439	44,665
Salary component of total remuneration	21,658	29,439	44,665
Pay ratio information	9:1	7:1	5:1

Consultancy and professional services spend

Total consultancy and professional services expenditure in 2023/24 was £3,002k (2022/23 £3,569k).

Trade Union Disclosures

Table 1

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
1	0.6 WTE

Table 2

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	-
1-50%	-
51%-99%	1
100%	-

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£28,173
Provide the total pay bill	£262,832k
Provide the percentage of the total pay bill spent on facility time, calculated as: £262,832.00 (total cost of facility time ÷ total pay bill) x 100	0.01%

Table 4**Paid trade union activities**

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	60.00

Off Payroll Engagement**Table 1: Length of all highly paid off-payroll engagements**

For all off-payroll engagements as of 31 March, for more than £245(1) per day:

	31 March 2024 Number	31 March 2023 Number
Number of existing engagements as of 31 March	-	-
Of which, the number that have existed:		
for less than one year at the time of reporting	-	-
for between one and two years at the time of reporting	-	-
for between 2 and 3 years at the time of reporting	-	-
for between 3 and 4 years at the time of reporting	-	-
for 4 or more years at the time of reporting	-	-

Note

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.



Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245(1) per day:

	31 March 2024 Number	31 March 2023 Number
No. of temporary off-payroll workers engaged between 1 April and 31 March 2024	-	-
Of which,		
No. not subject to off-payroll legislation(2)	-	-
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	-	-
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	-	-
No. of engagements reassessed for compliance or assurance purposes during the year	-	-
Of which: no. of engagements that saw a change to IR35 status following review	-	-

Notes

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

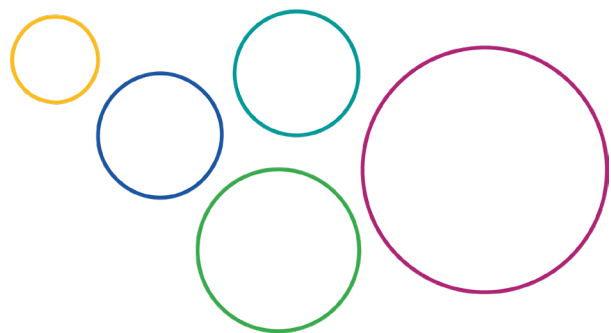


Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April and 31 March:

	31 March 2023 Number	31 March 2024 Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	-	-
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure must include both on payroll and off-payroll engagements (2)	-	-

Notes

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero in any cases where individuals are included within the first row of this table the department should set out:

- Details of the exceptional circumstances that led to each of these engagements
- Details of the length of time each of these exceptional engagements lasted

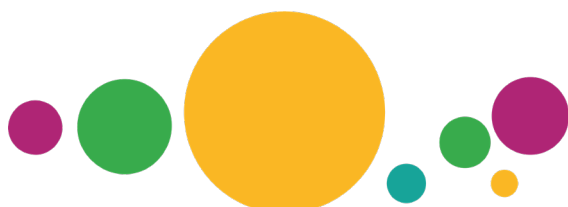
Employee benefits and staff numbers (subject to audit)

The consultant pay award accrued for 2023-24 is £157k, based on an estimate by NHS England.

This pay settlement reflects the offer announced by the Secretary of State on 25 March 2024 contained revised pay terms for the 2023/24 financial year for Consultants.

Per IAS 19 paragraph 19, DHSC judges that the offer constitutes a present legal or constructive obligation to make such payments, for which a reliable estimate of the obligation can be made. Accordingly, the 2023/24 component of the settlement offer has been accrued as an expense within the 2023/24 accounts, for PAH Consultants, per paragraph of 11 of IAS 19.

The 2023/24 pay award for Very Senior Managers has been disclosed as salary in the Remuneration Report. For the fair pay disclosure, the additional non-consolidated award has been included in the definitions of salary and remuneration.



Employee benefits

Gross expenditure	Permanently employed	Other	2023/24 total	2022/23 total
	£000's	£000's	£000's	£000's
Salaries and wages	169,691	118	169,809	156,229
Social security costs	18,693		18,693	16,514
Apprenticeship levy	882		882	763
Employer's contributions to NHS pensions	28,931		28,931	25,849
Pension costs - other	28		28	27
Temporary staff	-	48,356	48,358	47,495
Total employee benefits	218,225	48,474	266,699	246,877
Less: Employee costs capitalised	2,642	926	3,568	1,089
Redundancy	300	-	300	21

Average staff numbers

	Permanent number	Other number	2023/24 total	2022/23 total
Medical and dental	339	330	669	537
Ambulance staff	-	-	-	-
Administration and estates	1,151	115	1,266	1,146
Healthcare assistants and other support staff	675	22	697	667
Nursing, midwifery and health visiting staff	1,250	47	1,297	1,192
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	264	19	283	263
Healthcare science staff	98	9	107	107
Social care staff	-	-	-	-
Other	-	-	-	-
Total	3,777	542	4,319	3,912
Staff engaged on capital projects (included in above)	91	17	108	23

Staff sickness and ill health retirements

Annual references for staff sickness absence relate to calendar years. For ill health retirements, year references relate to financial years.

Staff sickness absence data can be accessed via NHS Digital using the [following link - NHS Digital Staff Sickness Data >](#)

Ill health retirements	2023/24	2022/23
	Number	Number
Number of persons retired early on ill health grounds	4	5
	£000s	£000s
Total additional pensions liabilities accrued in the year	172	385

Reporting of compensation schemes - exit packages 2023/24 (subject to audit)

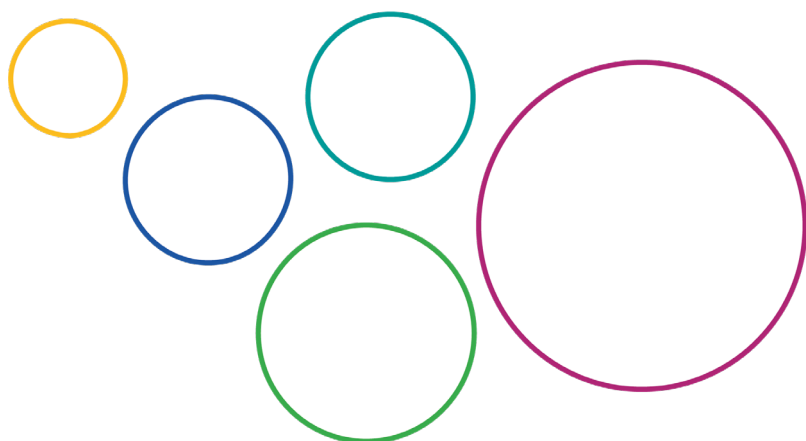
There were no exit packages provided in 2023/24 (£0k 2022/23).

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	-	-	-
£10,000 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total	-	-	-
Total resource cost (£)	-	-	-

Redundancy and other departure costs have been paid for in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Reporting of compensation schemes - exit packages 2022/23 (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	-	-	-
£10,000 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total	-	-	-
Total resource cost (£)	-	-	-



Exit packages (non-compulsory) departure payments (subject to audit)

2023/24			2022/23	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000's	Number	£000's
Contractual payments in lieu of notice	-	-	-	-
Exit payments following employment tribunals or court orders	-	-	-	-
Total	-	-	-	-



Table of salaries - non-executive directors (subject to audit)

		2023/2024							2022/2023						
Name	Title	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000's	£'s	£000's	£000's	£000's	£000's		£000's	£'s	£000's	£000's	£000's	£000's
Harriet Lydia Rose Llewelyn-Davies ⁽¹⁾	Trust Chair	All Year	45-50	-	-	-	-	45-50	All Year	45-50	-	-	-	-	45-50
Darshana Bawa ⁽¹⁾	Non-Executive Director	All Year	10-15	-	-	-	-	10-15	All Year	10-15	-	-	-	-	10-15
Robin David Gerlis ⁽¹⁾	Associate Non-Executive Director	All Year	10-15	-	-	-	-	10-15	04/04/22 - 31/03/23	10-15	-	-	-	-	10-15
HelenMary Glenister ⁽³⁾	Non-Executive Director	All Year	-	-	-	-	-	-	All Year	10-15	-	-	-	-	10-15
Helen St Claire Howe ⁽¹⁾	Non-Executive Director	All Year	10-15	-	-	-	-	10-15	All Year	10-15	-	-	-	-	10-15
John Russell Keddie ⁽²⁾	Associate Non-Executive Director	01/04/23 - 30/06/23	00-05	-	-	-	-	00-05	All Year	10-15	-	-	-	-	10-15
Colin Bruce McCready ⁽¹⁾	Non-Executive Director	All Year	10-15	-	-	-	-	10-15	All Year	10-15	-	-	-	-	10-15
Anne Wafula Strike ⁽¹⁾	Associate Non-Executive Director	All Year	10-15	-	-	-	-	10-15	All Year	10-15	-	-	-	-	10-15
George Wood ⁽¹⁾	Non-Executive Director	All Year	10-15	-	-	-	-	10-15	All Year	10-15	-	-	-	-	10-15
Kim Handel (RIP) ⁽²⁾	Non-Executive Director	01/04/23 - 28/02/24	10-15	-	-	-	-	10-15	-	-	-	-	-	-	-
Dr John Hogan ⁽³⁾	Non-Executive Director	-	-	-	-	-	-	-	01/04/22 - 08/07/22	00-05	-	-	-	-	00-05
Liz Baker ⁽¹⁾	Non-Executive Director	All Year	05-10	-	-	-	-	05-10	All Year	10-15	-	-	-	-	10-15
Dr Ogesomekwu Austin-Chukwu ⁽²⁾	Associate Non-Executive Director	04/09/23 - 31/03/24	00-05	-	-	-	-	00-05	-	-	-	-	-	-	-

