

Annual Report

2024 - 2025



modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

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The performance report 2024-25

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:

- 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
- Statement on adopting Going Concern basis
- A summary of the Trust's performance (covering clinical, operational, financial and people)

Foreword from the chair and the chief executive officer

Welcome to our Annual Report for 2024-25.

The NHS continues to change and evolve at a significant pace and we are proud of our colleagues for their ongoing achievements in delivering care for our local population in this challenging context.

It is important that we, as an organisation, embrace these changes and, in particular, make progress in delivering the Government's 'three shifts':

- Analogue to digital
- Sickness to prevention
- Acute to community

On analogue to digital, we successfully introduced our new electronic health record (EHR), Alex Health, in November 2024. Alex Health is core to the delivery of our digital strategy and will substantially improve the quality of services we are able to offer to our local population. Thank you to every colleague involved in introducing Alex Health – a fantastic achievement.

In addition, we know that locally, we need to continue to work with our health and care partners across West Essex and beyond, ensuring that the care we provide to patients is proportionate to need, seamless and, where possible, delivered closer to home; working within newly established Integrated Neighbourhood Teams.

Where acute care is required, we want to be able to provide the most therapeutic physical environment for our population. On this, in January 2025, the government

confirmed the funding and timetable for a new hospital for Harlow, following a review of its New Hospital Programme (NHP). The Princess Alexandra Hospital scheme is in wave two and we are now planning to begin construction in 2032. Our new hospital will be part of the wider growth and regeneration agenda for Harlow and its neighbouring communities.

We recognise the challenges of the NHS landscape, including the national NHS financial position and the ongoing impact of the extremely high demand for our services.

We are proud to lead PAHT and to work alongside our fantastic colleagues who are committed to providing the best care for our local population.

We are pleased to welcome Darshana Bawa as acting chair from 28 March 2025, with I (Hattie) wishing a fond farewell to PAHT as I take on a new role as chair of Essex Partnership University NHS Foundation Trust (EPUT).

Best wishes



Hattie Llewelyn-Davies
Chair



Thom Lafferty
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, Bishops 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):

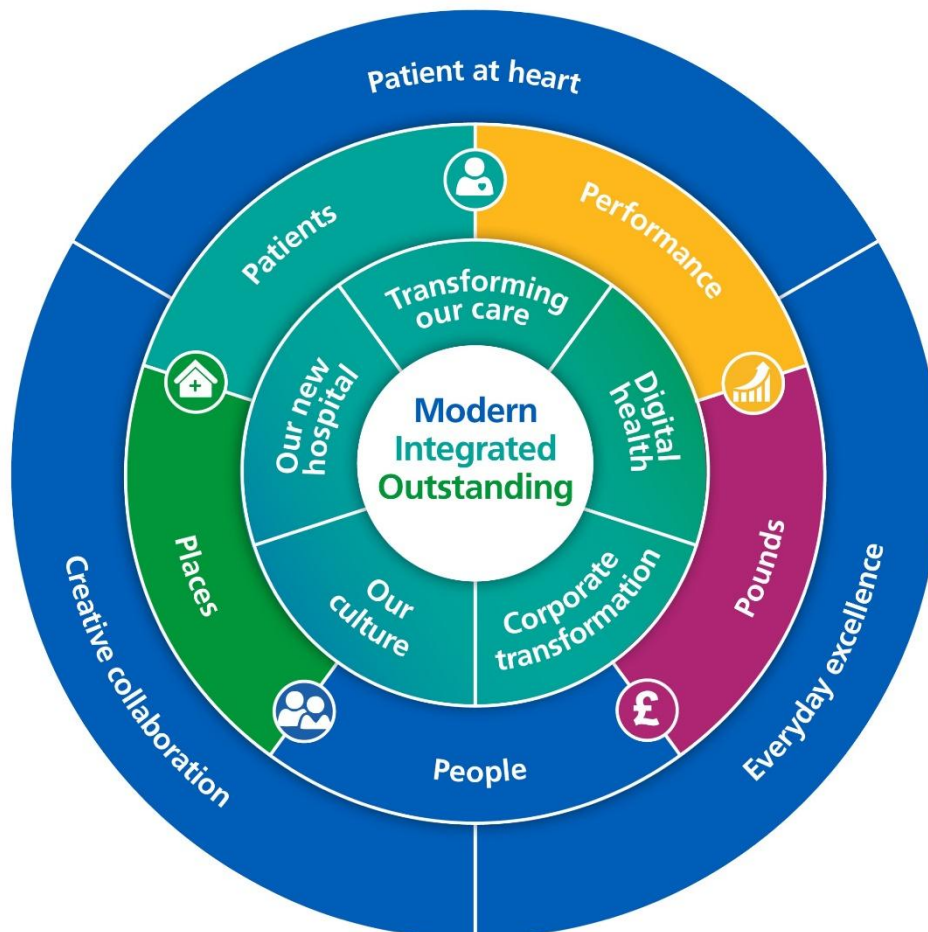
Table 1: Directory of our services			
Children's & Women's Services			
Antenatal and New born screening	Children's ward including patient at home (delivered by community provider)	Colposcopy and hysteroscopy services	Community midwifery
Early Pregnancy Unit	Foetal Medicine	Gynaecology ambulatory service	Gynaecology including Termination of Pregnancy Services
Infant Feeding support	New-born 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 – in-patients, out-patients, assessment services

Specialist antenatal services	Tongue tie service		
Clinical Support Services			
Audiology	Blood tests	Breast surgery	Chemotherapy
Clinical Haematology	Dermatology	Dietetics	Infection prevention & control services
Interventional radiology	Medical Oncology	Mortuary & Bereavement services	Neurology
Oncology services	Outpatients	Patient appliances	Pathology: Microbiology, Cellular pathology, blood sciences, biochemistry (delivered by Health Service Laboratories)
Pharmacy services	Physiotherapy and occupational therapy	Radiology	Speech and language therapy
Tissue viability	Transfusion services	Medical Photography	
Medicine			
Cardiology	Diabetic medicine	Endocrinology	General medicine
Podiatry (delivered by community provider)	Geriatrics including Frailty	Medical in-patient wards	Older People Assessment & Liaison
Oncology services relevant to medical care	Respiratory Medicine	Rheumatology	Specialist palliative care and end of life services
Surgery & Critical care			
Day surgery	Colorectal services	Ear Nose & Throat	Endoscopy services

Gastroenterology	General surgery	High Dependency Unit	Intensive Care unit
Maxillo-facial surgery	Ophthalmology	Oral surgery	Perioperative Medicine (Anaesthetics and ICU)
Genito-urinary medicine (Urology – Sur)	Surgery – in-patients	Trauma and orthopaedics	Vascular services
Urology			
Urgent & Emergency Care			
Adult assessment services incorporating same day emergency care & urgent” hot” clinics.	Integrated Urgent Treatment Centre – in collaboration with Stellar Health, Stort Valleys Federation, Essex Partnership University Trust & Herts Community Trust.	Emergency Department	Paediatric Emergency Department
Patient at home, adult (delivered by community provider)			

Strategic objectives

Following significant consultation in 2021, we launched our strategy, PAHT2030, with its 5 key strategic priorities; Transforming our care, Digital health, Corporate transformation, Our culture and Our new hospital. We are now in our 4th year of successful delivery, working collaboratively with our clinical and management teams to achieve our vision of becoming modern, integrated and outstanding.



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.

From 2022, our people and patients have worked together to develop and 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, integrated 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, 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 are harnessing new technology and digital solutions to transform patient care and improve how we work.

We will:

- Implement and embed 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 will build 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, overseen 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 (recruitment, innovation and (re)use of existing resources and training
3. The use and adoption of technology
4. Alignment and integration of clinical services
5. Prevention and addressing inequalities

Transforming our care has delivered a number of improvements including the increased use of virtual ward and virtual hospital. Work has continued to develop clinical strategies across all our specialities, outlining how our care will transform over the next 5 years as we approach 2030. These clinical strategies have been aligned to the HCP (Health Care Partnership) clinical priorities to ensure a fully integrated and joined up approach to healthcare spanning all provider organisations. Work has been undertaken to ensure that we have a clear understanding of our population needs and clinical outcomes for key pathways, linked to, and in the context of, the core 20+5 standards. There has been a focus on proactive prevention at PAHT linked to the WEHCP (West Essex Health Care Partnership) priorities.

Finally, this year work has been undertaken to ensure that as an organisation we have a strategy that enables PAHT to deliver on its commitment to be a continuously learning organisation that embeds and sustains the changes and improvements that we continue to make.

Our Culture

Our Culture work stream has focused on the patient and staff surveys, 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 feedback. The embedding of the Trusts 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 embedded across nursing, midwifery and 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 and organisational development offering and access to resources is ongoing through the embedding and refining of our digital platform including TIMS (This is Me System) and ESR (Electronic Staff Record) and the 'Ready to Manage' programme have been embedded. A review of our communications team and approach has been completed and included within our People Strategy 2025-2030 which will shortly be launched providing a roadmap in our journey to enhance our culture at PAHT.

Our recruitment and our onboarding processes have been reviewed as part of our commitment to being a continuously improving organisation. As a result, and linked to our PQP (patients, quality and productivity) programme, PAHT has delivered substantial reductions in our temporary workforce whilst providing a higher standard of continuous care for patients and substantial cost improvements.

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 has been the replacement of our patient administration system with an electronic health record (EHR). The successful launch in November 2024 of the Trusts EHR (Alex Health) has already enabled significant improvement through enhanced system integration, with further improvement and realised benefits, identified in the Trust's business case to be delivered from November 2025. This year has also seen the start of the sustainment and embedding process which will continue into 2025. Alex Health is a significant change and the largest transformation project undertaken at the Trust and a key step and enabler of our Trust vision to become modern, integrated and outstanding.

Other digital developments and improvements have also taken place this year including the deployment and refinement of AI in Radiology, with plans to also introduce the CDS i-refer system in Pathology, the use of 'Bots' as part of Alex Health to automate administration processes and the introduction of robotic surgery in theatres. Remote healthcare delivery continues to be adopted across clinical services as well as remote monitoring and the use of wearable technologies.

New Hospital

Preparations for the new hospital have continued with work undertaken to revisit and refine the demand and capacity and population health work to ensure that we build a hospital that aligns with the future needs of our patients. Work continues to progress the new hospital through the National Hospital Programme (NHP) and following the government's announcement confirming a commitment that construction on a new hospital for Harlow will commence from 2032.

A Community Diagnostic Centre (CDC) has been planned, developed and is currently under construction with an expected completion date of December 2025. The CDC will provide enhanced diagnostic capability, capacity and access for our patients.

The Elective Hub, which is an ICS (integrated care system) initiative, is also progressing, although construction is yet to start, the elective hub would provide additional elective and surgical capacity across the ICS to enable reduced waiting lists and aid the elective recovery programme.

This year has seen the deployment of a Vanguard theatre and ward at PAHT. The Vanguard theatre and ward have been deployed to aid elective recovery and are being used to undertake non-complex procedures and surgical activity such as cataracts, in a dedicated unit. This is enabling our main theatres to focus on more complex surgical procedures, reducing our waiting times and improving care for patients.

Corporate Transformation

The corporate transformation programme focussed on improving and rationalising corporate functions to enhance the support provided to clinical and front-line teams. The finance team has achieved both ATT and ACCA accreditation and are building on the achievement of FFF accreditation level 1 with a submission for level 2 accreditation in the coming weeks, with the outcome expected in August.

The adoption and use of technology has continued to modernise corporate functions, with the introduction of the SBS automation 'bot' in finance and the successful launch of the new inventory management system which has seen efficiency improvements in both Theatres and Diagnostics. In the Medical Secretariat, digital dictation and Alex Health have been successfully adopted, with work continuing to develop the post Alex Health Medical Secretariat function, following the adoption of streamlined processes and automaton of administration functions.

The rationalisation of corporate buildings and ensuring our estate meets our organisational needs continues both at PAH but also across the ICS (Integrated Care System) with system partners. The implementation of this work will be a key priority for 2025-26 and key efficiency and productivity opportunity.

The ICS Pathology laboratory outsourcing has been successfully completed. The new provider went live on the 1st March with key improvements expected to be delivered in terms of turnaround times, service provision and costs.

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. Our aim is “To help everyone in our area live long and healthy lives by supporting independence and providing seamless care”

Core partners include PAHT, Hertfordshire and West Essex Integrated Care Board, (HWEICB), 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 colleagues.

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
- 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 focussed on the following programmes of work in 2024-25:

Priority 1: Prevention

Through a “Healthy Places” approach led by our District Councils our plans have addressed the prevalence of obesity, wellbeing and resilience of children and young people by developing a healthy pregnancy project called “Bump to Five” and launching the Five Dinners website for residents and employees of Harlow. Adult mental health and wellbeing has been supported by the While You Are Waiting project, establishing a Healthy Places working group and bringing together partners to discuss sharing public buildings and working together on employability and education.

We have also focussed on cardiovascular disease by supporting people to manage their long-term condition and reduce acute hospital admissions. In addition we have increased identification of hypertension by offering blood pressure checks in dentists, opticians and GPs.

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

The partnership has developed a proactive and preventative model of care that meets individual needs in the community, maintaining independence and managing episodes of ill health in the community to prevent ED attendances and inpatient admissions. This care is led through the Primary Care Networks with support from pharmacy, therapy, social prescribers and adult community services. The first year of this initiative has delivered small reductions in acute hospital admissions and this initiative is being expanded into the coming year.

The partnership has also supported residents being discharged from acute hospital care by delivering Home First support and assessment and improving the delivery of complex bedded care for patients that need consideration of supported care or ongoing health care.

Priority 3: Community Urgent and Emergency Care

The HCP has improved 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 Hospital at Home and the continued improvement of the primary care led Integrated Urgent Assessment and Treatment Centre (IUATC). The introduction of the DVT pathway has been positively received with swift access to assessment & treatment through the IUATC.