- 1) Indicates that the post holder has been in post for the whole year
2) Indicates that the post holder has been in post part year only
3) Indicates that the post holder has not been in post at all during the year

The accountability report

Table of salaries - executive directors (subject to audit)

		2023/2024							2022/2023						
Name	Title	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000's	£'s	£000's	£000's	£000's	£000's		£000's	£'s	£000's	£000's	£000's	£000's
Lance McCarthy ⁽¹⁾	Chief Executive	All Year	210-215	-	-	-	0-2.5	210-215	All Year	200-205	-	-	-	70-72.5	275-280
Sharon McNally ⁽¹⁾	Director of Nursing and Midwifery	All Year	150-155	-	-	-	0-2.5	150-155	All Year	140-145	-	-	-	50-52.5	195-200
Stephanie Lawton ⁽¹⁾	Chief Operating Officer	All Year	150-155	-	-	-	0-2.5	150-155	All Year	140-145	-	-	-	47.5-50	190-195
James McLeish ⁽¹⁾	Director of Quality Improvement	All Year	120-125	-	-	-	0-2.5	120-125	All Year	120-125	-	-	-	35-37.5	155-160
Michael Meredith ⁽¹⁾	Director of Strategy	All Year	130-135	-	-	-	32.5-35.0	165-170	All Year	130-135	-	-	-	30-32.5	160-165
Ogechi Emeadi ⁽¹⁾	Director of People, Comms & OD	All Year	125-130	-	-	-	0-2.5	125-130	All Year	115-120	-	-	-	0	115-120
Phil Holland ⁽¹⁾	Chief Information Officer	All Year	105-110	-	-	-	0-2.5	105-110	All Year	110-115	-	-	-	27.5-30	140-145
Thomas Burton ⁽¹⁾	Director of Finance	All Year	145-150	-	-	-	32.5-35.0	180-185	01/08/22- 31/03/23	95-100	-	-	-	72.5-75	165-170
Saba Sadiq ⁽³⁾	Director of Finance	-	-	-	-	-	-	-	01/04/22- 29/04/22	10-15	-	-	-	5-7.5	15-20
Fay Gilder ⁽¹⁾	Medical Director	All Year	205-210	-	-	-	0-2.5	205-210	All Year	195-200	-	-	-	42.5-45	240-245

- 1) Indicates that the post holder has been in post for the whole year
- 2) Indicates that the post holder has been in post part year only
- 3) Indicates that the post holder has not been in post at all during the year

The accountability report

In 2023/24 the Trust paid out a total of £3,678.00 (2022/23- £1,892.00) in expense payments to 5 (2022/23- 3) Trust Board members.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

Where a member is affected by rollback the benefits in respect of their rolled back pensionable service during the remedy period are valued as being in the 1995/2008 Scheme. Where this results in negative real increase in pension, lump sum or CETV to be disclosed in the remuneration report tables, the negative figures must not be shown and a zero must be substituted.



Salary pension entitlement of senior managers (subject to audit)

Name	Title	Real increase / (decrease) in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023 (£000's)	Real increase in Cash Equivalent Transfer Value (CETV) (£000's)	Cash Equivalent Transfer Value at 31 March 2024 (£000's)	Employer's contribution to stakeholder pension (£000's)
Lance McCarthy ⁽¹⁾	Chief Executive	-	52.5-55.0	75-80	210-215	1,325	262	1,747	27
Sharon McNally ⁽¹⁾	Director of Nursing and Midwifery	-	-	60-65	185-190	1,409	35	1,609	18
Stephanie Lawton ⁽¹⁾	Chief Operating Officer	-	32.5-35.0	60-65	160-165	1,036	156	1,316	20
James McLeish ⁽¹⁾	Director of Quality Improvement	-	-	35-40	95-100	40	20	80	16
Michael Meredith ⁽¹⁾	Director of Strategy	2.5-5.0	-	20-25	20-25	316	69	434	18
Ogechi Emeadi ⁽¹⁾	Director of People, Comms & OD	-	27.5-30.0	50-55	135-140	962	107	1,183	17
Fay Gilder ⁽¹⁾	Medical Director	-	5.0-7.5	60-65	185-190	1,340	20	1,620	4
Tom Burton ⁽¹⁾	Finance Director	2.5-5.0	-	30-35	0-5	289	125	463	20
Phil Holland ⁽¹⁾	Chief Information Officer	-	27.5-30.0	25-30	70-75	430	105	591	14

- 1) Indicates that the post holder has been in post for the whole year
2) Indicates that the post holder has been in post part year only
3) Indicates that the post holder has not been in post at all during the year

The accountability report

CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase / (decrease) in CETV - this reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.



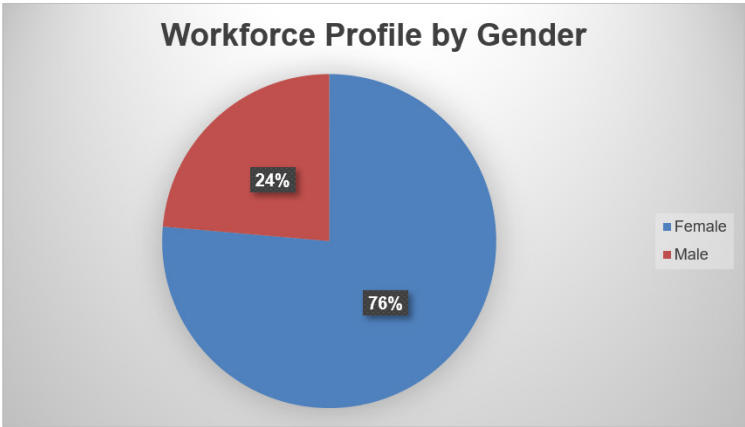
Our staff breakdown

March 2024 staff composition	Male	Female
Executive directors	5	4
Other employees	977	3172
Total	982	3176

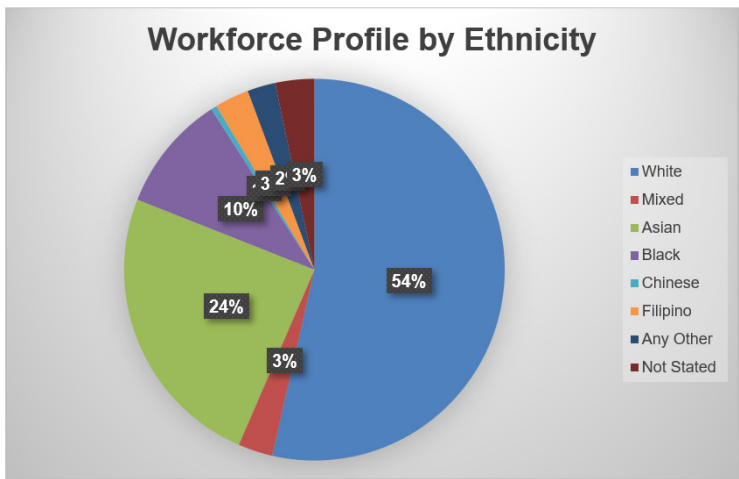
Turnover rate

Turnover rate	2022/23	2023/24
Voluntary turnover	16.30%	11.63%
Overall staff turnover	18.59%	13.60%

Our workforce - gender profile

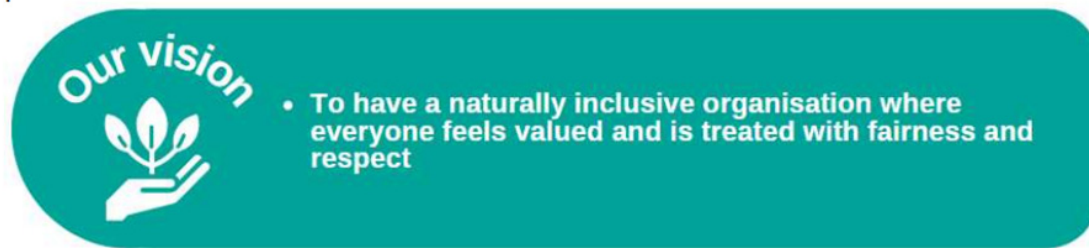


Our workforce - ethnic profile



Equality, diversity and inclusion

Our vision is to have a naturally inclusive organisation where everyone feels valued and is treated with respect.



To achieve this, our EDI strategy was approved in 2023 and contains our aims to:

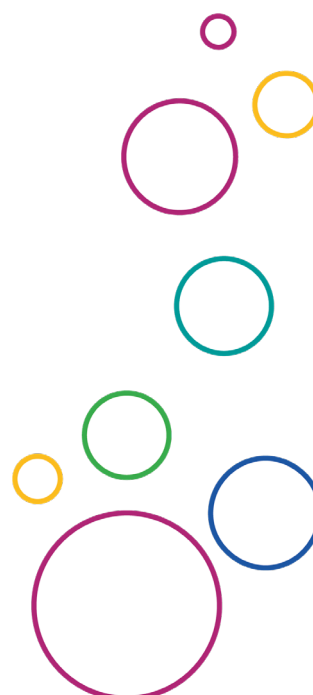
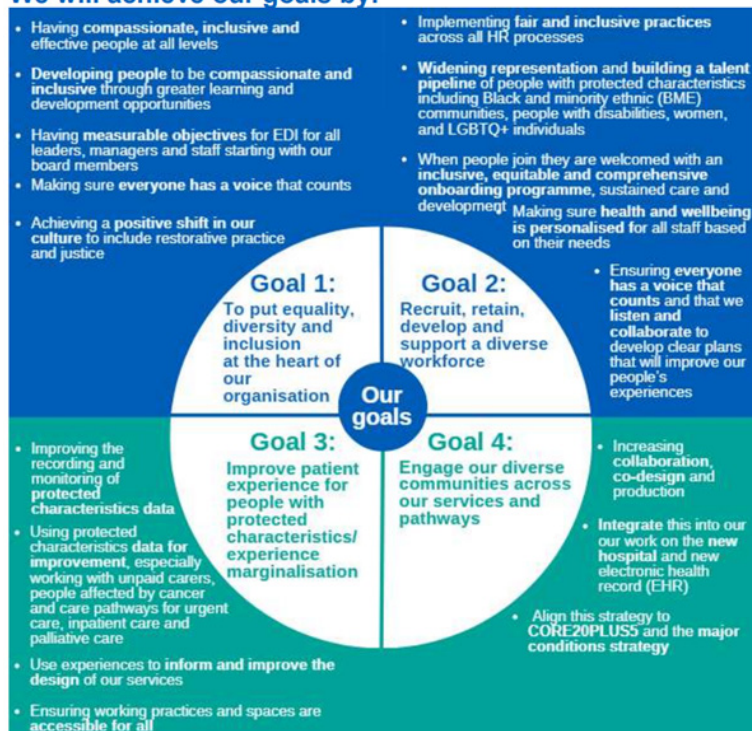
- Ensure the voice of our people, patients and communities we serve are heard
- Promote equality of opportunity, dignity and respect for all our patients, service users, families, carers and our people.
- Value and harness people's differences



Which will achieve our goals to:

- Put equality, diversity and inclusion at the heart of our organisation
- Recruit, retain, develop and support a diverse workforce
- Improve patient experience for people with protected characteristics and those who experience marginalisation
- Engage our diverse communities across our services and pathways

We will achieve our goals by:



To embed and transform our EDI strategy:

- An EDI delivery group was established with clinical triumvirates to ensure divisional plans incorporate EDI and, more specifically, have actions aligned to the goals and objectives outlined in the EDI strategy
- The EDI steering group meets bi-monthly to help shape the organisation's strategies and policies to improve the experience of staff and patients with protected characteristics. The group consists of a diverse range of representation from teams and departments across the Trust and regularly reports progress to the People Committee, as a sub-committee of the board, to ensure visibility and scrutiny of all interventions
- Three staff networks, the Disability and Wellbeing Network (DAWN), the Race Equality and Cultural Heritage (REACH) staff network and the LGBTQ+ staff network, were formed in response to feedback from staff and a review of Staff Survey findings. These groups continue to meet to ensure the needs of all staff and patients with protected characteristics are considered and such needs are fed into the divisional plans

Programmes and initiatives which promote inclusion for our people

Disability Confidence scheme

We are ensuring we achieve the actions we put in the Disability Confidence scheme self-assessment/accreditation for level 2.

Rainbow Badge scheme

We continued to promote the pledges and promote with information leaflets. We held interactive events on inclusion and intersectionality at This is Us Week in June 2023.

Unison Anti-Racism pledge

We are committed to ensuring we meet the requirements set out in the pledge.

Disability Champions

People were identified and trained to be disability champions.

Inclusion Champions

Our recruitment team reviewed our training and supported training for Inclusion Champions who sit on all interview panels for appointments to Band 8a roles and above.

Training

EDI sessions were built into the corporate induction programme.

Managing inclusively became part of our Ready to Manage development programme and we also provided 60-minute virtual bite size sessions around disability.

Project Search

This project provides employment opportunities for young adults with a learning disability and/or autism spectrum conditions. 11 interns commenced in October 2023.

Cultural festivals

The Race, Equality and Cultural Heritage (REACH) staff network ran a cultural festival for our people in September 2023, a colourful Diwali celebratory event was held in November and, in February we celebrated LGBT+ history month.

Pictured: The cultural festival at Our Lady of Fatima Church Hall in Harlow on Saturday, 16 September 2023.



Glossary of terms

Acute kidney injury (AKI) - AKI is defined as an abrupt (within hours) decrease in kidney function, which encompasses both injury (structural damage) and impairment (loss of function).

Allied health professionals - Healthcare professionals working in dietetics, occupational therapy, physiotherapy, operating department assistants, radiography and speech and language therapy.

Ambulatory care - Medical care provided on an outpatient basis, includes diagnosis, observation, consultation, and treatment.

Antenatal – This is the care you receive from health professionals during your pregnancy.

Antimicrobial resistance - The ability of a bacteria to resist the effects of medication (antibiotics) that once could successfully treat the infection.

Antimicrobial stewardship - A coordinated intervention designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

Audiology - The study of hearing and balance.

Bacteraemia – An infection of bacteria in the blood.

Board Assurance Framework (BAF) - The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the board's strategic objectives.

Cardiac arrest – Sudden loss of blood flow from failure of the heart to pump

effectively.

Cardiology - The branch of medicine that deals with diseases and abnormalities of the heart.

Care Quality Commission (CQC) - CQC is an executive non-departmental public body of the Department of Health United Kingdom. Established in 2009, it is the independent regulator of all health and social care services in England.

Chemical pathology – A branch of pathology dealing with biochemical basis for disease.

Chemotherapy - The treatment of disease by the use of chemical substances, especially the treatment of cancer by cytotoxic and other drugs.

Chronic obstructive pulmonary disease (COPD) - The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

Clinical audits - A process aimed to improve quality of patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Clinical coding - The process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the activity that happens to patients.

Clostridium difficile (C.difficile) - Clostridium difficile, also known as C. difficile, or C. diff, is a type of bacterial infection that can affect the digestive system.

Community-onset healthcare associated infection (COHA) – is when an infection is detected when a patient is at home but they have

only arrived home within two days of admission to hospital, and the patient was an inpatient in the Trust in the previous four weeks.

Colorectal care - Treatments for patients with symptoms of the gastrointestinal tract including colorectal cancer and inflammatory bowel disease.

Colposcopy and hysteroscopy services - A procedure used to examine the cervix and inside of the womb (uterus).

Community Diagnostic Centre (CDC) - Community Diagnostic Centres (CDCs) provide a broad range of elective diagnostics (including checks, scans and tests) away from acute facilities, so reducing pressure on hospitals, providing quicker access to tests and greater convenience to patients.

CQUIN - Commissioning for Quality and Innovation is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Datix - Software used in healthcare to collect patient safety incidents and for reporting adverse events.

Delirium - Is a state of mental confusion that can happen if you become unwell. It is also known as an acute confusion.

Dementia champions - A group of staff who have had specific training in dementia care. Their aim is to make other colleagues more understanding of why a patient may be more challenging and encourages them to tailor therapies accordingly.

Dermatology - The branch of medicine concerned with the diagnosis and treatment of skin disorders.

Diagnostics - Tools used to help identify disease and illness.

Dietetics – A branch of healthcare concerned with the diet and its effects on health, especially with the practical application of a scientific understanding of nutrition.

Endocrinology - The branch of physiology and medicine concerned with endocrine glands and hormones.

Endoscopy - A procedure that allows a view of the inside of a person's body.

ENT clinics – An area where diagnosis and treatment are provided to conditions of the ear, nose and throat.

Eneterovirus – a common cause of infection in people of all ages.

Escherichia coli (E.coli) bacteraemia - A type of bacterial infection and a blood stream infection.

Frailty service – Reviews frail older people using a holistic assessment of physical, mental and social needs.

Friends and Family Test (FFT) - Test aimed at providing a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience. It asks: "How likely are you to recommend our services to friends and family if they needed similar care or treatment?" with answers on a scale of extremely likely to extremely unlikely.

Gastroenterology - The branch of medicine which deals with disorders of the stomach and intestines.

Genito-urinary - The branch of medicine relating to the genital and urinary organs.

Governance - Establishment of policies, and continuous monitoring of their proper implementation, by the members of the governing body of an organisation.

Gram negative blood stream

infections (GNBSIs) - Type of bacterial infection and a blood stream infection.

Gynaecology - The branch of physiology and medicine that deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.

Haematology - The branch of medicine involving the study and treatment of the blood.

Healthcare associated infections

(HCAI) - Infections that are acquired as a result of healthcare. The burden of healthcare-associated infections has mainly been in hospitals where more serious infections are seen.

Health Overview and Scrutiny

Committee – Local authority committees that scrutinise health issues and care in their area.

Healthwatch – Obtain the views of people about their health needs and experiences of having care and social services.

Hepato-pancreato-biliary (HPB)

- involved in the management of gallstone disease along with benign and malignant diseases of the liver, pancreas and gall bladder.

Hospital onset healthcare associated infection (HOHA)

– this is an infection that is detected three or more days after admission to hospital therefore considered to be hospital acquired.

Hospital Standardised Mortality Ratio (HSMR)

- Calculation used to monitor death rates in a Trust.

Integrated Care System (ICS)

– are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete.

Inflammatory bowel disease – The name for a group of conditions that cause the digestive system to become inflamed.

Intravenous – Giving fluids or drugs directly into a vein.

Klebsiella bacteremia - Type of bacterial infection and a blood stream infection.