2025-26 and beyond

The Partnership has produced a three-year Integrated Delivery Plan (IDP) 2025/26 – 2027/28. The IDP incorporates the NHS operational planning requirements for 2025/26 and the HCP's contributions to delivering the H&WEICB's Medium-Term Plan for its population. The IDP also aligns with the priorities of its partner organisations. The IDP sets out how WEHCP will deliver these requirements through transformation programmes and collaborative working focussing on the following priority areas over the next 3 years:

Addressing Health Inequalities:

- Continuing to identify people with hypertension and offer services
- Expanding the uptake of winter vaccinations
- Continued work on preventing childhood obesity
- Supporting adult mental health & wellbeing
- Active Essex & healthy places
- Implementing an integrated heart failure pathway

Proactive care of our frail population:

- Extending the Integrated Neighbourhood Team approach to proactive care to support patients most at risk of deterioration and hospital admission
- Development of an integrated frailty pathway

Improving access to Urgent Care services:

- Expanding capacity in community urgent care services & Hospital at Home care
- Further co-ordinating care for both urgent conditions and discharge from services through the Care Co-ordination Centre and Transfer of care Hub.
- Improving urgent care in PAHT and the Integrated Urgent Assessment and Treatment Centre.

Reducing waiting times for planned care:

- Cancer care recovery programme
- Reducing the waiting times for routine elective care
- Outpatient and theatre utilisation improvements

Improving outcomes for children and young people:

- Design of a children's family hub in Harlow
- Integrated pathways that improve access to care and reduce A&E attendances and emergency admissions

Efficient use of our resources:

- Achieving financial balance and sustainability of services in West Essex

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.

At the end of 2024-25 there were 11 risks on the Board Assurance Framework.

Nine of the 11 BAF risks are red-rated (scoring 15 and above) at the end of the financial year:

- 1.1 Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.
- 1.3 Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.
- 1.4 EHR: There is a risk to the delivery of safe and high quality care caused by the stabilisation of Alex Health post go live
- 1.5 Cyber: There is a risk of Trust-wide loss of IT infrastructure and systems from Cyber attack
- 2.3 Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust
- 3.1 Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & 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
- 3.5 New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.
- 4.2 ED performance: Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.

Two of the 11 risks on the BAF are amber-rated (scoring between 8 and 12):

- 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.
- 5.1 Risk that the Trust will fail to meet the financial plan

During 2024-25 three BAF risks were closed:

- 1.2 EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.
- 4.3 Industrial action: There is a risk that patient safety will be impacted by further industrial action
- 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.

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 2024-25 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 carefully evaluated potential local and national policy decisions that may impact the ongoing funding and provision of services by the Trust. As a member of the Hertfordshire and West Essex Integrated Care System (ICS), the Trust is aligned with the ICS's Medium-Term Financial Plan for 2025/26 - 2028/29, which ensures the continued provision of our services. The Trust, being one of the three acute providers within the ICS, plays a crucial role in delivering future healthcare services for Hertfordshire and West Essex.

The Trust is actively progressing with plans for a new hospital, which will receive direct funding from the Treasury. Following the announcement in January 2025 by the government, the Trust has moved into Wave 2 of the New Hospital Programme moving the estimated construction start date to 2032. The Trust continues to develop an Outline Business Case (OBC) and has garnered support from a broad spectrum of stakeholders at both local and national levels.

The Directors have not identified any factors or circumstances that would lead them to question the ability of The Princess Alexandra Hospital NHS Trust to continue providing healthcare services through the 2025-26 period.

For the 2024-25 financial year, the Trust reported a system performance deficit of £1.1m against the system breakeven plan. Income from our local Integrated Care Boards (ICBs) was primarily derived from the NHS Payment Scheme (NHSPS), which replaced the National Tariff Payment System on 1 April 2024. This transition provided relative certainty regarding our income and cash flow, with the majority of the Trust's income based on a combination of the adapted finance regime introduced in response to the COVID-19 pandemic and activity-based contracting, rather than being linked to cost and volume. We are nonetheless in need of non-recurrent support from our ICB every year; we believe this links to recurrent structural issues that we have sought funding for recurrently.

Additionally, the Trust is spearheading the development of Place within the system and will assume lead provider status for adult community services in 2025-26. We are also advancing with the establishment of Host Provider arrangements.

For 2025-26, 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 Elective Recovery (ERF) to reduce the longer wait elective patients.

The financial requirement for 2025-26 will be reducing the Trust's underlying cost base and delivering efficiencies to achieve a breakeven plan. This position includes a £26.2m Patient, Quality & Performance (PQP) efficiency target and an agreement with the ICS to deliver efficiencies across the system which have been collectively agreed as an ICS.

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

Performance Analysis

Financial Performance

2024-25 has seen NHS organisations continue to tackle and reduce elective waits. The Trust did receive some additional income support for winter and continued to receive significant levels of non-recurrent income seen over the previous 2 financial years.

The Trust implemented Alex Health, a new Electronic Health Record System in 2024-25. While this has given the Trust some initial challenges on reporting elective recovery income in 2024-25, longer term, it will assist in our ability to capture, report and bill for income. Local arrangements around block income in 2024-25 safeguarded against some of the reporting risks set out above.

The Trust achieved a significant reduction in its use of agency staff during 2024-25; seeing a reduction in agency expenditure compared to the previous year. The impact of the ageing estate created higher estates costs and reduced productivity as a result of capacity closures.

Operating and Financial Review

The Trust reported an adjusted financial performance deficit of £1.1m for the financial year 2024-25 (refer to note on page 56 of the accounts). This represents an improvement of £5.8m compared to the deficit recorded in 2023-24.

Cost improvement

The Trust made efficiency savings of £18.58m in 2024-25, of which 49.8% were non-recurrent. Throughout 2024-25, the Trust used the PQP programme, putting the patient at the centre of everything we do and making sure we optimise productivity through high quality care.

Capital investment

The Trust invested £40.4m in capital infrastructure and equipment to enhance service delivery in 2024-25 and beyond. Key projects included significant investment in and completion of our Electronic Health Records (EHR) development, infrastructure upgrades across our Estate and ICT to bolster system sustainability and resilience, the Community Diagnostic Centre (CDC), Urgent Treatment Corridor Works, and Energy Efficiency initiatives.

Approximately half of the expenditure was financed through the Trust's self-funded capital programme, with the remaining half provided via Public Dividend Capital (PDC) from the Department of Health and Social Care (DHSC).

The Trust's investment in the PAHT New Hospital Programme continued in 2024-25, focusing on further developing the business case and preparing for site acquisition.

The planned capital investments for 2025-26 includes

- Continued investment in CDC and imaging capacity
- Phase 2 UTC Corridors to improve flow.
- Redevelopment of our Children's ED.
- Estates and ICT infrastructure developments
- The development of our New Hospital Programme

These capital investments enable the Trust to fulfil our vision of providing high-quality care for all patients daily and underscore our commitment to Corporate Social Responsibility within the communities we serve. While we are planning for a new hospital, we acknowledge the necessity of optimizing our current estate to address the short- to medium-term health needs of our patients. However, this presents funding challenges and remains one of the ongoing cost pressures we are striving to balance.

Looking ahead

Looking ahead to 2025-26, the payment mechanism remains the same as 2024-25, 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 ICS capital allocation remains constrained, with the Trust's capital allocation amounting to £14.8m from internally generated resources. Additional external capital funding, in the form of Public Dividend Capital (PDC), will be received to support the Community Diagnostic Centre, other estate programmes, and the new hospital programme. These significant capital investment projects will continue to enhance the care we provide while maintaining the existing hospital. Consistent with previous years, we anticipate further funding in the form of PDC in 2025-26 and may consider bidding for some of this funding

We will continue to explore opportunities to invest in our hospital to deliver the best possible care to our local population, both now and in the future, in collaboration 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	2024/25 £000's	2023/24 £000's
Adjusted Financial Performance deficit	(1,097)	(6,125)
Public Dividend Capital Dividend Payable	(5,331)	(4,357)
Value of Property, Plant and Equipment	189,054	179,127
Right of Use Assets (Leases – IFRS 16)	43,098	41,698
Value of borrowings (Leases - IFRS 16)	(42,920)	(41,620)
Value of borrowings (including loans)	-	-
Cash at 31 March	28,628	28,242
Creditors – trade and other	(45,098)	(51,215)
Debtors – Current trade and other	10,094	14,953
Revenue from patient care activities	379,134	342,014
Clinical negligence costs	(14,629)	(13,591)
Gross employee benefits	(294,596)	(266,699)

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 on page 56 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

The Trust remains committed to making supplier payments within 30 days of the invoice date. Where feasible and appropriate, the Trust will expedite payments to suppliers, acknowledging its responsibility to support businesses in maintaining cash flow. Consequently, performance in 2024-25 showed improvement compared to 2023-24. As part of our enhanced focus on cash management in 2024-25, we will continue to review our payment performance and policy.

Anti-Fraud and Bribery

The Trust remains dedicated to fostering a culture that actively prevents fraud, bribery, and corruption, supported by a comprehensive range of policies and procedures

designed to minimize risk in this area. We are committed to upholding the highest standards of honesty and integrity in managing our assets. Our commitment extends to the elimination of fraud, bribery, and illegal activities within the Trust, ensuring thorough investigation and appropriate disciplinary or other actions in response to any allegations. The Trust adheres to best practices as recommended by the NHS Counter Fraud Authority.

Operational performance

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

- Regular Divisional Review Meetings between members of the executive team and each division or department
- Executive Board
- Operational Board
- Executive Cabinet
- Quality and Safety Committee
- Alex Health Operational Advisory and Readiness Board
- Patients, Quality and Productivity meetings (PQP)
- Divisional Board
- The Cancer Board
- The 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/Improvement and its commissioners.

Targets and national standards

Delivery of all national standards has continued to be impacted by the increased elective waiting lists caused by the Covid-19 pandemic, industrial action, high numbers of emergency patients requiring care and the deployment of the Trust's new Electronic Health Care Record; Alex Health.

The Trust has focussed 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 during the winter period with a one week closure of the orthopaedic ward to support the increased emergency admissions. Critical care capacity has been challenged during 2024-25 with a number of elective critical care cases requiring re-scheduling due to emergency pressures. Plans are being developed to increase capacity in conjunction with the East of England Critical Care Network.

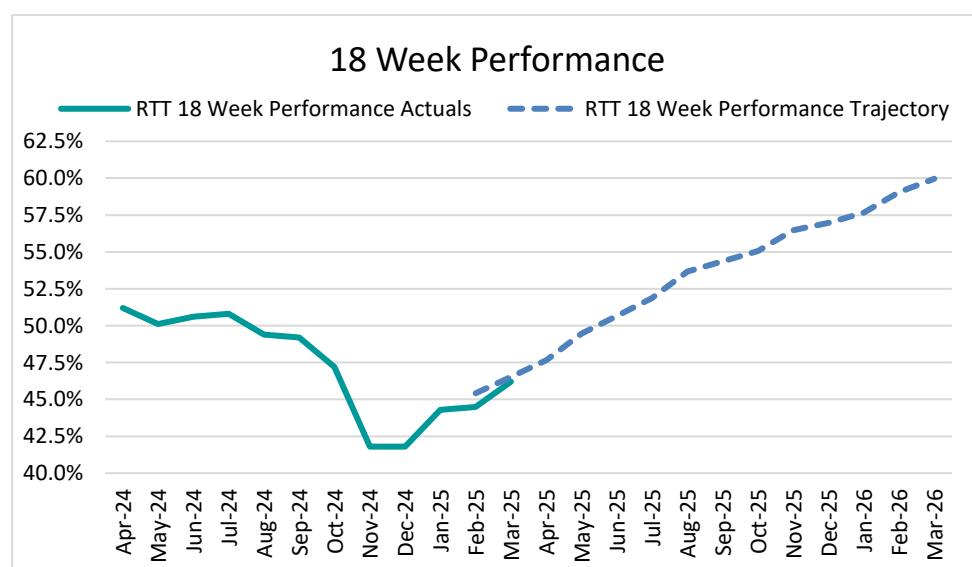
Referral to Treatment Performance

Throughout 2024-25, the 18-week Referral to treatment (RTT) standard was negatively impacted as the Trust focused on reduction of our long waiting patients.

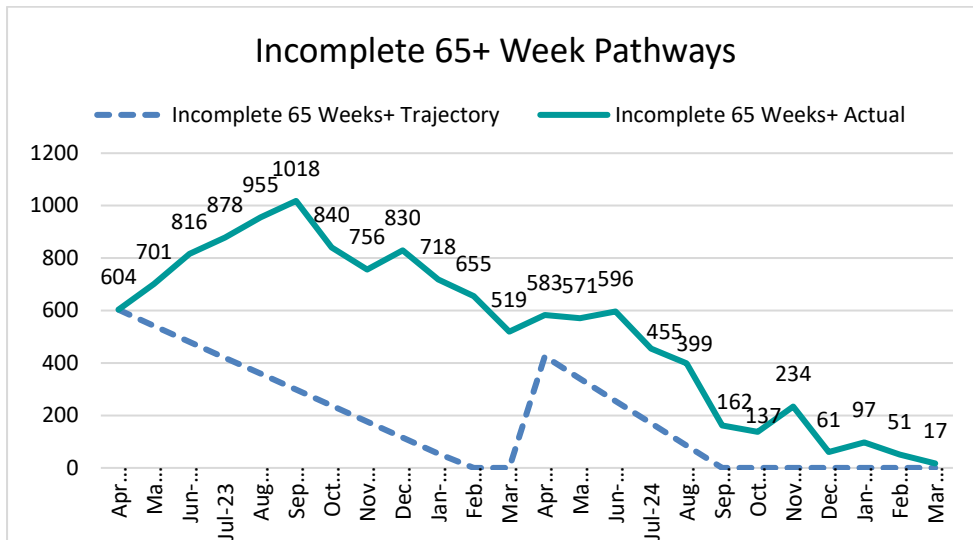
Due to the complex and evolving nature of healthcare demand and delivery, it is not possible to project RTT (Referral to Treatment) activity with accuracy over a 3–5 year period. Several key variables such as changes in population health needs, national policy direction, funding allocations, workforce availability, and unforeseen external pressures like pandemics or major service reconfigurations can significantly alter activity levels. Additionally, planned service transformation initiatives, emerging technologies, and the pace of recovery from current backlog pressures introduce further uncertainty. As such, while shorter-term forecasting is used to support operational planning, longer-term projections would be speculative.