Laparotomy - A surgical incision into the abdominal cavity, used for diagnosis or in preparation for major surgery.

Maternal and Fetal Assessment Unit

- Outpatient Antenatal Unit offering planned appointments for assessment of the mother and unborn baby in pregnancy.

Maxillofacial department – An area where diagnosis and treatment are provided to conditions of the mouth, face and adjacent structures.

Medical examiner – senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

Medicines optimisation - the process of ensuring patients are prescribed the most effective and fewest medications.

Methicillin-Resistant Staphylococcus Aureus (MRSA) / Methicillin-Sensitive Staphylococcus Aureus (MSSA) – A specific bacterial infection.

Morbidity and mortality (M&M)

- Meetings established to review deaths as part of professional learning.

Myocardial ischaemia - When blood flow to your heart is reduced, preventing the heart muscle from receiving enough oxygen.

National Confidential Enquiries

(NCEPOD) - National Confidential Enquiry into Patient Outcome and Death.

New Hospital Programme (NHP)

– programme of work initiated in 2020, when the government committed to build 40 new hospitals by 2030.

National Reporting and Learning

System (NRLS) - A central database of patient safety incident reports.

Neonatal (NICU) - New-born children and new-born intensive care unit.

Nervecentre – electronic data base where observations are recorded.

Neurology - The branch of medicine or biology that deals with the anatomy, functions, and organic disorders of nerves and the nervous system.

NHS Digital – the national information and technology partners to the health and social care system.

NHS Hertfordshire and West Essex Integrated Care Board (ICB) - is the local NHS organisation that plans and oversees how NHS money is spent and makes sure health services work well and are of high quality.

NHSE - NHS England is responsible for overseeing Trusts and NHS services, as well as independent providers that provide NHS-funded care.

NICE - The National Institute for Health and Care Excellence provides guidance, which supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.

Norovirus - A type of viral infection that can affect the digestive system.

Nosocomial – a disease originating in

a hospital.

Obstetrics - The branch of medicine that deals with the care of women during pregnancy, childbirth, and the recuperative period following delivery.

Oesophago-gastric care – Treating patients with problems of the gullet (oesophagus) and stomach.

Oncology - The study and treatment of cancer and tumours.

Ophthalmology - The study of the structure, functions, and diseases of the eye.

Orthopaedic - The branch of medicine that deals with the prevention and correction of injuries or disorders of the skeletal system and associated muscles, joints, and ligaments.

Paediatrics - The specialty of medical science concerned with the physical, mental and social health of children from birth to young adulthood.

Palliative care - An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Parechovirus – a common cause of mild infection in people.

Pathogen – microorganisms that cause disease.

Pathology - The scientific study of the nature of disease and its causes, processes, development and consequences.

Patient Advice and Liaison Service (PALS) - Offering confidential advice, support and information on health-

related matters. Provides a point of contact for patients, their families and their carers.

Patient Panel - A group of volunteers who represent patients, families and carers of The Princess Alexandra Hospital NHS Trust.

Patient Safety Incident Response Framework (PSIRF) - The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient, Quality and Performance (PQP) – the Trust's cost and efficiency programme.

Perioperative medicine - care of patients from the time of contemplation of surgery through the operative period to full recovery.

Personal protective equipment (PPE) - will protect the user against health or safety risks at work, examples are FFP 2/3 face masks medical grade.

Polymerase chain reaction (PCR) testing - a method widely used to look for genetic code of the COVID-19 virus, this involves taking a swab of the throat and nose. The test will confirm if a person with symptoms has the virus currently .

Pressure ulcer – injury to the skin and underlying tissue primarily caused by prolonged pressure on the skin.

Pseudomonas – a specific bacterial infection.

Rapid Assessment and Treatment (RAT) - A treatment model used in emergency care to provide an early senior assessment and early treatment.

Radiology - The branch of medicine that deals with the use of radioactive substances used in diagnosis and treatment of disease.

Referral to Treatment (RTT) – A constitutional standard that trusts are measured against in which a person's waiting time starts on the day the hospital receives the referral letter from a GP to the time of first appointment or treatment.

Respiratory medicine – The branch of medicine that deals with the act of breathing.

Respiratory Syncytial Virus (RSV) – Respiratory syncytial virus is a contagious infection causing infection of the respiratory tract.

Rheumatology - The study and treatment of arthritis, autoimmune diseases, pain disorders affecting joints, and osteoporosis.

Rhinovirus – a common cause of infection in people of all ages.

SAFER care bundle – practical tool that uses five elements of best practice.

Sepsis and septicaemia - Sepsis is a serious blood stream infection. A serious complication is septicaemia, which is when inflammation occurs throughout the body, which can be life-threatening.

Serious Incidents (SIs) - An unexpected or unplanned event that caused harm or had the potential to cause harm to a patient, member of staff, student, visitor or contractor.

SMART – mnemonic for objectives that are Specific, Measurable, Achievable, Realistic and Timely.

Stakeholders - A stakeholder is anyone with an interest in a business. Stakeholders are individuals, groups or

organisations that are affected by the activity of the business.

Standard Operating Procedures

– A set of step-by-step instructions compiled to help workers carry out complex routine work, aimed to achieve efficiency and uniformity of performance.

Standardised Mortality ratio (SMR) and Summary Hospital-level Mortality Indicator (SHMI)

- Ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die, based on average England figures given the characteristics of the patients treated there.

Streptococcus – a type of bacteria causing infection.

Structured judgement review

– allows trained reviewers to identify and describe the quality of care received and in so doing can create a score of that quality.

TIMS (This is Me System) – a learning and performance platform/system

Trauma Audit and Research Network (TARN)

– An audit where information is collected and analysed for patients who are moderately or severely injured after an injury. Data is submitted by trusts and a comparison can be undertaken.

UK Health Security Agency (UKHSA)

– responsible for protecting every member of every community from the impact of infectious disease.

Urology - The study of urinary organs in females and the urinary and sex organs in males.

Urgent Treatment Centre (UTC)

– UTCs provide urgent medical help when it is not a life-threatening emergency.

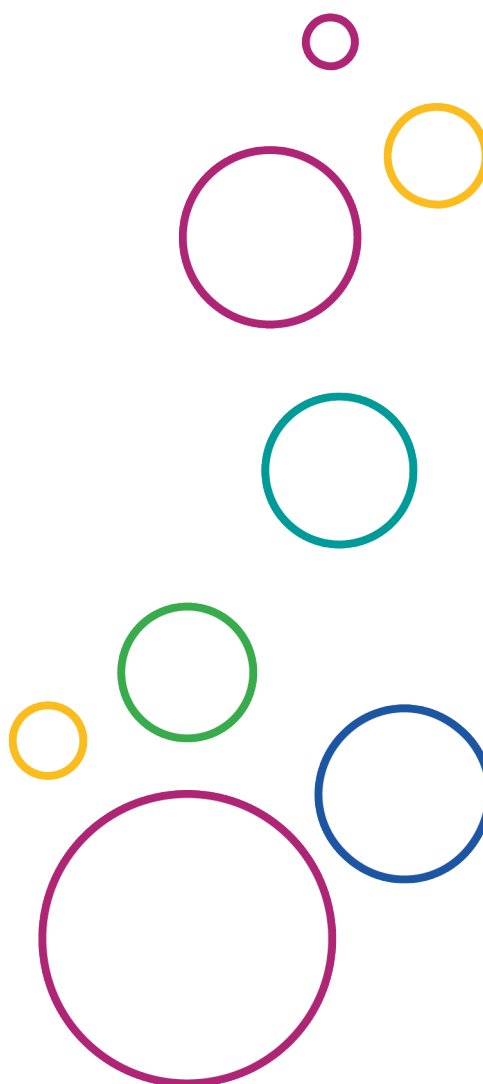
Vascular surgery – Specialists that treat people with diseases of the circulation, which can be conditions affecting arteries, veins and where there are blockages to the flow of blood.

Venous thromboembolism (VTE)

- A condition where a blood clot forms in a vein, most commonly in a leg where it is known as deep-vein thrombosis (DVT), a blood clot in the lungs is called a pulmonary embolism (PE).

VTE prophylaxis/

thromboprophylaxis - The giving of a medicine or treatment to prevent a VTE



**The Princess Alexandra Hospital NHS Trust,
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01279 44 44 55**



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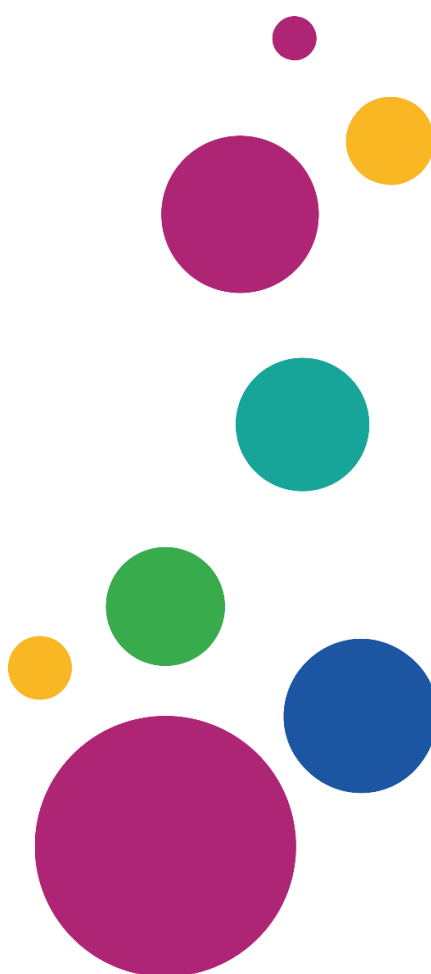
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The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital NHS Trust

**Annual accounts for the
year ended 31 March 2024**



Statement of Directors' responsibilities in respect of the Accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting policy laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the Accounts; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

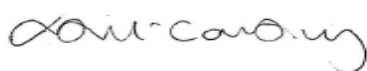
The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

**Chief
executive**



Date: 11 July
2024

**Director of
finance**



Date: 11 July
2024

Statement of Comprehensive Income

		2023/24	2022/23
	Note	£000	£000
Operating income from patient care activities	2	342,014	339,047
Other operating income	3	41,748	22,534
Operating expenses	5, 6	<u>(390,263)</u>	<u>(372,660)</u>
Operating surplus/(deficit) from continuing operations		<u>(6,501)</u>	<u>(11,079)</u>
Finance income	8	1,378	775
Finance expenses	9	(309)	(250)
PDC dividends payable		<u>(4,357)</u>	<u>(4,014)</u>
Net finance costs		<u>(3,288)</u>	<u>(3,489)</u>
Other gains / (losses)	10	<u>(3,688)</u>	<u>-</u>
Surplus / (deficit) for the year from continuing operations		<u>(13,477)</u>	<u>(14,568)</u>
Deficit for the year		<u><u>(13,477)</u></u>	<u><u>(14,568)</u></u>

On a day to day basis the Trust is measured against a control total defined by NHS England, which excludes costs outside of the control of the Trust. The deficit against the breakeven duty financial performance surplus / (deficit) was £6,125k in 2023-24. A reconciliation from the accounting deficit to this figure is provided in note 29.

Statement of Financial Position

		31 March 2024	31 March 2023
	Note	£000	£000
Non-current assets			
Intangible assets	10	20,135	16,046
Property, plant and equipment	11	179,127	164,432
Right of use assets	14	41,698	31,655
Receivables	16	1,074	1,196
Total non-current assets		242,034	213,329
Current assets			
Inventories	15	5,035	5,141
Receivables	16	14,953	14,408
Cash and cash equivalents	17	28,242	39,196
Total current assets		48,230	58,745
Current liabilities			
Trade and other payables	18	(51,215)	(51,994)
Borrowings	20	(2,402)	(1,863)
Provisions	21	(918)	(798)
Other liabilities	19	(246)	(811)
Total current liabilities		(54,781)	(55,466)
Total assets less current liabilities		235,483	216,608
Non-current liabilities			
Borrowings	20	(39,218)	(26,080)
Provisions	21	(932)	(1,342)
Total non-current liabilities		(40,150)	(27,422)
Total assets employed		195,333	189,186
Financed by			
Public dividend capital		356,329	340,936
Revaluation reserve		11,394	6,985
Income and expenditure reserve		(172,390)	(158,735)
Total taxpayers' equity		195,333	189,186

The notes on pages 7 to 56 form part of these accounts.

The financial statements on pages 2 to 6 were approved by the Board on 11 July 2024 and signed on its behalf by:



Name: Lance Daniel McCarthy

Position: Chief executive

Date: 11 July 2024

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	340,936	6,985	(158,735)	189,186
Surplus/(deficit) for the year	-	-	(13,477)	(13,477)
Impairments	-	(139)	-	(139)
Revaluations	-	4,548	-	4,548
Public dividend capital received	15,393	-	-	15,393
Other reserve movements	-	-	(178)	(178)
Taxpayers' and others' equity at 31 March 2024	356,329	11,394	(172,390)	195,333

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	326,639	1,201	(147,809)	180,031
Implementation of IFRS 16 on 1 April 2022	-	-	3,688	3,688
Surplus/(deficit) for the year	-	-	(14,568)	(14,568)
Impairments	-	(892)	-	(892)
Revaluations	-	6,676	-	6,676
Public dividend capital received	14,297	-	-	14,297
Other reserve movements	-	-	(46)	(46)
Taxpayers' and others' equity at 31 March 2023	340,936	6,985	(158,735)	189,186

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

		2023/24	2022/23
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		(6,501)	(11,079)
Non-cash income and expense:			
Depreciation and amortisation	5	14,661	14,529
Net impairments	5.3	2,931	1,320
(Increase) / decrease in receivables and other assets		(1,179)	(2,381)
(Increase) / decrease in inventories		106	39
Increase / (decrease) in payables and other liabilities		(3,406)	5,793
Increase / (decrease) in provisions		(300)	(944)
Net cash flows from / (used in) operating activities		6,312	7,277
Cash flows from investing activities			
Interest received		1,378	775
Purchase of intangible assets		(10,262)	(6,650)
Purchase of PPE and investment property		(17,639)	(20,292)
Net cash flows from / (used in) investing activities		(26,523)	(26,167)
Cash flows from financing activities			
Public dividend capital received		15,393	14,297
Finance lease payments		(2,236)	(2,248)
Interest paid on finance lease liabilities		(296)	(228)
PDC dividend (paid) / refunded		(3,601)	(4,770)
Cash flows from (used in) other financing activities		(3)	(15)
Net cash flows from / (used in) financing activities		9,257	7,036
Increase / (decrease) in cash and cash equivalents		(10,954)	(11,854)
Cash and cash equivalents at 1 April - brought forward		39,196	51,050
Cash and cash equivalents at 1 April - restated		39,196	51,050
Cash and cash equivalents at 31 March	17	28,242	39,196

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements'. IAS1 requires management to assess, as part of the Accounts preparation process, the Trust's ability to continue as a going concern. The HM Treasury Financial Reporting Manual directs that in the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without transfer to another entity

In approving the Trust's Annual Accounts, the Board of Directors has satisfied itself that the Trust has prepared the accounts on the basis of going concern, recognising the following:

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS has published its Medium-Term Financial Plan for the period 2024/25 - 2027/28 and this plan includes the continued provision of services by the Trust. In addition, the Trust continues to develop an Outline Business Case to build a new hospital, which is being supported by a variety of stakeholders. No circumstances were identified causing the Directors to doubt the continued provision of NHS services. For the 2023/24 financial year, the Trust achieved an adjusted control performance of £6.1m against a reforecast plan of £6.1m deficit. Income from our local Integrated Care Systems was a return of a mixture of the adapted finance regime introduced in response to the COVID-19 pandemic and activity-based contracting. This provided predictability and improved cash flow with the Trust finishing the year with a £28.2m cash balance.

For 2024/25, we continue with the funding arrangements as a mixture of fixed payment and activity-based contracting, with COVID funding as a percentage (0.1%) of the contract embedded. The Trust has agreed contracts with key ICBS's for continuing delivery of NHS acute services in West Essex for 2024/25 and beyond.

In addition, the Trust has access to working capital arrangements should the need for this arise. In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Note 1.3 Critical judgments in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates, and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors considered relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which both the estimate is revised if the revisions affect only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- The Trust has considered whether there is a need for an impairment in PPE, for the current value of capitalised assets relating to the New Hospital Programme, and assessed that no impairment is required. The Trust is assured that the new Hospital Programme is continuing, despite delays in the National New Hospital Programme. The Trust has received a commitment from the New Hospital Programme, and continued funding for £1.7m in 2024/25 for Land Purchase.

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore, the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The MEA valuation approach continues to be adopted by the Trust (Note 1.7.2). The Valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. The valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation.

The Trust Management have made a judgement for the Heart and West Essex PFI Lease that the lease term is 42 years based off recent information from conversations with the lessor NHS Property Services Ltd, whilst the formal legal agreement is being drawn up

Note 1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. IAS 1 states that specific disclosure requirements as set out in individual standards or interpretations need not be satisfied if the information is not material, and on that basis the Trust has not consolidated its Charitable Funds.

Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System

on 1 April 2023. The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 The majority of the Trust income is in the form of fixed payment and variable element. The Trust earned income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, and chemotherapy delivery activity. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the fixed payments to reimburse specific costs incurred and, in 2023/24, the other income top-ups supported the delivery of services. Reimbursement and top-up income is accounted for as a variable consideration.

In 2023/24, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Where the effects of practical expedients mandated by the GAM are material, these should be disclosed as accounting policies. These include: (1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5.1 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The

carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.8.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

The valuation exercise was carried out on 2 March 2024 with the valuation date being 31 March 2024. Valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted, and applied by the HMT Treasury FReM compliant with Department of Health Group Manual for Accounts. They are also prepared in accordance with the professional standards of the Royal Institution of

Chartered Surveyors: RICS Valuation - Global Standards 2017 and RICS UK National Supplement, commonly known together as the 'Red Book'.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.8.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs

Note 1.8.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2023/24, this includes assets donated to the Trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Note 1.8.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	Max life
	Years	Years
Buildings, excluding dwellings	15	30
Plant & machinery	5	15
Transport equipment	3	7
Information technology	5	8
Furniture & fittings	5	15

Note 1.9 Intangible assets

Note 1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.9.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9.3 Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	8
Development expenditure	5	8

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Note 1.12.2 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.12.3 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss.