Performance at the start of the 2024-25 financial year was 51.2%, with performance at 46.2% in March 2025. A recovery trajectory has been developed to achieve 60% by March 2026 (figure 33). During 2024-25, the Trust successfully eradicated patients waiting over 78 weeks and our cohort of patients waiting over 65 weeks at the start of the 2024-25 financial year was 583 in comparison with 17 at the end of March 2025 (figure 34). The Trust continues to book patients in clinical priority order with urgent and cancer treatments prioritised at every opportunity.

Referral to Treatment access target – Incomplete standard



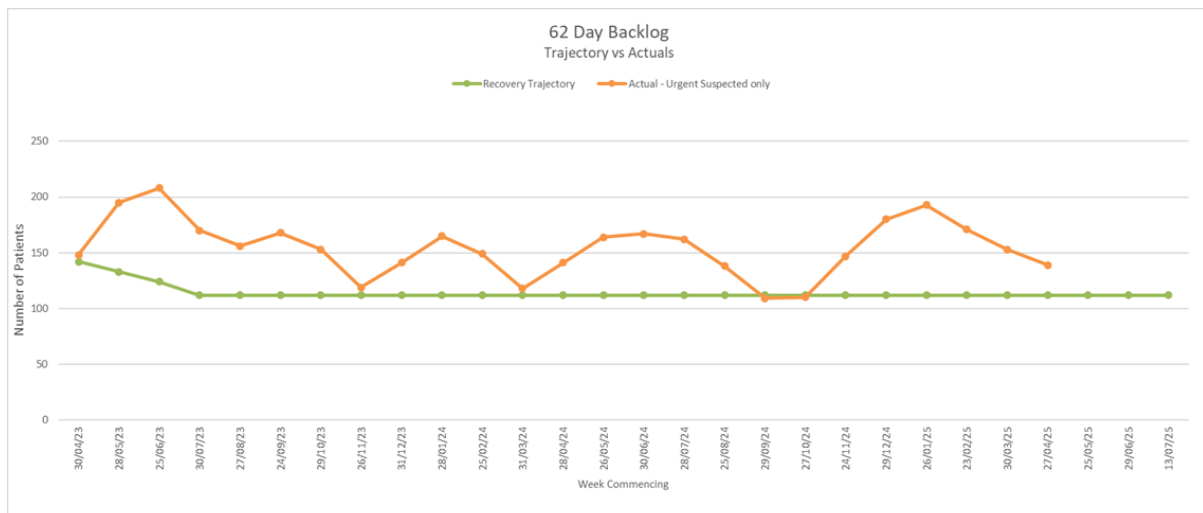
Referral to Treatment access target – patients waiting over 65 weeks



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, and in 2024-25 the Trust achieved the national target, however in November, the backlog increased as a result of the new EHR implementation. Work is continuing to reduce this backlog and the aim is to exceed the target in 2025-26 (figure 35).

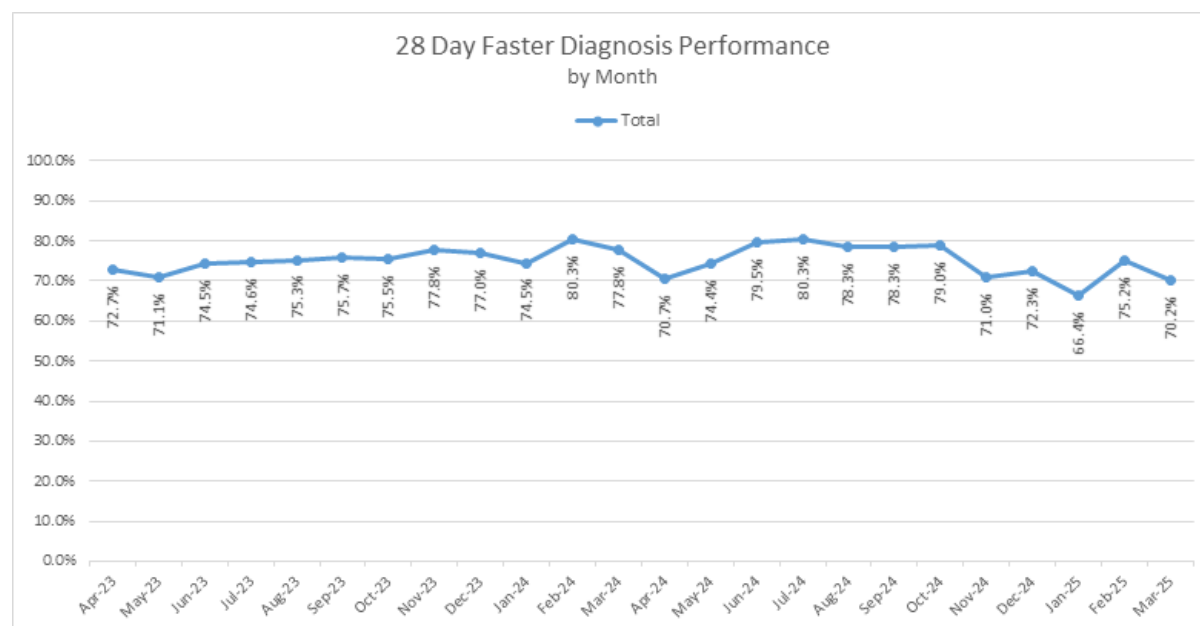
62 Day cancer backlogs



The Trust is one of three trusts in the East of England to consistently achieve the clinical safety standard that ensures suspected cancer patients receive a diagnosis of cancer or no cancer within 28 days of referral, however the implementation of our EHR system in November has impacted performance. Recovery trajectories and further

actions are being developed to support oversight and bring performance back in line with the national standard.

28 day Faster Diagnosis Standard



Diagnostic performance

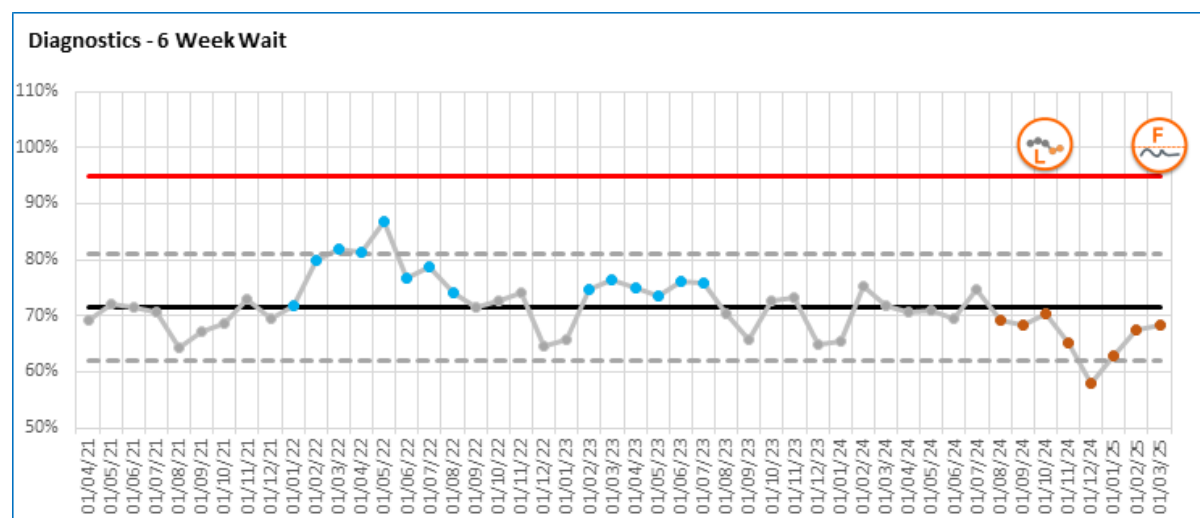
Diagnostic performance has been impacted by backlogs of routine patients waiting longer than 6 weeks for their diagnostics. There have been significant increases in referrals across the imaging modalities; MRI increases of 24%, 10% in Ultrasound and 20% in CT. The opening of additional capacity at the St Margaret's site for the Community Diagnostic Centre 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. MRI and CT have achieved DM01 100% for circa 6 reporting months in 2024-25 to date.

Additional capacity in the Audiology service via the commissioning of a second Audiology booth at the CDC spoke site of HEH has improved waiting times for paediatric assessments specifically and as such this modality achieved 95% compliance at the end of March 2025, adult audiology continues on an upward trajectory.

The implementation of the Trust's new EHR system in November adversely affected the reporting for Urodynamics, Colonoscopy, Flexi Sigmoidoscopy, Cystoscopy and Gastroscopy modalities. This impacted the service's ability to validate the position for accurate performance reporting. Significant progress has been made with performance reports available for validation going into the new financial year. It is the ambition to improve performance throughout 2025-26, with recovery of the diagnostic standard dependent on providing additional capacity, insourcing, recruitment drives,

demand and capacity modelling and overall pathway efficiencies across relevant modalities. Recovery plans are in place and are being regularly monitored.

Diagnostic times – Patients seen within 6 weeks



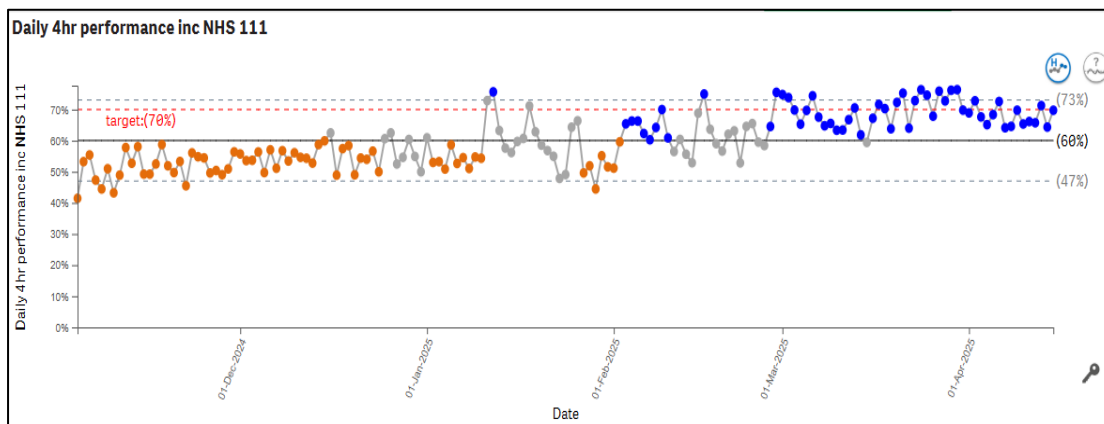
Key to SPC chart:



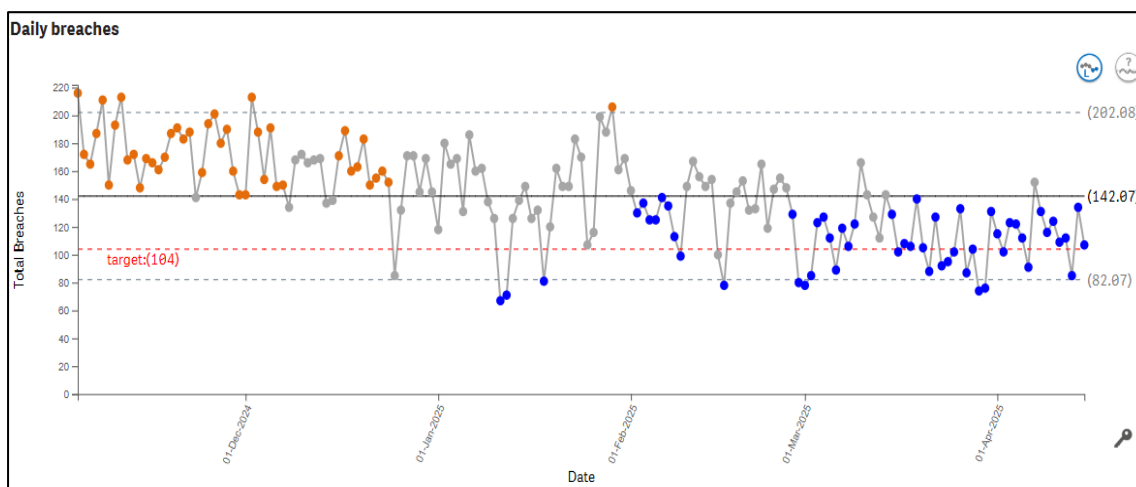
Urgent & Emergency Care Performance

The percentage of patients being admitted, transferred, or discharged within four hours in the emergency department has significantly improved and is in improving special cause variation. While the Trust has not achieved the national 76% four hour standard during 2024-25 and with the implementation of our EHR system in November 2024 impacting performance, following a recovery period we have increasingly achieved or exceeded our regionally agreed 70% four hour standard. There has been consistent improvement in the reduction in breaches of the four hour standard (figure 39). Further to this, the Trust has also seen a significant reduction in the percentage of patients who remain in the emergency department for 12 hours or more (figure 40). The Trust continues to work hard to reduce the length of time patients stay in the emergency department and a comprehensive improvement plan has been developed to support further improvements.