Financial liabilities are classified into the following categories: financial liabilities at amortised cost, financial liabilities at fair value through other comprehensive income, and financial liabilities at fair value through profit and loss.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

All outstanding non-NHS receivables over one year old are included in the credit loss allowance. Any receivable relating to prescription charges that are over six months old plus any receivable where the Trust considers there to be a high risk of being uncollectable are included. The amount included for Injury Cost Recovery receivables follows the DHSC GAM guidance (an allowance of 23.07% of outstanding receivables is included - was previously 23.86% in 2022/23).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.12.4 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.13.1 The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The Trust in this financial year been able to regularised most of our right of use leased buildings with other DHSC groups for a term 25 years where there was no initial lease documentation

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate

Where existing leases are modified the Trust determines whether the arrangement constitutes a separate lease and apply the standard accordingly

Note 1.13.2 The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust was an intermediate lessor, classification of all continuing sublease arrangements was been reassessed with reference to the right of use asset.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation resulting from a past event, of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury. The discount rate used by the Trust for Early Retirements is 2.45% in real terms (2022/23 rate was minus 1.70%):

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 21.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 22 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 22, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sales or lease of assets at below market value.

Note 1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accrual basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Early adoption of standards, amendments and interpretations

IFRS 18 was issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on our accounts in the future.

Note 1.23 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date where the liability meets the recognition criteria of IAS 37. These are based on judgements and estimates of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

Public liability claims are based on information received from the NHS Resolution (NHSR, previously NHS Litigation Authority) which handles claims on behalf of the Trust. For cases not yet concluded, provision, or contingent liability, is made according to NHSR assessment of expected outcomes.

Pensions provisions are based on information received from NHS Pension Agency (part of NHS Business Services Authority).

Other provisions for legal and constructive obligations (including employment) are made by management, and informed by professional opinion. Provisions are made where past events are known and settlement by the Trust is probable and a reliable estimate can be made. As actual settlement is not known at the reporting date provisions are calculated on the best information available on likely settlement at the date the Accounts are approved.

At the end of each accounting period management review expenditure items that are outstanding and estimate the amount to be accrued in financial statements. Accruals are generally based on estimates and judgements of historical trends and outcomes. Any variation in prior periods has not been material to the Accounts.

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 2.1 Income from patient care activities (by nature)

	2023/24	2022/23
	£000	£000
Income from commissioners under API contracts - variable element*	59,253	
Income from commissioners under API contracts - fixed element*	247,907	287,615
High cost drugs income from commissioners	18,858	18,208
Other NHS clinical income	5,784	10,888
All services		
Private patient income	462	286
Elective recovery fund	-	6,744
National pay award central funding***	157	6,629
Additional pension contribution central funding**	8,887	7,910
Other clinical income	706	767
Total income from activities	342,014	339,047

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

Note 2.2 Income from patient care activities (by source)

	2023/24	2022/23
	£000	£000
Income from patient care activities received from:		
NHS England	36,776	41,091
Clinical commissioning groups		70,803
Integrated care boards	304,062	226,052
Department of Health and Social Care	8	21
Other NHS providers	-	29
Non-NHS: private patients	462	286
Non-NHS: overseas patients (chargeable to patient)	167	151
Injury cost recovery scheme	539	614
Total income from activities	342,014	339,047
Of which:		
Related to continuing operations	342,014	339,047

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2023/24	2022/23
	£000	£000
Income recognised this year	167	151
Cash payments received in-year	36	75
Amounts added to provision for impairment of receivables	105	200
Amounts written off in-year	37	138

Note 3 Other operating income

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	656	-	656	664	-	664
Education and training	11,095	955	12,050	10,065	834	10,899
Non-patient care services to other bodies	27,341		27,341	8,189		8,189
Reimbursement and top up funding				612		612
Charitable and other contributions to expenditure		57	57		614	614
Revenue from operating leases		101	101		104	104
Other income	1,543	-	1,543	1,452	-	1,452
Total other operating income	40,635	1,113	41,748	20,982	1,552	22,534

Of which:

Related to continuing operations	41,748	22,534
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Note 4 Operating leases - The Princess Alexandra Hospital NHS Trust as lessor

Note 4 Operating lease income

	2023/24 £000	2022/23 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	101	104
Total in-year operating lease income	101	104

Note 4.1 Future lease receipts

	31 March 2024 £000	31 March 2023 £000
Future minimum lease receipts due in:		
- not later than one year	101	89
Total	101	89

Note 5 Operating expenses

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,798	4,449
Purchase of healthcare from non-NHS and non-DHSC bodies	6,355	11,061
Staff and executive directors' costs	262,831	245,767
Remuneration of non-executive directors	172	181
Supplies and services - clinical (excluding drugs costs)	22,993	23,784
Supplies and services - general	6,396	5,181
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	26,256	24,631
Inventories written down	-	207
Consultancy costs	3,002	3,569
Establishment	2,632	1,641
Premises	15,729	15,265
Transport (including patient travel)	514	398
Depreciation on property, plant and equipment	11,660	11,493
Amortisation on intangible assets	3,001	3,036
Net impairments	2,931	1,320
Movement in credit loss allowance: contract receivables / contract assets	(144)	1,557
Fees payable to the external auditor		
audit services- statutory audit	153	111
Internal audit costs	128	204
Clinical negligence	13,591	13,242
Legal fees	568	455
Insurance	122	99
Education and training	2,604	2,647
Variable lease payments not included in the liability	-	210
Redundancy	300	21
Car parking & security	1,181	1,514
Hospitality	41	19
Losses, ex gratia & special payments	118	91
Other services, eg external payroll	440	185
Other	(109)	322
Total	390,263	372,660

Of which:

Related to continuing operations	390,263	372,660
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The audit fee for KPMG shown above of £153k is inclusive of VAT which is not recoverable and includes variation fees for 2022-23. Excluding VAT the audit fee is £128k (2022-23: £93K)

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2022/23: £1 million).

Note 5.3 Impairment of assets

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,931	1,320
Total net impairments charged to operating surplus / deficit	2,931	1,320
Impairments charged to the revaluation reserve	139	892
Total net impairments	3,070	2,212

Note 6 Employee benefits

	2023/24	2022/23
	Total	Total
	£000	£000
Salaries and wages	169,809	156,229
Social security costs	18,693	16,514
Apprenticeship levy	882	763
Employer's contributions to NHS pensions	28,931	25,849
Pension cost - other	28	27
Temporary staff (including agency)	48,356	47,495
Total gross staff costs	266,699	246,877
Of which		
Costs capitalised as part of assets	3,568	1,089

Note 6.1 Retirements due to ill-health

During 2023/24 there were 4 early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £172k (0k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the the employer contribution rate will increase to 23.7% from 1 April 2024 (previously 20.6%).

The 2016 funding valuation also tested the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed defined contribution scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2023/24 was 3% (2022/23 3%).

Note 8 Finance income

Finance income represents interest received on assets and investments in the period.

	2023/24	2022/23
	£000	£000
Interest on bank accounts	1,378	775
Total finance income	1,378	775

Note 9.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	296	228
Total interest expense	296	228
Unwinding of discount on provisions	10	(22)
Other finance costs	3	44
Total finance costs	309	250

	2023/24	2022/23
	£000	£000

Note 10 Other gains / (losses)

	2023/24	2022/23
	£000	£000
Loss on Modification of lease liability	(3,688)	-
Total other gains / (losses)	(3,688)	-

The Trust took on a full lease at the year ended 31 March 2024 therefore modifying the previously held peppercorn lease that was held since the implementation of IFRS 16 Leases during the 2022/23 reporting year.

Note 10 Intangible assets - 2023/24

	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023 - brought forward	10,890	15,746	4,596	31,232
Additions	-	298	6,792	7,090
Valuation / gross cost at 31 March 2024	10,890	16,044	11,388	38,322
Amortisation at 1 April 2023 - brought forward	1,619	13,567	-	15,186
Provided during the year	1,535	1,466	-	3,001
Amortisation at 31 March 2024	3,154	15,033	-	18,187
Net book value at 31 March 2024	7,736	1,011	11,388	20,135
Net book value at 1 April 2023	9,271	2,179	4,596	16,046

Note 10.1 Intangible assets - 2022/23

	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2022 - as previously stated	7,415	15,746	-	23,161
Valuation / gross cost at 1 April 2022 - restated	7,415	15,746	-	23,161
Additions	3,475	-	4,596	8,071
Valuation / gross cost at 31 March 2023	10,890	15,746	4,596	31,232
Amortisation at 1 April 2022 - as previously stated	558	11,592	-	12,150
Provided during the year	1,061	1,975	-	3,036
Amortisation at 31 March 2023	1,619	13,567	-	15,186
Net book value at 31 March 2023	9,271	2,179	4,596	16,046
Net book value at 1 April 2022	6,857	4,154	-	11,011

Note 11 Property, plant and equipment - 2023/24

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2023 - brought forward	8,054	110,830	24,026	44,005	303	29,870	1,332	218,420
Additions	-	1,970	12,239	3,572	-	5,093	-	22,874
Impairments	(331)	(2,547)	-	-	-	-	-	(2,878)
Reversals of impairments	-	139	-	-	-	-	-	139
Revaluations	-	4,548	-	-	-	-	-	4,548
Reclassifications	-	7,931	(7,931)	-	-	-	-	-
Valuation/gross cost at 31 March 2024	7,723	122,871	28,334	47,577	303	34,963	1,332	243,103
Accumulated depreciation at 1 April 2023 - brought forward	-	4,054	-	28,054	188	20,512	1,180	53,988
Provided during the year	-	3,854	-	3,255	29	2,501	18	9,657
Impairments	-	192	-	-	-	-	-	192
Reversals of impairments	-	139	-	-	-	-	-	139
Accumulated depreciation at 31 March 2024	-	8,239	-	31,309	217	23,013	1,198	63,976
Net book value at 31 March 2024	7,723	114,632	28,334	16,268	86	11,950	134	179,127
Net book value at 1 April 2023	8,054	106,776	24,026	15,951	115	9,358	152	164,432