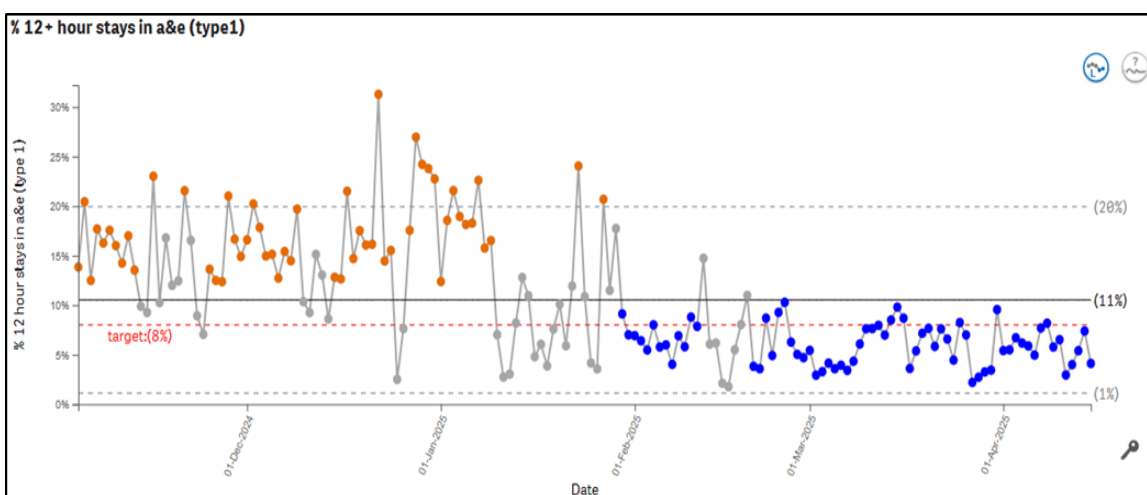
4 hour quality standard achievement



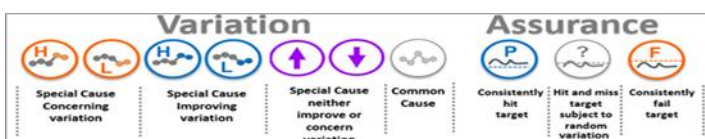
Breaches of the 4 hour standard



Percentage of patients who remain within the emergency department for 12 hours or more



Key to SPC charts:



Responding in an emergency

PAHT has achieved substantial compliance across the 10 domains of the NHSE Core Standards, which include governance, business continuity (BC) and co-operation. Overall 57 of the 62 areas were fully compliant and 5 were partially compliant which is a significant improvement on the previous 2 years. A plan has been developed to ensure the Trust is fully compliant in 2026.

Over the course of 2024-25 PAHT took part in eight test exercises both internally and externally with ICB and regional partners. These included a fire and evacuation major incident test and a Multi-Agency MTA exercise.

Clinical performance

Infection Prevention & Control

Respiratory viruses

In 2024 - 2025 there has been a shift in focus from the impact of COVID-19 in hospitals and the community, to the increase in other respiratory viruses over the winter months. Our local surveillance data reflected the national picture quite closely, with a significant increase in Influenza A infections in our patients. We recorded 107 Influenza A cases in January 2025, compared to 39 cases in the same month in the preceding year. Nationally, as well as at PAHT, cases of Influenza B increased, but not significantly compared to Influenza A. Our Trust recorded 46 cases of Influenza B in 2024 - 2025, compared to just 12 cases in 2023 -2024. IPC control measures were implemented as soon as cases were identified clinically.

Human metapneumovirus (hMPV) was increasingly reported by the World Health Organisation (WHO), but the WHO confirmed that this virus did not show pandemic potential. Our in-house laboratory respiratory viral testing panel includes testing for this virus and we recorded 70 infections associated with this particular virus.

We continue to report the four main viral respiratory infections affecting the UK on our local IPC dashboard. These are Influenza A and B, COVID-19 and Respiratory Syncytial Virus (RSV). In line with the national IPC manual, patients were successfully managed clinically at our Trust as part of a wider group of respiratory viral infections, with further cohorting of patients once PCR testing had identified a specific viral cause.

We managed a total of 16 COVID-19 outbreaks across our wards in 2024 - 2025, compared to 32 in the previous year, and some lateral flow testing was carried out on wards. Patients generally had mild symptoms.

Clostridioides difficile (C.difficile)

We reported a total of 65 hospital and community onset health care associated *C. difficile* cases during 2024-2025. Of these, 42 were hospital-onset, health care associated (HOHA), detected three or more days after admission, and 23 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 48 cases in 2023-2024, 38 of which were HOHA, and 10 were COHA. Our increase in cases of healthcare associated *C.difficile* infections is reflective of regional and national activity. Although the Trust was over the threshold that was allocated for the year (47 cases), it should be noted that PAHT was given a significantly lower threshold than other Trusts in the ICS and the region (due previously having lower case numbers). Of the 14 acute Trusts in the region, only two had a lower trajectory than PAHT. Additionally, the Trust had a slightly lower rate than the EoE average at 31.70, compared to the region at 33.79.

All healthcare associated cases of *C. difficile* are investigated to ensure that gaps in practice and corresponding actions are identified and monitored. Management of *C.difficile* is further supported by multidisciplinary ward rounds with the Microbiology Consultants, Antimicrobial Pharmacist and the IPC nursing team.

Meticillin Resistant *Staphylococcus Aureus* (MRSA) Blood Stream Infections (BSIs)

There were two cases of HOHA MRSA BSIs this year, and no COHA cases. Both cases had full investigations undertaken in conjunction with the ward clinical teams (medical and nursing), which ensure any gaps in practice are managed appropriately and that learning is identified to help prevent future cases. PAHT was below the East of England (EoE) regional average rate per 100,000 occupied bed days at 0.98 compared with 1.19 for the region. There is a continued focus on the management of peripheral intravenous catheters, which are known to be the source of some BSIs.

Meticillin Sensitive *Staphylococcus Aureus* (MSSA) BSIs

The Trust has continued to closely monitor and review its cases of MSSA. This year, we had a total of seven HOHA cases and seven COHA cases. In comparison to the region, the Trust has a significantly lower infection rate than the EoE average rate per 100,000 occupied bed days at 6.83 compared to 12.07 for the region. Over last two years, the Trust has reduced its cases of MSSA; however, as with MRSA, it is important that there is a continued focus on peripheral intravenous catheters as they have been a contributing factor to some cases of MSSA.

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 continued to monitor trends in GNBSIs throughout the year. We have focussed on improving our local data as we reported more respiratory source GNBSIs in 2023-2024 than average; our 2024-2025 data is now in line with national figures. The Trust was under trajectory for both *E.coli* and *Klebsiella species*, and on trajectory for *Pseudomonas aeruginosa*. For all three organisms, the Trust was below the EoE average per 100,000 bed days.

Various strategies are in place to reduce these infections including sepsis prevention, urinary tract infection (UTI) and catheter-related UTI prevention,

dissemination of patient information (hygiene, good hydration), improved education and training of staff, antimicrobial stewardship (improved antibiotic treatment of UTIs), and surveillance. This year we have also started to focus on the GNBSI patient group with hepato-pancreato-biliary (HPB) disease.

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. In the latter winter months, there were a number of norovirus outbreaks in the Trust, some of which were prolonged, whilst others were shorter. An increase in Norovirus at this time was reflective of national and regional data.

Measles

An increase in cases of measles has been a public health concern, with cases rising in the East of England region towards the end of 2023-2024, and several positive cases attended the hospital this year (which is now reducing). Incident review meetings were held for all measles cases to ensure the correct actions were taken. The IPC team continued to review the measures implemented in 2023-2024, focussing on supporting our emergency department to ensure that the measles admission pathway is followed, and that this diagnosis is considered when patients are triaged. Towards the latter part of this year, the number of cases has reduced.

Group A Streptococcus (GAS)

Reflecting the national picture, locally there has been a reduction in total community associated case numbers for 2024-2025, with 474 cases in children less than 16 years, compared to 738 cases in 2023-2024. This has reflected in reduced ED attendance compared to last year.

The concern with GAS is not only the pathogenicity of the organism with its associated morbidity and mortality, but the increasing reports of antimicrobial resistance associated with GAS. Fortunately, GAS is universally (100%) susceptible to penicillin, but there has been an increasing resistance to some other antibiotics.

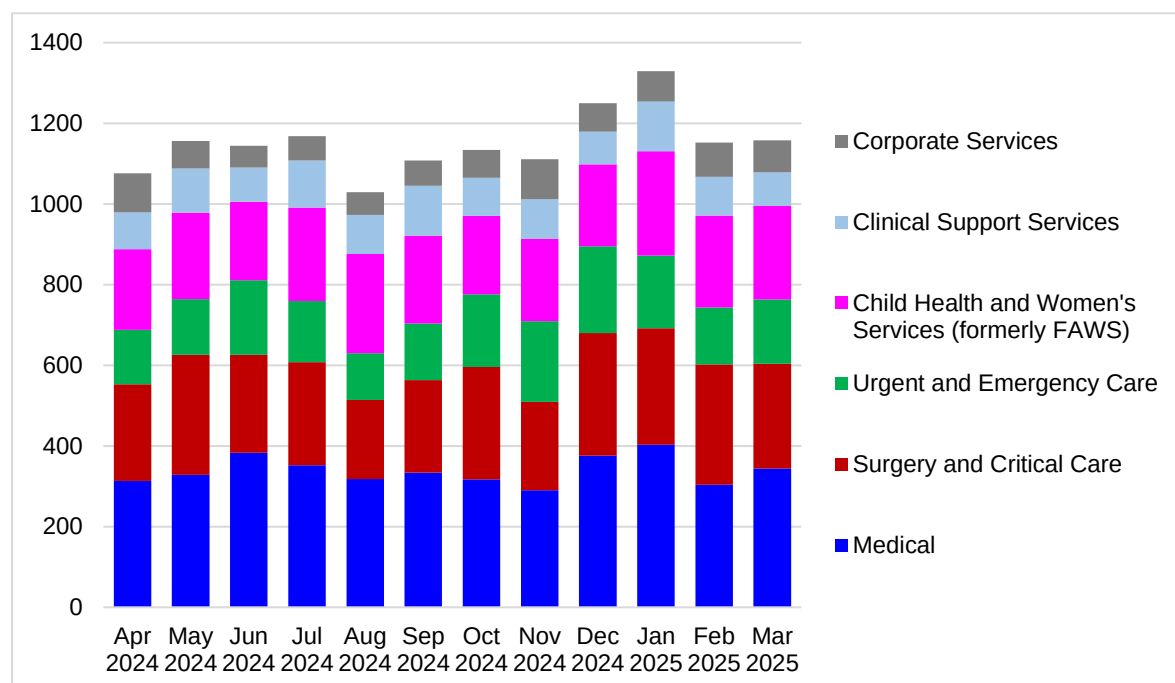
Learning from patient safety incidents

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 refers to any unintended or unexpected event that 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 2024 to 31 March 2025, 13,815 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.

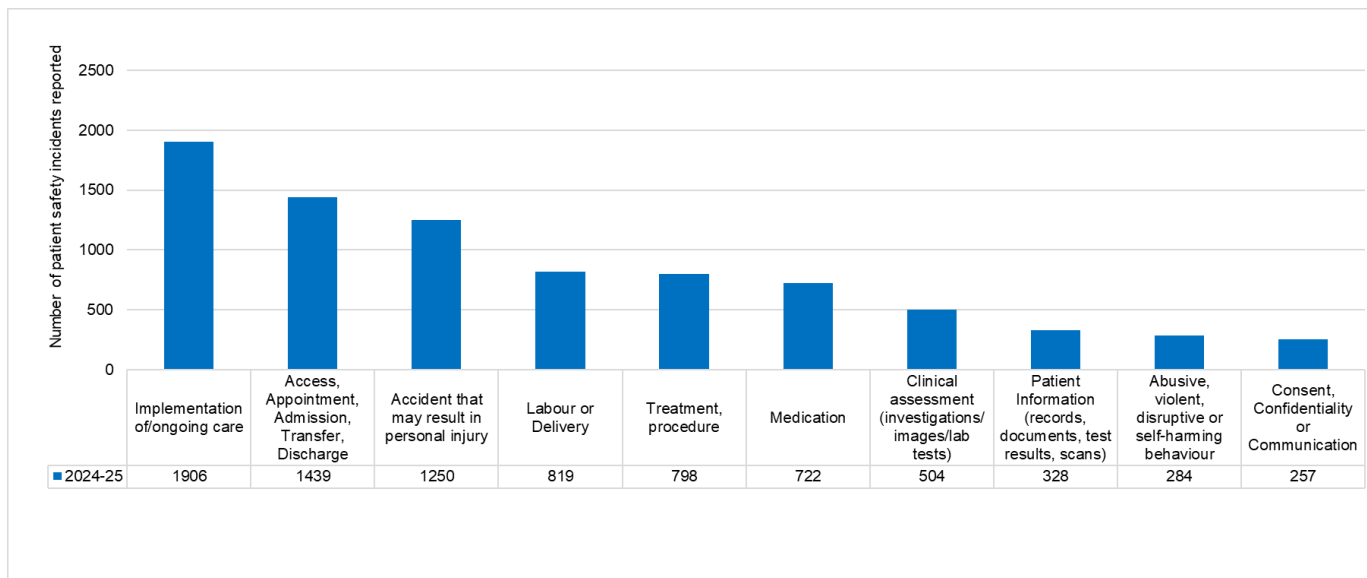
Incident reporting data for period 1 April 2024 – 31 March 2025



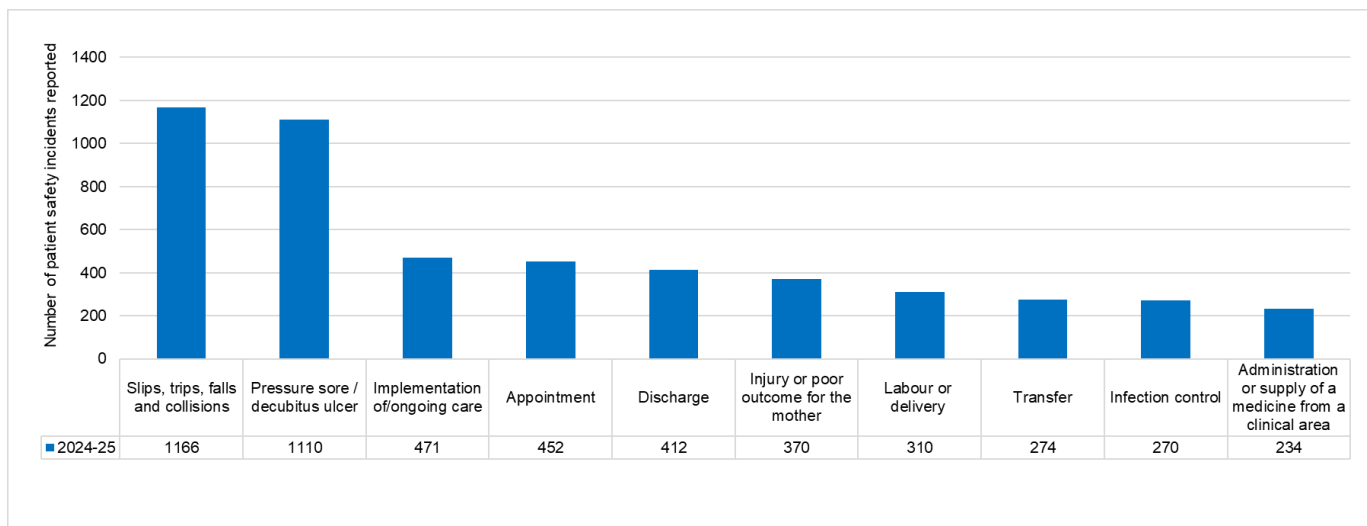
Patient safety incidents

The top 10 categories of patient safety incidents reported during 1 April 2024 to 31 March 2025 are summarised in the table 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 2024 – 31 March 2025



Top 10 themes of patient care incidents for 1 April 2024 – 31 March 2025

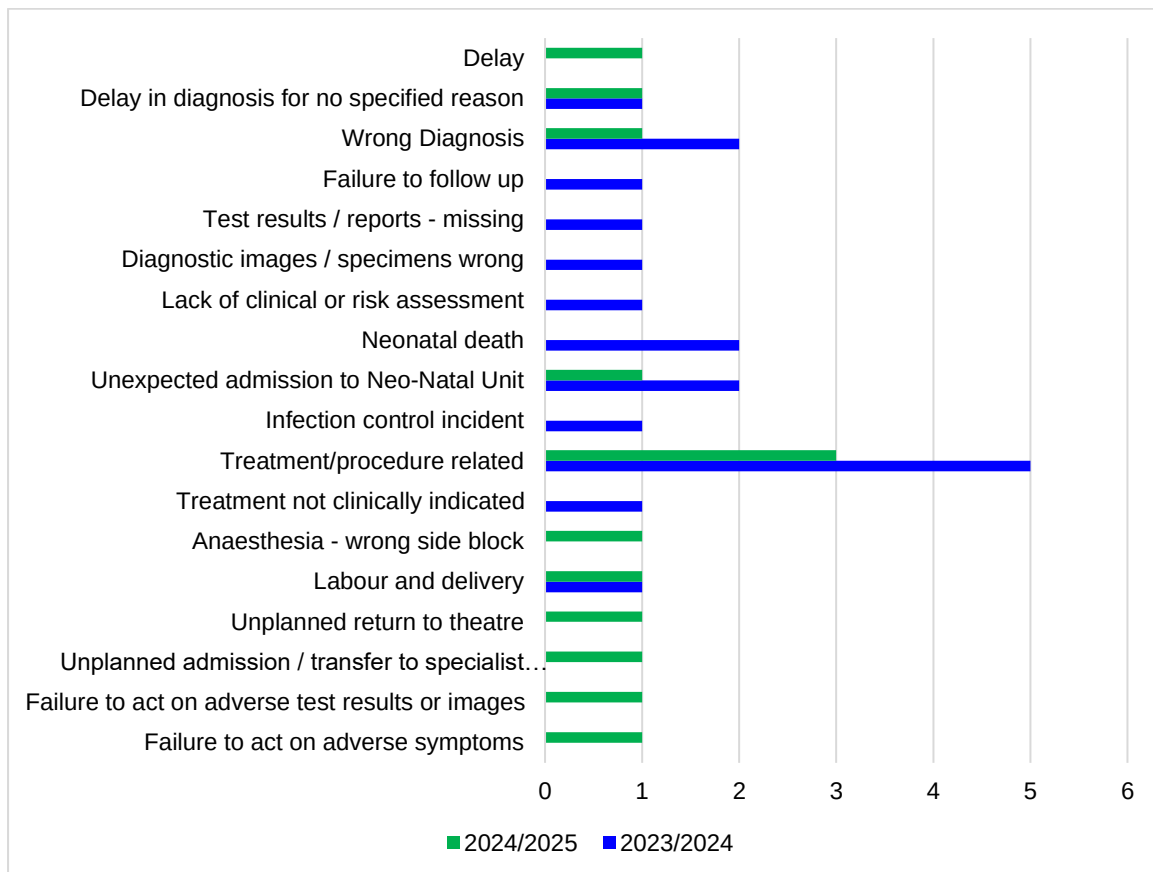


Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) is the national system that supports organisations in identifying incidents that require investigation, focusing on learning to enhance patient safety. This system replaced the Serious Incident (SI) process and was fully implemented from 1 January 2024 at The Princess Alexandra Hospital NHS Trust.

Incident investigations commissioned under the PSIRF framework are called Patient Safety Incident Investigations (PSII's). The Trust raised 13 PSII during the period 1 April 2024 to 31 March 2025.

Reasons why Patient Safety Incident Investigations were commissioned - 1 April 2024-25 compared to Trust data for 2023/2024:



Once a PSII investigation is concluded, an action plan is developed to capture the learning and recommendations that need to be implemented 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 report is presented and shared widely within the local teams where the incident occurred and if relevant to other clinical areas with divisions and across the Trust. This information is reported Trust wide monthly to the Patient Safety Group and quarterly to the Quality and Safety Committee.

The trust reported three Never Events in 2024 -2025:

- Two incidents of wrong site surgery (wrong site nerve block): 2 patients received wrong site nerve block on hip, one incident was investigated and closed, the second case relates to incorrect reporting of X-ray site which was identified after the incorrect nerve block was given. Both patients did not require any additional hospital stay or treatment.
- Retained foreign object (retained swab following C-section): this investigation is in progress.

In total investigations for five of the 13 PSII incidents have concluded with robust action plans developed and shared.

Examples of changes implemented as part of learning from incidents

Nerve block sites

All members of the anaesthetic team are present prior to the commencement of a surgical site nerve block being commenced. This provides a double checking process for all procedures.

Site markings are made using a single arrow as close to the operation site as possible to ensure it is always visible within the operative field following the patient's skin being cleansed and draped for their surgical procedure.

In-patient falls

Additional education and training has been implemented to improve compliance with the completion of lying and standing blood pressure assessments. There has been additional focus on increasing frequency of documented medication reviews and the impact of medication on increasing the risk of a patient falling. Finally, a pilot study for the completion of vision assessments has commenced. This will support reducing the risk of patients falling and sustaining injury whilst in hospital.

Blood transfusion

The mandatory blood transfusion training for clinical staff now includes appropriate use of blood products based on blood tests taken prior to attending hospital on non-symptomatic patients to avoid any unnecessary blood transfusions.

Ophthalmology

A post-operative cataract community pathway has been established that will comprise of two digital pathways for cataract care (one of the first in the country). This will support the timely treatment and follow up care for patients.

Consent Process

Consent forms now include the need to discuss and document the potential for an unsuccessful procedure outcome with the patient. This will ensure that patients are aware that a procedure or treatment may not have the desired outcome and what that means for their ongoing care.

Sepsis care

Teaching and discussion on identifying sepsis (use of the sepsis six bundle) has been completed. This will remain an ongoing regular training session for the future. Within this training the following is included:

- To act on an increase in temperature
- Collect blood cultures as soon as possible
- Immediate management of sepsis interventions designed to improve outcomes for patients with sepsis
- The Trust Infection Prevention & Control team will deliver additional sessions for new staff as part of Trust induction to discuss invasive devices insertion and ongoing care to reduce risk of sepsis.

Safe administration of insulin

Introduced an e-learning package on insulin safety which is available on the Trusts training system (TIMs). The training supports the safe prescribing and administration of insulin avoiding deterioration related to diabetes.

Hospital acquired pressure ulcers

Quality improvement action plans for pressure ulcer prevention have been introduced in all appropriate clinical areas. More than 100 new footstools have been purchased to assist patients to take pressure from their heels and two new patient information leaflets for pressure ulcer prevention have been introduced; these are aimed to inform both patients and their family members/carers. A dedicated pressure ulcer prevention practitioner is identifying earlier skin changes due to closer monitoring, and the “care colour circles” project has been implemented as a visual aid to assist staff with prioritising patients at high-risk of developing pressure ulcers. These improvements are underpinned by the new e-learning packages introduced 'Essentials of pressure ulcer prevention' and 'PURPOSE T' a new pressure ulcer risk tool both available on the Trusts training system to support the work in reducing the number of hospital acquired pressure ulcers

Non-patient safety incidents

63% of all incidents raised within the Trust relate to patient safety. 37% of the incidents are not regarding patient safety, the categories for these are detailed below:

Category of all incident categories	2024/2025
Patient Safety (these are detailed in the figures above)	8650 (63%)
Non-Patient safety incident categories	5165 (37%)
Monitoring	1841 (13%)
Staff Incident	1260 (9%)
Staff Shortage	677 (5%)
Equipment	602 (4%)
Security	370 (3%)
Environmental	327 (2%)
Visitor	88 (1%)

Patient experience

The patient advice and liaison service

The patient advice and liaison service is the public's first point of contact service and responded to 4729 concerns in year. The service has been proactively working with

clinical teams. Following a workshop which took place in March 2025 the service will offer bespoke support for case management and implementation of standardised, best practice processes across all five divisions.

Complaints – section 18 report

Every year, the Trust must make a statement under section 18 of the NHS Health and Social Care Act 2009 about how many complaints it received, whether or not they were well founded, their subject, the issue they raise, and any actions taken. This report is intended to satisfy that requirement.

How many complaints were received

The Trust received 318 complaints in 2024-25, an increase of 172 (84%) from 2023-24.

How many were well founded ('upheld')

Of the 226 complaints closed in the period (the point at which we determine if the complaint can be upheld) 66 complaints were not upheld (including those who failed to return consent or ended contact) 149 partially upheld, 11 fully upheld.

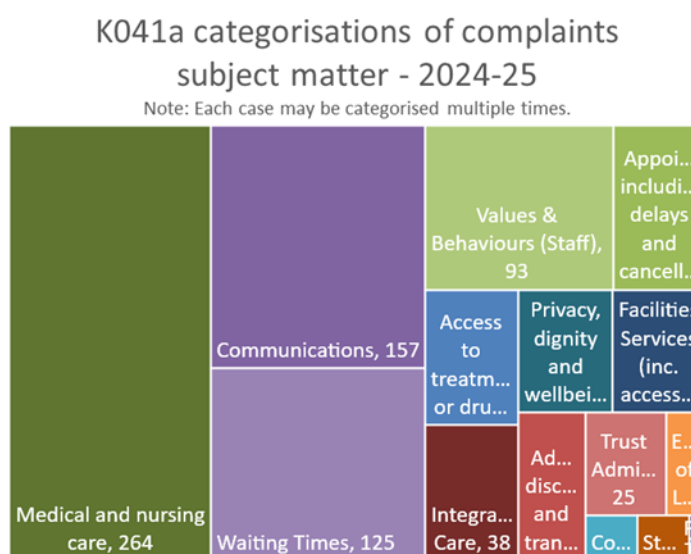
By identifying a case as upheld, we mean that at least one of the concerns raised meant action was required by the Trust to address the issue.

What were the subjects?

Of 318 cases, 919 categorisations were made (each case is categorised multiple times). The most frequently occurring themes related to:

- Medical and nursing care
- Communication
- Waiting times

Other subjects are noted as in the diagram.



What issues do those cases raise and then what actions were taken?

The patient experience strategy relates to three core themes of improving our communication, effective use of technology and centred kindness and compassion in the services we provide.

Our actions in response to those themes were:

Improving our communication

- 1076 nursing midwifery and AHP staff have been trained in Sage and Thyme Foundation Level communication skills, with the first doctors attending on 9 April 2025. .

- Work has been undertaken with the Deaf Community to improve cancer information in partnership with Cambridge based Anglia Ruskin University Masters students.
- An event was held for people with learning disabilities working with 11 community Learning disabilities and autism and cancer teams across West Essex.
- Outreach events in Harlow, Epping and Stortford to support access to the resolution of PALS concerns and involvement in the patient panel.
- A 10-week BSL training session launched and fully subscribed with 30 trainees.
- A sensory training pilot using clinical simulations to improve communication with RNID and HealthWatch Essex Disability Ambassadors.
- An outreach event in children's centres and the African community working cancer services.

The effective use of technology

- The implementation of My Alex Health, a patient portal which went live in March 2025 with 875 patients registered in the first month in Dermatology followed by a phased roll out by specialty to support staff and public confidence in the roll out. Of 300 patients invited to register on the portal in the first week, 99% registered on first invitation. All specialties will be live by Summer 2025.
- Digital inclusion. A project in partnership with West Essex Community Action Network (WECAN) to combat digital exclusion is enabling us to give away 120 devices, securely wiped and prepared for use by patients who do not currently have a device. WECAN helps us achieve this as they are the West Essex Community Action Network, an alliance of local voluntary organisations set up to build stronger links between the voluntary sector and statutory partners for the benefit of the community in Harlow and Epping Forest.
- A new technology driven noise at night project launched this year which aims to reduce noise by using sound meters to show the sound level in decibels.
- Development of a project plan to procure new wheelchairs for bariatric patients.

Enabling kindness and compassion

- Development of projects focussing on enabling personalised care, such as on food and drink, discharge support, end of life care through the butterfly end of life volunteers hub, bringing greater visibility to the challenges of marginalised groups through board stories on maternal mortality, deaf-blindness and outreach to the community.
- Development of sensory and therapeutic gardens on the hospital site.
- Joint working with the Herts and West Essex Surgical Centre to support the development of adjustments for patient travelling to St Alban's for surgery who are usually treated at The Princess Alexandra Hospital NHS Trust.
- Chair of patient panel wins Unsung Heroes Award for Volunteer of the year 2024.



Compliments

We receive hundreds of compliments for every single one of our services. Here are a selection of just a few of those received in 2024-25.

"I attended Princess Alexandra Hospital on Saturday 22nd for a CT scan. I must say the young gentleman who done my scan was brilliant. Very kind caring and most helpful. Even pushed my wheelchair back to the reception area when my scan was finished. He was on his own wished I had taken his name. Cannot praise him enough. I do hope you find him and pass this message to him."

"I want to extend my appreciation to all the clinicians that were involved in my care starting with the triage nurse who was very polite and attentive, a young female radiographer who was sensitive and respectful to me when preparing me for the chest x-ray, and finally to the doctor who took the time and trouble to listen to my concerns and to address them in so far as he could despite his busy schedule. Dr N was also very polite and respectful when explaining the limitations of what was available in the A and E setting as opposed to through my GP".