Note 11.1 Property, plant and equipment - 2022/23

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2022 - as previously stated	8,946	104,708	14,567	41,535	279	25,580	1,332	196,947
Prior period adjustments	-	-	-	-	-	-	-	-
Additions	-	2,402	11,147	2,470	24	4,290	-	20,333
Impairments	(892)	(1,320)	-	-	-	-	-	(2,212)
Revaluations	-	3,352	-	-	-	-	-	3,352
Reclassifications	-	1,688	(1,688)	-	-	-	-	-
Valuation/gross cost at 31 March 2023	8,054	110,830	24,026	44,005	303	29,870	1,332	218,420
Accumulated depreciation at 1 April 2022 - as previously stated	-	3,686	-	24,939	162	17,872	1,157	47,816
Provided during the year	-	3,692	-	3,115	26	2,640	23	9,496
Revaluations	-	(3,324)	-	-	-	-	-	(3,324)
Accumulated depreciation at 31 March 2023	-	4,054	-	28,054	188	20,512	1,180	53,988
Net book value at 31 March 2023	8,054	106,776	24,026	15,951	115	9,358	152	164,432
Net book value at 1 April 2022	8,946	101,022	14,567	16,596	117	7,708	175	149,131

Note 11.2 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,723	114,632	28,334	14,731	86	11,950	134	177,590
Owned - donated/granted	-	-	-	1,537	-	-	-	1,537
Total net book value at 31 March 2024	7,723	114,632	28,334	16,268	86	11,950	134	179,127

Note 11.3 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	8,054	106,776	24,026	14,094	115	9,358	152	162,575
Owned - donated/granted	-	-	-	1,857	-	-	-	1,857
Total net book value at 31 March 2023	8,054	106,776	24,026	15,951	115	9,358	152	164,432

Note 12 Donations of property, plant and equipment

The Trust did not receive any cash donation in the year 2023-24.

Note 13 Revaluations of property, plant and equipment

The Trust appointed Gerald Eves (GE), independent firm of professional valuers, to provide a report on the movement in building costs and land values during 2023/24 in order to update the fair value of land and buildings.

The valuations from GE have been carried out in accordance with the Valuation – Global Standards (January 2022 edition) published by the Royal Institution of Chartered Surveyors (RICS) as at 31 March 2024. We refer in this report to those Global Standards and the national standards and guidance set out in the UK national supplement (November 2018 edition) collectively as “the Standards”.

Basis of Valuations

In the preparation of the valuation under IFRS, Gerald Eves have had regard to the Standards and in particular, reference to the following:

In compliance with your requirements, the valuations have been prepared to comply with IFRS, specifically with regard to IAS 16 Property, Plant and Equipment, IAS 40 Investment Properties, Department of Health Group Manual for Accounts 2023/24 and to the Government Financial Reporting Manual (FReM) 2023-2024.

For valuations of property to be included in financial statements in accordance with IFRS, the International Valuation Standards prescribe a Fair Value basis, defined in IFRS 13 ‘Fair Value Measurement’ (at paragraph 9) as:

“.. the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants at the measurement date.”

A full commentary on the meaning of and implicit assumptions within this definition is included in the Standards and a copy of this can be provided on request.

Operational property – Table 6.2 of FReM ‘Interpretations and adaptations of IAS 16 for the public sector context’ states that:

“Assets which are held for their service potential (i.e. operational assets) and are in use should be measured at current value in existing use. For non-specialised assets current value in existing use should be interpreted as market value for existing use. In the RICS Red Book, this is defined as Existing Use Value (EUV).”

Existing use value is defined in the standards as:

The estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm's length transaction after proper marketing and where the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the asset required by the business, and disregarding potential alternative uses and any other characteristics of the asset that would cause its market value to differ from that needed to replace the remaining service potential at least cost."

Specialised properties

The standards define a specialised property as:

"A property that is rarely, if ever, sold in the market, except by way of a sale of the business or entity of which it is part, due to the uniqueness arising from its specialised nature and design, its configuration, size, location or otherwise."

The FReM confirms at 6.2 that:

"For specialised assets current value in existing use should be interpreted as the present value of the asset's remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential."

The lack of demand or market for the Trust's property in isolation from its own use means that the land and buildings identified at 5.1 qualify as a "specialised property" under the definitions in the current standards.

The standards require such properties to be valued on a Depreciated Replacement Cost (DRC) method. Information on this valuation method is provided in the Depreciated Replacement Cost Method of valuation for financial reporting guidance note (the "DRC Guidance Note"). This guidance note quotes the international valuation standards definition of DRC as:

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Non-specialised operational properties

For the Trust's non-specialised operational properties, we have reported Existing Use Values (EUV) in line with the adaptation of IAS 16 as defined in the FReM.

Note 14.1 Right of use assets - 2023/24

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	30,207	3,320	125	33,652	20,951
Additions	-	-	-	-	-
Remeasurements of the lease liability	11,980	-	66	12,046	11,507
Valuation/gross cost at 31 March 2024	42,187	3,320	191	45,698	32,458
Accumulated depreciation at 1 April 2023 - brought forward	1,343	654	-	1,997	493
Provided during the year	1,422	581	-	2,003	658
Accumulated depreciation at 31 March 2024	2,765	1,235	-	4,000	1,151
Net book value at 31 March 2024	39,422	2,085	191	41,698	31,307
Net book value at 1 April 2023	28,864	2,666	125	31,655	20,458
Net book value of right of use assets leased from other DHSC group bodies					31,307

Note 14.2 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
IFRS 16 implementation - adjustments for existing operating leases / subleases	30,207	3,320	-	33,527	20,951
Remeasurements of the lease liability	-	-	125	125	-
Valuation/gross cost at 31 March 2023	30,207	3,320	125	33,652	20,951
Provided during the year	1,343	654	-	1,997	493
Accumulated depreciation at 31 March 2023	1,343	654	-	1,997	493
Net book value at 31 March 2023	28,864	2,666	125	31,655	20,458
Net book value of right of use assets leased from other DHSC group bodies					20,458

Note 14.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 20.

	2023/24	2022/23
	£000	£000
Carrying value at 31 March	27,943	10
IFRS 16 implementation - adjustments for existing operating leases		30,066
Lease additions	-	-
Lease liability remeasurements	15,734	125
Interest charge arising in year	296	228
Other Lease liability movements	179	(10)
Lease payments (cash outflows)	(2,532)	(2,476)
Carrying value at 31 March	41,620	27,943

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 5. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets in £0k and is included within revenue from operating leases in note 3.

Note 14.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies: 31 March 2024	Total	Of which leased from DHSC group bodies: 31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,402	1,074	1,863	299
- later than one year and not later than five years;	10,868	5,858	12,468	4,829
- later than five years.	33,467	30,534	15,860	12,249
Total gross future lease payments	46,737	37,466	30,191	17,377
Finance charges allocated to future periods	(5,117)	(4,660)	(2,248)	(684)
Net lease liabilities at 31 March 2024	41,620	32,806	27,943	16,693
Of which:				
Leased from other DHSC group bodies		32,806		16,693

Note 15 Inventories

	31 March 2024	31 March 2023
	£000	£000
Drugs	1,265	1,171
Consumables	3,607	3,801
Energy	163	169
Total inventories	5,035	5,141
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £36,762k (2022/23: £40,718k). Write-down of inventories recognised as expenses for the year were £0k (2022/23: £207k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £57k of items purchased by DHSC (2022/23: £614k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 16 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables	12,075	11,838
Allowance for impaired contract receivables / assets	(2,251)	(2,395)
Prepayments (non-PFI)	2,794	2,911
PDC dividend receivable	-	756
VAT receivable	1,829	1,253
Other receivables	506	45
Total current receivables	14,953	14,408
Non-current		
Contract receivables	576	577
Other receivables	498	619
Total non-current receivables	1,074	1,196
Of which receivable from NHS and DHSC group bodies:		
Current	9,353	10,467
Non-current	498	619

Note 16.1 Allowances for credit losses

	2023/24	2022/23
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	2,395	1,344
New allowances arising	664	1,557
Reversals of allowances	(808)	-
Utilisation of allowances (write offs)	-	(506)
Allowances as at 31 Mar 2024	2,251	2,395

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2023/24	2022/23
	£000	£000
At 1 April	39,196	51,050
Net change in year	(10,954)	(11,854)
At 31 March	28,242	39,196
Broken down into:		
Cash at commercial banks and in hand	124	1,482
Cash with the Government Banking Service	28,118	37,714
Total cash and cash equivalents as in SoFP	28,242	39,196
Total cash and cash equivalents as in SoCF	28,242	39,196

Note 17.1 Third party assets held by the Trust

The Princess Alexandra Hospital NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2024	31 March 2023
	£000	£000
Bank balances	22	21
Total third-party assets	22	21

Note 18 Trade and other payables

	31 March 2024 £000	31 March 2023 £000
Current		
Trade payables	7,581	10,298
Capital payables	9,610	7,547
Accruals	21,829	19,773
Social security costs	2,604	2,248
Other taxes payable	2,436	2,277
Pension contributions payable	2,725	2,427
Other payables	4,430	7,424
Total current trade and other payables	51,215	51,994
Of which payables from NHS and DHSC group bodies:		
Current	2,632	3,450
Non-current	-	-