"I am writing to say thank you to all of the staff working last night in the ED and Further Assessment Unit at PAH. From the receptionist to the observation nurse, streaming clinician and phlebotomist the journey took 20 minutes. Then a wait at the Further Assessment Unit for the blood results. What a nice touch bringing sandwiches round for those waiting. The staff at the Unit were also amazing and very efficient. Once in I had medication administered and a CT scan arranged within an hour".

"I am writing to you with nothing but praise for St Margaret's Hospital. I was referred there from my GP early last year and have been so impressed with the efficiency of the Breast Unit in particular. Everyone including doctors, radiologists, nurses and receptionists has treated me with kindness and care on all my visits and has explained everything to me as and when necessary.

Earlier this month I had to be admitted quickly to Princess Alexandra Hospital and once again I was treated with kindness and reassurance at a rather worrying time".

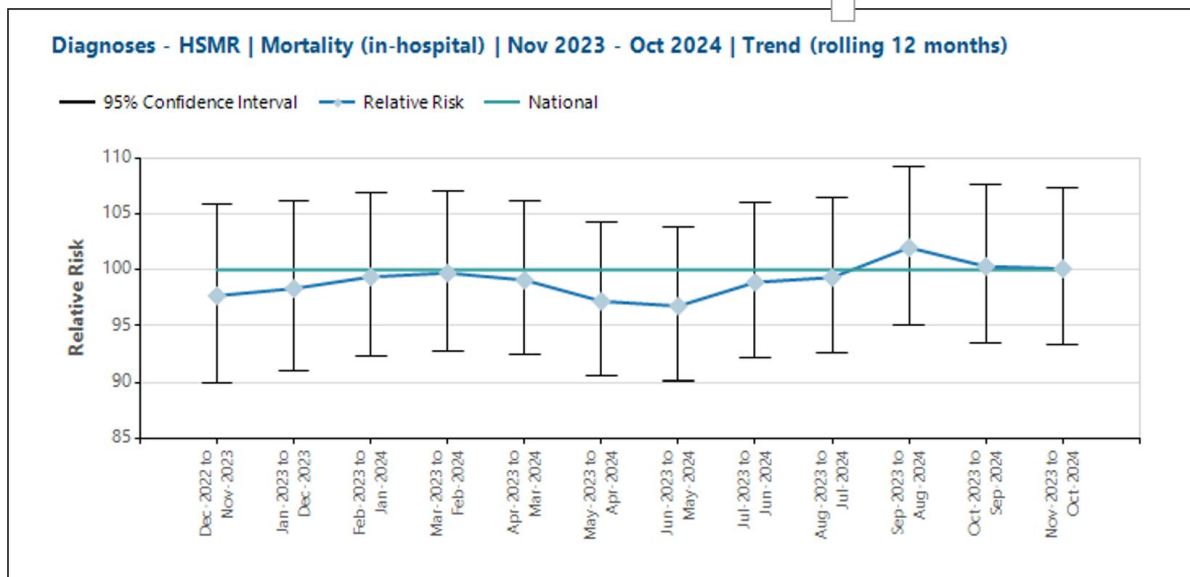
Mortality

The Trust has stable mortality indices (Hospital Standardised Morality ratio – HSMR and Standardised Mortality ratio - SMR) for the year 2024-25

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 November 2023 to October 2024 is 100.09 and "within-expected" as below:

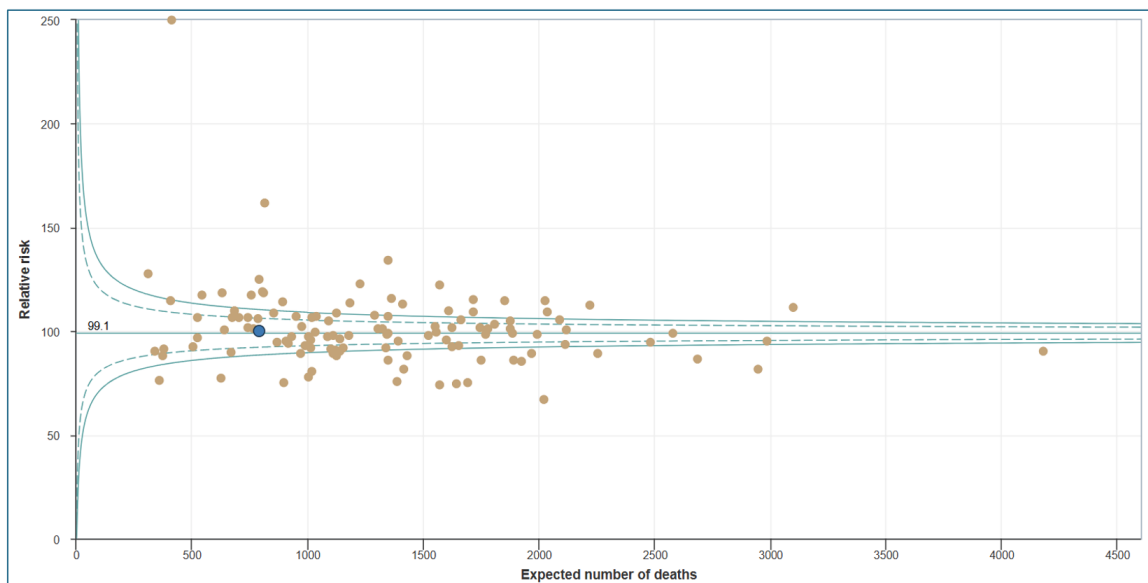
HSMR 12 Month Rolling Trend



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

HSMR | National Peer Comparison (Last 12 Months)

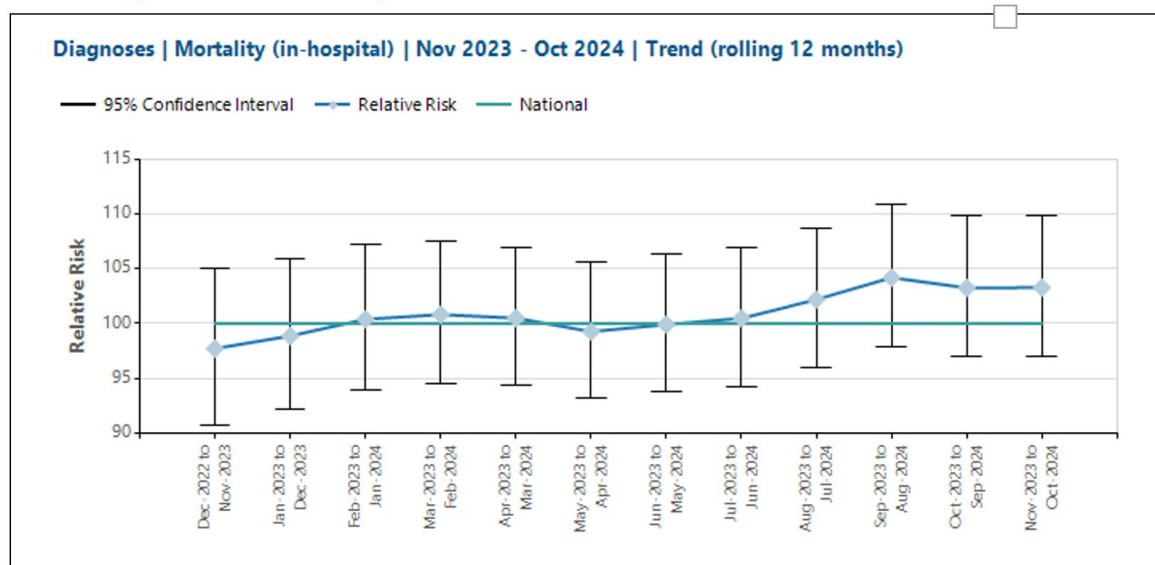
(PAH = blue; all other acute, non-specialists = brown)



The 12 month rolling SMR for the period November 2023 to October 2024 is 103.3 and “within-expected”.



SMR All Diagnoses 12 month Rolling Trend



In summary:

- The main mortality indices in 2024-25 are stable and are 'within expected'.
- 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

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 Trusts 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.
- AlexHealth (PAHT electronic health record) was implemented in November 2024. We anticipate there may be some data quality issues which we will be working jointly with our clinical, coding and Telstra teams to understand and rectify as they arise.
- 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
- A clinical Lead for Sepsis was appointed in 2024 to support excellence in the treatment of sepsis 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

Quality improvement



The most recent inspections of the Trust were completed by the Care Quality Commission (CQC) through unannounced focused inspections, this included a review of Trust wide Well Led Key Line of Enquiry in 2021.

The care services inspected were:

- Maternity care
- Medicine (including elderly care)

The most recent specific focused inspection was of the Urgent and Emergency Care department

The CQC completed an unannounced focused inspection of the emergency department in March 2023 to monitor our progress against the Trust action plan and review our performance against their Key Lines of Enquiry standards.

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

The recommendations received from the 2021 and 2023 CQC inspections were collated into individual projects and were updated by the relevant divisional teams using our quality improvement methodology to enable a consistent and sustained approach to the achievement of these objectives. Each project has a designated executive, a senior responsible officer (SRO) and we have appointed a quality project management team to provide additional support.

We used our CQC quality improvement plan as a dynamic document; during the year we have added additional improvement topics into it, as we identified further areas that required improvement. The quality improvement plan is monitored

monthly through the Clinical quality improvement group that reports into the Trust Compliance group and onto the Quality and Safety Committee.

Our people use the CQC inspection outcomes as the foundation upon which to critically examine our services and focus on how we plan and deliver the fundamental aspects of safe care. We have taken decisive action to change everyday activities, which have led to significant improvements.

The new CQC inspection framework was amended during 2024 and going forward the Trust has completed self-assessments against the quality statements.

The Trust is actively working across all our clinical services to measure our current performance position and identify the evidence we have in place to support each quality statement.

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. Due to portfolio changes within the senior management team the Director of Finance is now chair of the Health & Safety Committee, being the Director with delegated responsibility for health and safety within 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 & 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 principals 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 2025/5 the team has worked hard to continue with their inspection programme. These continue to be received well by the organisation. The team have also worked with the Divisions and Departments on several additional local initiatives.

The team has continued to promote positive health and safety working practices with the delivery of a manager's training module. The team are programmed to deliver sessions every 2 months as part of the ready to manage programme within the Trust.

The team has been instrumental in the project for new wheelchairs and hearing loops within the Trust, both of which are about to come to fruition. As well as this the manual handling lead within the team has been proactively working with the falls team, procurement team and wards to improve the complement of manual handling equipment available.

Safety Sub groups for the relevant HTM's (Health Technical Memorandums) had been set up and continued to be facilitated by the team throughout the year, to monitor

progress against issues, maintenance, compliance requirements set for each. The HTM groups cover, electrical, ventilation, fire, water, waste, medical gases, lifts. In turn these report into the H&S Committee, as referenced above.

Externally, the Essex Country Fire and Rescue service have undertaken a number of inspections of departments within the PAHT site as listed below:

Gibberd Ward	Stores (goods receiving)	MacMillan Bungalow
Basement	ADSU (Adult Day Stay Unit)	WDU (Williams Day Unit)
Paediatric ED	UTC (Urgent Treatment Centre) – prior to latest refurb.	Facilities Corridor including Mortuary

The actions from their findings have been managed by the Fire Safety Group (Health Technical Memorandum 0503). Notable improvements have been made in the basement including clearances and installation of new fire doors. We have also commissioned a full review of fire risk assessments, which is a long-term project expected to complete in September 2026.

Interaction with HSE has been minimal over this year, mainly in the form of RIDDOR (reporting of incident, dangerous diseases and occurrences regulations) submissions. Where relevant these have been followed up further.

Overall, the team has worked well with internal and external stakeholders, following up incidents and activities to support improvement.

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 lead to us being modern, integrated and outstanding for our patients, people, places, performance and pounds.’

Quality First Programme Focus and Scope

The quality improvement (QI) team have two key roles. The first, is to support the Trust in building quality improvement capability and capacity by providing learning and development as well as facilitating and coaching others to achieve their quality improvement aims and objectives. The second, is to manage improvement and transformation programmes and projects that address organisational risks or the realisation of strategy. The following improvement programmes are supported by the QI team:

- PAHT2030 Change Strategy
- Alex Health Transformation
- Outpatients Programme
- Urgent Care Programme (UEC, SDEC and discharge)
- Theatres

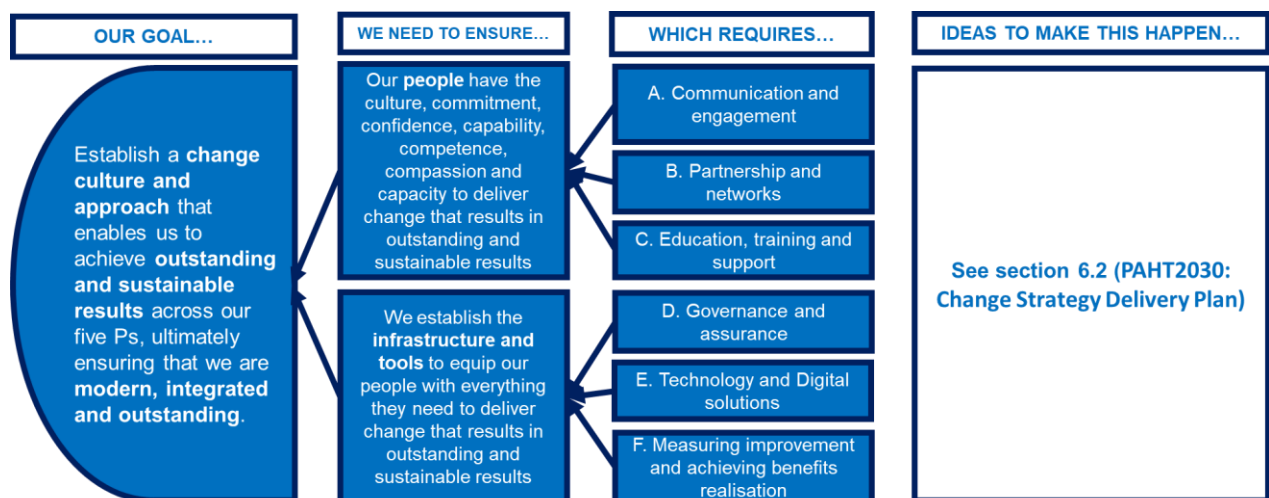
- MSK lead provider
- West Essex HCP Transformation (frailty, adult as well as children and young people)

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 that form the 'DNA' of all evidence-based improvement methods, these principles 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:



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. The Improvement Partnership is central to achieving this. Our goal is to equip all staff at appropriate levels with the improvement training and support so that everyone at PAHT can run improvement projects and improve their daily work.