Note 19 Other liabilities

	31 March 2024	31 March 2023
	£000	£000
Current		
Deferred income: contract liabilities	246	811
Total other current liabilities	246	811

Note 20 Borrowings

	31 March 2024	31 March 2023
	£000	£000
Current		
Lease liabilities	2,402	1,863
Total current borrowings	2,402	1,863
Non-current		
Lease liabilities	39,218	26,080
Total non-current borrowings	39,218	26,080

Note 20 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2023	27,943	27,943
Cash movements:		
Financing cash flows - payments and receipts of principal	(2,236)	(2,236)
Financing cash flows - payments of interest	(296)	(296)
Non-cash movements:		
Lease liability remeasurements	15,734	15,734
Application of effective interest rate	296	296
Early terminations	179	179
Carrying value at 31 March 2024	41,620	41,620

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2022	10	10
Cash movements:		
Financing cash flows - payments and receipts of principal	(2,248)	(2,248)
Financing cash flows - payments of interest	(228)	(228)
Non-cash movements:		
Impact of implementing IFRS 16 on 1 April 2022	30,066	30,066
Lease liability remeasurements	125	125
Application of effective interest rate	228	228
Early terminations	(10)	(10)
Carrying value at 31 March 2023	27,943	27,943

Note 21 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2023	409	965	-	766	2,140
Change in the discount rate	-	-	-	(111)	(111)
Arising during the year	33	427	300	49	809
Utilised during the year	(68)	(28)	-	(9)	(105)
Reversed unused	-	(889)	-	(38)	(927)
Unwinding of discount	10	-	-	34	44
At 31 March 2024	384	475	300	691	1,850
Expected timing of cash flows:					
- not later than one year;	122	427	300	69	918
- later than one year and not later than five years;	-	48	-	187	235
- later than five years.	262	-	-	435	697
Total	384	475	300	691	1,850

Note 21.1 Clinical negligence liabilities

At 31 March 2024, £119,478k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Princess Alexandra Hospital NHS Trust (31 March 2023: £143,158k).

Note 22 Contingent assets and liabilities

	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities		
NHS Resolution legal claims	(14)	(20)
Employment tribunal and other employee related litigation	(188)	(576)
Gross value of contingent liabilities	(202)	(596)
Net value of contingent liabilities	(202)	(596)
Net value of contingent assets	-	-

Note 23 Contractual capital commitments

	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment	3,728	5,239
Intangible assets	3,489	3,201
Total	7,217	8,440

Note 23 Financial instruments

Note 23.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking activities. Because of the continuing service provider relationship that the Trust has with Commissioners and the way Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which financial reporting standards mainly apply.

The Trust's cash management operations are undertaken by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust can borrow from the government for capital expenditure, subject to approval from NHS England. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest charges at the national loans fund rate, fixed for the life of the loan. The Trust can also borrow from the government for revenue support funding, subject to approval from NHS England. Interest rates are confirmed by the lender (Department of Health and Social Care) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations

Credit risk

A majority of the Trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk

Liquidity risk

The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust mainly funds its capital from internally generated funds. The Trust is therefore not exposed to significant liquidity risks.

Note 23.2 Carrying values of financial assets

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2024		
Trade and other receivables excluding non-financial assets	11,402	11,402
Cash and cash equivalents	28,242	28,242
Total at 31 March 2024	39,644	39,644
	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2023		
Trade and other receivables excluding non-financial assets	10,683	10,683
Cash and cash equivalents	39,196	39,196
Total at 31 March 2023	49,879	49,879

Note 23.3 Carrying values of financial liabilities

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2024		
Obligations under leases	41,620	41,620
Trade and other payables excluding non-financial liabilities	40,507	40,507
Total at 31 March 2024	82,127	82,127
	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2023		
Obligations under leases	27,943	27,943
Trade and other payables excluding non-financial liabilities	47,468	47,468
Total at 31 March 2023	75,411	75,411

Note 23.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2024	31 March 2023
	£000	£000
In one year or less	44,421	49,331
In more than one year but not more than five years	10,868	12,468
In more than five years	<u>33,467</u>	<u>15,860</u>
Total	<u>88,756</u>	<u>77,659</u>

Note 24 Losses and special payments

	2023/24		2022/23	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	1,082	83	488	258
Stores losses and damage to property	12	33	2	268
Total losses	1,094	116	490	526
Special payments				
Compensation under court order or legally binding arbitration award	6	15	10	36
Ex-gratia payments	5	70	7	342
Total special payments	11	85	17	378
Total losses and special payments	1,105	201	507	904
Compensation payments received				

Details of cases individually over £300k

There was no case exceeding £300k during the 2023/24 financial year, (2022/23 £300K).

Note 25 Related parties

During the year none of the DHSC Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken transactions within The Princess Alexandra Hospital NHS Trust.

The DHSC is regarded as related party. During the year, The Princess Alexandra Hospital Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department.

Related parties may include but are not limited to:

The Department of Health and Social Care

NHS England

HM Revenue and Customs

Other NHS Providers

NHS North East London ICB

NHS Hertfordshire and West Essex ICB

Local Authorities

NHS Blood and Transplant services

NHS Mid and South Essex ICB

NHS North Central London ICB

Essex Partnership University NHS FT

NHS Resolution

NHS Business Service Authority

NHS Humber and North Yorkshire ICB

NHS Professionals

NHS Pensions Agency

Health Education England

NHS Property Services

The Princess Alexandra Hospital Charity (registered charity 10547745). The Trust receives revenue and capital payments from this charity and certain trustees are also members of the Trust board. The charity's objective is to provide support both generally and in certain areas of the Trust's activities. During the year the charity contributed £393k (unaudited) to the Trust (2022/23 £502k, unaudited).

Note 26 Better Payment Practice code

	2023/24	2023/24	2022/23	2022/23
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	60,823	194,383	51,088	123,961
Total non-NHS trade invoices paid within target	57,051	180,326	47,645	110,338
Percentage of non-NHS trade invoices paid within target	93.8%	92.8%	93.3%	89.0%
NHS Payables				
Total NHS trade invoices paid in the year	1,901	48,358	1,874	68,213
Total NHS trade invoices paid within target	1,830	47,644	1,795	66,994
Percentage of NHS trade invoices paid within target	96.3%	98.5%	95.8%	98.2%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 27 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2023/24	2022/23
	£000	£000
Cash flow financing		
External Financing Limit (EFL)	24,717	23,903
Cash flow financing (from SOCF)	(24,111)	(23,903)
External financing requirement	606	-

Note 28 Capital Resource Limit

	2023/24	2022/23
	£000	£000
Gross capital expenditure	45,698	28,529
Charge against Capital Resource Limit	45,698	28,529
Capital Resource Limit	46,304	28,529
Under / (over) spend against CRL	606	-

Note 29 Breakeven duty financial performance

	2023/24	2022/23
	£000	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(13,477)	(14,568)
Remove impairments scoring to Departmental Expenditure Limit	2,931	1,320
Remove capital donations / grants / peppercorn lease i&E impact	316	283
Remove net impact of DHSC centrally procured inventories	417	(84)
Remove Loss on modification of lease liability	3,688	-
Breakeven duty financial performance surplus / (deficit)	(6,125)	(13,049)

Note 30 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		511	415	461	122	(16,403)	(21,998)	(37,714)
Breakeven duty cumulative position	1,536	2,047	2,462	2,923	3,045	(13,358)	(35,356)	(73,070)
Operating income		172,171	179,388	180,790	184,568	177,739	190,478	196,124
Cumulative breakeven position as a percentage of operating income		1.2%	1.4%	1.6%	1.6%	(7.5%)	(18.6%)	(37.3%)
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(26,715)	(28,435)	(16,542)	418	1,816	1,110	(13,049)	(6,125)
Breakeven duty cumulative position	(99,785)	(128,220)	(144,762)	(144,344)	(142,528)	(141,418)	(154,467)	(160,592)
Operating income	209,742	213,231	236,700	288,491	315,122	355,856	361,581	383,762
Cumulative breakeven position as a percentage of operating income	(47.6%)	(60.1%)	(61.2%)	(50.0%)	(45.2%)	(39.7%)	(42.7%)	(41.8%)

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the TAC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Staff costs

			2023/24	2022/23
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	169,691	118	169,809	156,229
Social security costs	18,693	-	18,693	16,514
Apprenticeship levy	882	-	882	763
Employer's contributions to NHS pension scheme	28,931	-	28,931	25,849
Pension cost - other	28	-	28	27
Temporary staff	-	48,356	48,356	47,495
Total gross staff costs	218,225	48,474	266,699	246,877
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	218,225	48,474	266,699	246,877

Of which

Costs capitalised as part of assets	2,642	926	3,568	1,089
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Average number of employees (WTE basis)

			2023/24	2022/23
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	339	330	669	537
Ambulance staff	-	-	-	-
Administration and estates	1,151	115	1,266	1,146
Healthcare assistants and other support staff	675	22	697	667
Nursing, midwifery and health visiting staff	1,250	47	1,297	1,192
Scientific, therapeutic and technical staff	264	19	283	263
Healthcare science staff	98	9	107	107
Total average numbers	3,777	542	4,319	3,912

Of which:

Number of employees (WTE) engaged on capital projects	91	17	108	23
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