As part of our 'PAHT2030: Change Strategy' we need to agree a 'dosing strategy' with divisions and corporate teams to better ensure staff have the capability and

capacity to deliver improvement. We have a proposed QI dosing model, which is based on guidance from NHSE, it includes a plan for numbers needing to be trained across PAHT, training course proposal and goals per staffing group.

This will encompass:

- Utilisation of those that are already trained in Improvement methodologies, this included Improvement Partners and QI Coaches
- Long-term QI training staff plan which includes roles/staff need to be trained at different levels of expertise and a trajectory for achieving this
- Plan to ensure all staff have a basic awareness of QI

Quality Management System (QMS)

Part of the PAHT2030 Change Strategy is to formally introduce a QMS. Much of this is in place; however, this is an opportunity to formally achieve a best practice approach built on the learning from other organisations that have change and quality improvement well established and embedded. The three elements of the QMS that is proposed are quality planning, quality improvement and quality control. 'People' are at the centre as a way of emphasising the fact that everything we do is enabled and driven by our people, which includes patients, partners and the wider community that we serve (as summarised in figure 1).

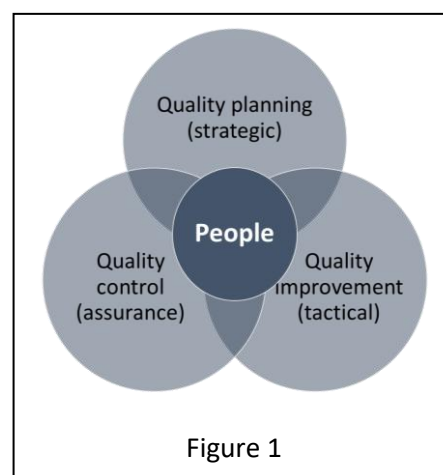


Figure 1

The three elements (phases) of the QMS of quality planning, quality improvement and quality control are explained below:

- **Quality planning** is a strategic process whereby we evaluate how a service or clinical area is performing and plan the quality priorities that need be addressed in order to redesign or shift these to a new level of performance to best meet the needs of our service users.
- **Quality improvement** is a consistent approach and methodologies to equip and enable us all to 'work together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.
- **Quality control** is about setting and meeting standards, benefits realisation, operational management tools to track and monitor data over time often against agree targets and trajectories.

People performance

In 2024-2025 the key workforce indicators for the year are reflected in the table below:

Table 2: People KPI	2024-25 target	Year to date performance
---------------------	----------------	--------------------------

Vacancy rate	9%	7.40%
Sickness absence	4.50%	4.46%
Voluntary turnover	12%	9.53%
Statutory and mandatory training	92%	89%
Appraisal	90%	78%
Time to hire	42 days	50 days

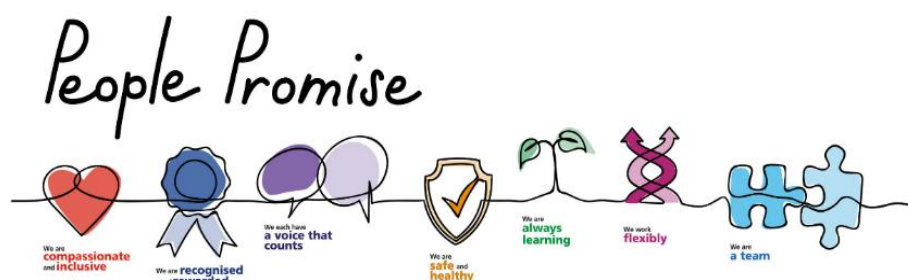
The five key pillars of the People Strategy are:

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

The focus of our NHS people plan 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

This is underpinned by:



Culture, Health and Wellbeing

The staff health and wellbeing team at PAHT is a nurse-led in-house service providing occupational health and wellbeing services which include:

- Pre-employment health screening

- Immunisation
- Self-referrals/Management referrals
- Health Surveillance
- Sharps/Body fluid injury management
- Seasonal vaccination campaigns
- Blood Born Virus management



The staff survey results showed a marginal reduction in our people feeling that we are keeping them safe and healthy. However the health and safety climate score has seen an improvement; this sub score includes the question relating to 'my organisation takes positive action on health and wellbeing' which increased by 0.76%.

As part of our focus on psychological support the Trust funded a psychological staff support service with Here for You (HFY) via EPUT after central funding ceased in January 2024. The Here for You (HFY) Staff support service is a core aspect of the Health and Wellbeing offer for staff at PAHT. While it is a specialist clinical service offering psychological assessment and intervention for staff and teams, the service also provides subject-expert led webinars and resources as well as consultation to the wider organisation and system.

People feeling safe to speak up and creating psychological safety remains a key focus for PAHT, there are currently 29 freedom to speak up (FTSU) ambassadors who have a wide range of ethnic and professional backgrounds. The guardians and the ambassadors continue to raise the profile of speaking up and deliver training and drop-in sessions across the organisation. There are also videos on Alexnet for staff to raise their awareness of how to speak up. The guardians work in collaboration with the Staff Health and Wellbeing team to ensure staff are supported through these situations.

In March 2025 the Trust had its first SEQOHS(Safe Effective Quality Occupational Health Service) inspection and achieved full SEQOHS accreditation for the next five years. The summary reported stated:

This is a well-managed, effective occupational health service that has done well to achieve accreditation at the first attempt. The service has effective and comprehensive operating procedures, and in interviews with team members, the assessors got a taste of a well-organised, happy, and supportive environment.

Our 'This is Us week' in June 2024 included the following health and wellbeing activities:

- Schwartz Rounds
- 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
- Vivup explaining the Employee Assistance programme available to all of our people.
- Retune workshop to which sets mental health in a musical context and offers a toolkit so that participants can measure their progress and discover what outlets work for them

Schwartz rounds continue to run in the Trust. These provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Feedback from the rounds continues to be very positive.

As well as the health and wellbeing activities for This is Us week a full programme of events took place throughout the week as outlined in the programme below:

 This is Us Week 2024 Join us at This is Us Week 2024, to recognise, develop and celebrate our amazing #PAHTPeople. Scan the QR code (right) to view the up to date schedule of events. One team... everyone has their part to play. modern • integrated • outstanding patient at heart • everyday excellence • creative collaboration		NHS The Princess Alexandra Hospital NHS Trust	Monday 24 June Connecting with our patients, people and volunteers	Tuesday 25 June Patient at heart
			All day events (all week) • Meet our teams – say hello and learn about the great initiatives our colleagues are working on, and bring your questions so that they can help you in real-time • Future focus – learn more about the future of healthcare technology, including robots and virtual reality • Our digital future powered by Alex Health – find out more and share your feedback (training room 2) • This is Me show reel – presenting your hidden talents, happy places and messages of thanks • Wellbeing sessions – tune in and tune out • Coffee roulette – an opportunity to get to know a colleague from a different team • Pets as Therapy – meet our furry friends • Walkabouts, giveaways, food vans, digital games, prizes and more • Hear about this year's Our Amazing People Awards and start thinking about your nominations • Allied health professionals career enhancement session (Monday 24 June, 12-3pm, training room 1) • Lunch and learn - dedicated Namaste training session (Wednesday 26 June, 12-2:30pm, training room 1)	
			9-10:30am: The Learning and Education Centre and via Teams • Welcome to This is Us Week 2024 - opening by Lance McCarthy, chief executive • Breakfast with... Shahid Sardar, associate director of patient engagement - sharing insights about patient personas	9:15-10:15am The Learning and Education Centre and via Teams Breakfast with... Michael Meredith, director of strategy and estates - creating spaces to optimise patient access and support our people
			10:45-11:45am The Learning and Education Centre and via Teams Learn about... Robotic surgery with Dr Vardhini Vijay, consultant laparoscopic and general and colorectal surgeon	10:30-11:30am The Learning and Education Centre and via Teams Learn about... The Patient Panel and their role in supporting our patients and people
			12noon-1:30pm The Learning and Education Centre and via Teams Team building - factors influencing team work with Silpa Dhaneesh, lead professional nurse/midwife advocate	12noon-2pm The Learning and Education Centre Schwartz Round – 'Patient at heart: A patient I will never forget' Includes a light lunch
			2-2:30pm The Learning and Education Centre and via Teams The DAISY Awards® winner presentation - hosted by Giuseppe Labriola, deputy chief nurse	2:30-4pm The Learning and Education Centre and via Teams Wellbeing o'clock with Vivup - understand the services our Employee Assistance Programme can offer you
			2:45-4:15pm The Learning and Education Centre and via Teams Wellbeing o'clock with Here for you - psychological support service for our people	4-6pm The Learning and Education Centre and via Teams Retune (mental wellbeing)
Wednesday 26 June Everyday excellence		Thursday 27 June Creative collaboration	Friday 28 June Reflection and wind down	Saturday 29 June Celebrate
9:15-10:15am The Learning and Education Centre and via Teams Breakfast with... Tom Burton, finance director - balancing the books and planning for the future		9:15-10:30am The Learning and Education Centre and via Teams Breakfast with... Deji Akinyemi, learning and development consultant - the leadership coin	9:15-10:15am The Learning and Education Centre and via Teams Breakfast with... Phil Holland, chief information officer - powering our digital future with Alex Health	
11am-12:30pm The Learning and Education Centre and via Teams Join our executive team to ask questions about PAHT2030 plans and the 5Ps		11am-12:30pm The Learning and Education Centre and via Teams Learn about... Our staff networks and how they can help make PAHT a safer place to work	10:30-11:45am The Learning and Education Centre and via Teams Learn about... Building mental resilience with Ian Beckett, representing Kintsugi Hope	
12:30-1:30pm The Learning and Education Centre Quality improvement and our PAHT people - your experience and how quality improvement can support you		1-2:30pm The Learning and Education Centre and via Teams Leadership stories from inspirational colleagues... with Deji Akinyemi, learning and development consultant	12:30-2pm The Learning and Education Centre and via Teams Wellbeing o'clock... Laughter yoga - an opportunity to gather and laugh. A non-religious, non-political event that does not involve any yoga, just heaps of laughter.	12:30-3:30pm On the green outside Parndon Hall
1:30-2:30pm The Learning and Education Centre The future of robotics with Patrick Holthaus, senior research fellow in the Robotics Research Group at the University of Hertfordshire		2:30-4pm The Learning and Education Centre and via Teams Wellbeing o'clock... Menopause café - an open place to gather and speak about the menopause.	2:30-3:30pm The Learning and Education Centre and via Teams The big thank you and 'this is me' competition winners – live	PAHT summer BBQ
2:30-4pm The Learning and Education Centre and via Teams Wellbeing o'clock with Andy's Man Club (men's suicide prevention charity) - ending the stigma surrounding men's mental health				

Workforce resourcing and planning

The Trust has continued to recruit both from the UK and overseas with an overall vacancy rate of 7.40% at the end March 2025 with a qualified nursing and midwifery vacancy rate of 5.47%. Allied health professional vacancies have reduced by 12.48% in 2024-25 and are now at 8.27%

A second cohort of the Project Search programme launched in 2024-25 with 8 people participating. The programme is a business-led, one-year work-preparation programme for young people with intellectual and developmental disabilities.

From the 2023 - 24 cohort, 4 young people have successfully transitioned into employment. Of these, 3 individuals secured positions within PAHT, showcasing the positive impact of our internal placements. One individual has found employment opportunities externally, demonstrating the broader reach of our initiative.



As part of our ongoing commitment to building a sustainable, inclusive local workforce, the Resourcing team has significantly expanded its outreach and engagement activities over the past year. Working closely with community partners, educational institutions, and employability services, we've strengthened pathways into healthcare careers and ensured our recruitment activity reaches a broad and diverse audience. Key highlights include:

Strategic Partnership with Harlow College:

- We formalised our collaboration by signing a Memorandum of Understanding (MoU) with Harlow College, agreeing to co-develop a Health and Science Academy. This initiative, modelled on the successful Stansted Airport College, will provide structured routes into healthcare careers for young people across the region.

Targeted engagement events with young people:

- Recruitment events specifically tailored for Health and Social Care leavers at Harlow College
- Support for school careers fairs, raising awareness of NHS career opportunities and inspiring the next generation of healthcare professionals.

Pre-employment support for jobseekers in partnership with the Department for Work and Pensions (DWP):

- Supported pre-employment programmes for DWP customers in partnership with Harlow College
- Monthly application and interview skills workshops at Jobcentre Plus and Harlow Library, helping individuals gain the skills and confidence to enter the NHS workforce.

Inclusion-focused career fairs that we proudly participated in:

- The Spectrum Works careers fair, a targeted event co-hosted by DWP and Harlow District Council for adults with learning disabilities or autism
- The REED in Partnership Careers Fair, connecting with a wide range of jobseekers and promoting inclusive employment opportunities
- Ran our first Essex Cares Limited (ECL) Innovation Day, showcasing careers in care and support services to those exploring new career options

These activities demonstrate our proactive and inclusive approach to recruitment, ensuring that we not only attract top talent but also offer accessible pathways into NHS careers for all segments of our community.

We have developed our workforce plan aligned to finance and activity for 2025-26. The plan aims to further reduce agency spend along with reviewing current roles in the Trust.

Optimising Technology

In the last year we have implemented a case management system to track all of our employment relations cases to support turnaround times and greater depth of reporting.

AI assisted shortlisting for recruitment processes began as a pilot in Q4. We continue to work towards maximising Electronic Staff Record (ESR) functionality in order to be able to be part of the new ESR rollout with full implementation expected in 2027 subject to national procurement.

Quality improvements on the internal payroll and recruitment process has enhanced efficiency and reduced pay errors due to automation of repetitive tasks, going paperless and the ongoing feedback mechanism within the teams.

The work experience team at PAHT co-designed the ICS work experience portal.

New service and workforce models

In 2024-25 we saw the successful TUPE transfer of pathology services to HSL as part of an ICS contracted service.

Learning, leadership and team development

Earlier in 2024, following the results of the annual staff survey (2023), the OD department prepared survey analysis and materials for each division and subdivision. 'Feedback To Action' leads were appointed, with workshops held to discuss results and generate improvement action plans.

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

1. People Promise: We are always learning
2. People Promise: We are safe and healthy
3. This is Us management practices and leadership promise

The Learning and OD team continued to build on our existing learning, leadership and team development offerings to support the action plans, and have introduced many new initiatives. For example, we have:

- Consolidated our 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. We have also designed and launched a digital appraisal system including a review of training and identifying development needs for the coming year.
- Re-launched the 'Ready to Manage' programme for staff with management responsibilities. The programme includes 16 different half-day, face-to-face modules, covering management essentials. 88 different module sessions were held at our Learning and Education Centre to improve management and leadership skills. 304 employees in a supervisory/management/leadership role attended at least one module.
- Oliver McGowan training for autism awareness was released including two e-learning modules and externally facilitated in-person sessions for patient facing staff.
- 546 employees attended the 2-day corporate induction designed to ensure that employees are work ready, covering a combination of mandatory training, safety, values, healthcare and cultural essentials.
- 175 staff joined our 'New Employee Forum' sessions, where new employees (within the first 3 months of service) have the opportunity to meet with the executive leadership team over the course of an afternoon.
- We engaged NHS Elect to improve patient experience through training of our bookers and receptionists in customer service skills.
- We continue to review all staff training profiles in a collaborative multi-disciplinary effort to ensure standardisation and consistency of role specific training needs.
- Achieved the Gold Award for Work Experience Quality Standard.
- Arranged 184 work experience placements across the Trust.
- Arranged work experience for our first cohort of 24 health 'T-Level' students from our local college (Harlow College).
- Increased the number employees on apprenticeships to 108

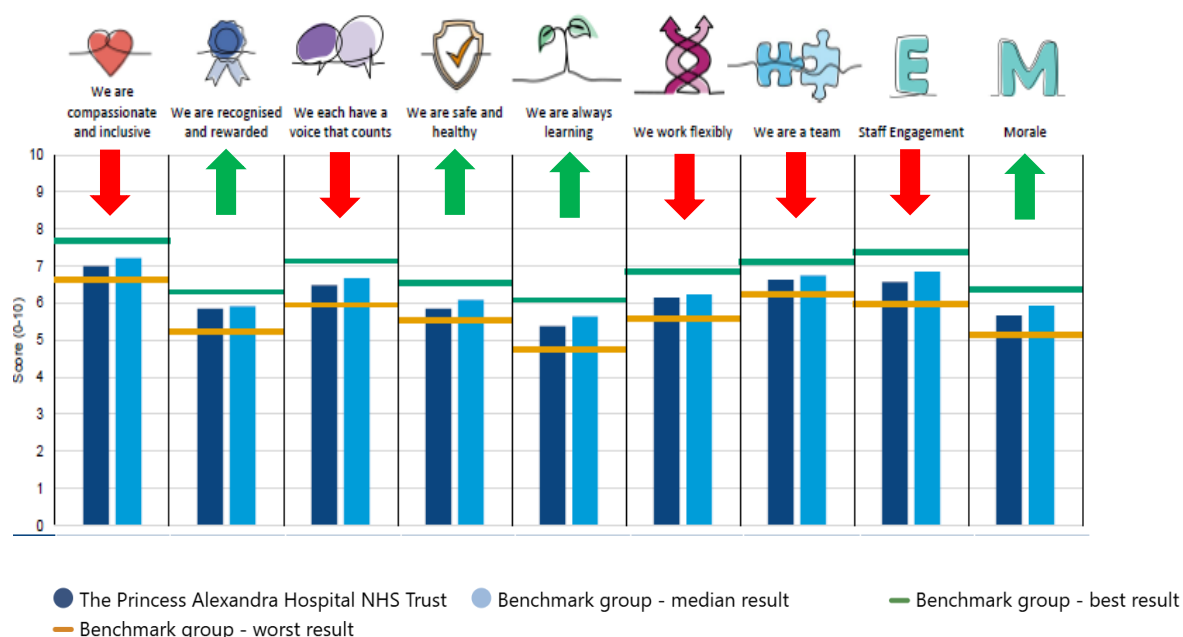
- Trained approximately 1000 employees through our CPD funds.
- Initiated First Aid at work training through St. John's Ambulance, for non-clinical staff, improving staff safety.
- Provided a variety of personal development opportunities through NHS Elect webinars focussing on interpersonal skills, building relationships, as well as developing a healthy mindset, resilience and conflict resolution.

We continue to support our ICS training schemes and four of our employees enrolled in the Mary Seacole programme. We continue to be successful in being allocated NHS graduates through the National Graduate Management Training Scheme (GMTS), taking on one more trainee in 2024.

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 2024 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. Over 2000 of our people completed the National Staff Survey in 2024. The response rate was 49%, a 1% decrease on 2023. 25% of respondents shared a free-text comment which offered further insights about specific issues important to our people. We achieved an improvement on the previous National Staff Survey results across four elements including morale, however declined in other areas such as engagement.



Two important questions showed no change/improvement:

1. Would you recommend PAHT as a place to work? This achieved 50%, which is equal to last year.
2. Would you be happy with the standard of care if a friend or relative needed treatment at PAHT? This achieved 46%, which is a 1% decrease on last year (47%).

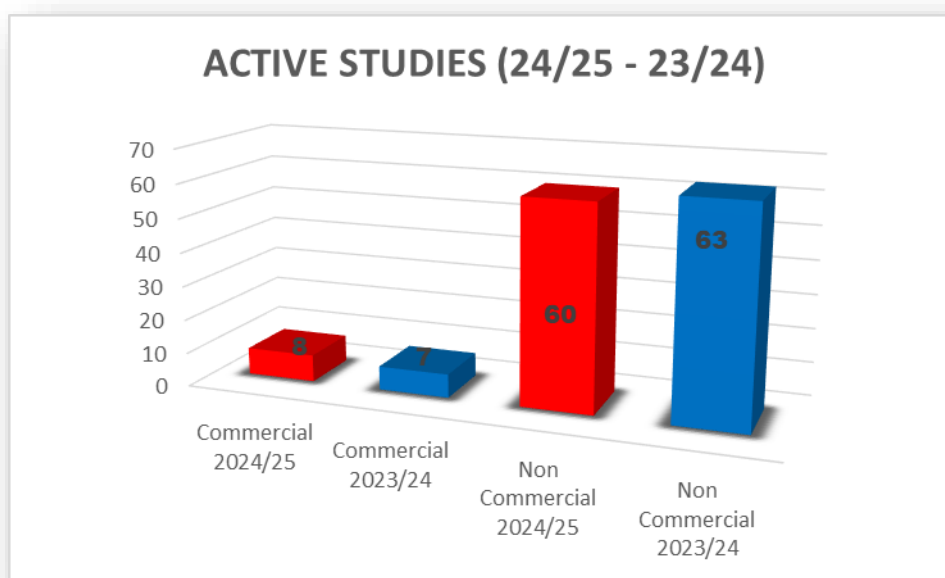
The executive board has identified three key areas for all divisions to concentrate on within their 2025 improvement and engagement plans;

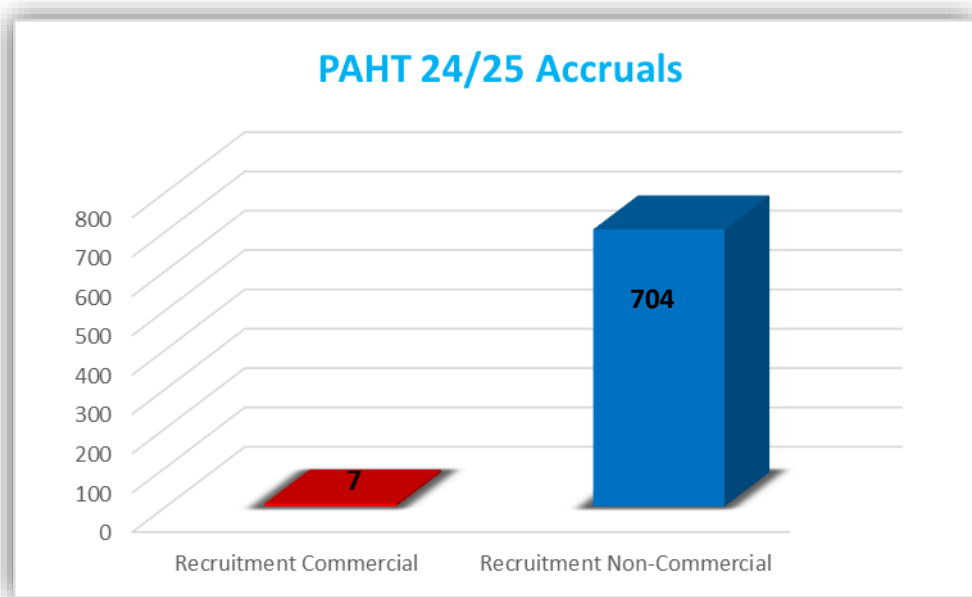
- People Promise: We are compassionate and inclusive
- People Promise: We are a team
- People Promise: We are recognised and rewarded

Furthermore, each division is to fully review the findings specific to their department and sub-departments and add any additional areas of focus to their engagement plans.

Research, development and innovation at PAHT

There were 8 commercial portfolio studies and 60 non-commercial studies open throughout 2024- 25.





The overall recruitment for 2024-25 is 711, made up of 7 recruits to our commercial studies and 704 to our non-commercial.

Research recruitment per speciality

		FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425	FY2425
Division	Managing Speciality	Total	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Division 1	Division Total	92	5	6	3	5	14	7	10	9	7	10	5	11
Division 1	Cancer	92	5	6	3	5	14	7	10	9	7	10	5	11
Division 2	Division Total	24	-	13	11	-	-	-	-	-	-	-	-	-
Division 2	Metabolic and Endocrine Disorders	24	-	13	11	-	-	-	-	-	-	-	-	-
Division 3	Division Total	16	10	1	-	-	-	1	2	-	-	-	-	2
Division 3	Children	10	10	-	-	-	-	-	-	-	-	-	-	-
Division 3	Reproductive Health and Childbirth	6	-	1	-	-	-	1	2	-	-	-	-	2
Division 5	Division Total	2	-	-	-	-	-	-	-	-	1	-	1	-
Division 5	Diabetes, Metabolic and Endocrine	2	-	-	-	-	-	-	-	-	1	-	1	-
Division 6	Division Total	567	30	56	47	56	54	27	32	31	43	26	30	135
Division 6	Anaesthesia, Perioperative Medicine and	35	1	7	5	2	6	2	3	2	2	1	2	2
Division 6	Critical Care	45	1	4	1	6	5	1	6	2	5	5	7	2
Division 6	Ear, Nose and Throat	11	7	2	-	-	1	-	1	-	-	-	-	-
Division 6	Gastroenterology and Hepatology	11	2	2	1	3	2	-	-	1	-	-	-	-
Division 6	Infection	92	-	-	-	-	-	-	-	20	36	18	18	-
Division 6	Respiratory	41	-	6	13	5	4	7	-	1	-	2	3	-
Division 6	Surgery	145	15	28	18	30	24	9	18	3	-	-	-	-
Division 6	Trauma and Emergency Care	187	4	7	9	10	12	8	4	2	-	-	-	131

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.

By understanding what we can do better to provide and maintain the very best environment to deliver and receive care, we have invested capital and backlog to directly support our patients and people.

Capital Investment

During the last year we have invested over £8m in the estate, transforming a number of key areas through Capital Projects that bring significant improvements to our operations particularly supporting Urgent & Emergency Care, Eye Surgery, Digital Health Record implementation, selected inpatients wards including Tye Green, Harold and Kingsmoor and public toilets in the Outpatient Department and Maternity waiting area. Physical work on a new Community Diagnostic Centre (CDC) started in January 2025 at the St Margaret's site in Epping, planned for completion in December 2025.

New Hospital and Backlog investment

With construction of the new Hospital now confirmed to start from 2032 we continued to invest in critical infrastructure risk backlog maintenance associated with fire detection and compartmentation, power supplies, heating, ventilation and air conditioning, domestic water supplies and waterproofing roofs. Investment in the main production kitchen, new ward kitchen fridges and domestic and housekeeping office refurbishment all directly supporting patients and staff with quality catering and maintaining high standards of cleanliness and hygiene. Upgrades and expansion to the CCTV and access control system increasing security for all. We are undertaking a review of our entire Estate and are developing an Estates Strategy for the next 10 years. We have employed healthcare-built environment experts to undertake surveys of our critical infrastructure and clinical and support environments to identify priorities and risk based capital investment plans so we use limited capital wisely.

Sustainability and the environment

We have a responsibility to improve our sustainability performance which supports the health of our local population, patients, people and the planet. We implemented a number of initiatives to reduce our environmental impact in line with wider NHS green targets. Including more stringent waste segregation to achieve the 60/20/20 requirement for clinical/high incineration /domestic higher levels of recycling and repair of furniture to avoid disposal, cardboard and building and metals recycling. We successfully bid for and received £431,000 National Energy Efficiency Fund (NEEF) Funding from NHS England to install LED lighting and air conditioning controls optimising operating times to minimise energy consumption.

Specific Capital Investment supporting our Patients

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:

- Installation of new 2 storey EHR Training build now Alex health Hub Creation of a new HV/LV transformer building to Northside with new UKPN supply to provide site resilience and Trust owned connecting switch panel.
- Upgrade of main kitchen to meet EHO requirements for serving.
- Upgrade of main Alex Restaurant areas for all users.
- Removal of nitrous oxide gasses from Main Theatres to meet National guidance along with 50 new AVSU's across site to provide safer and better control and monitoring
- Installation of new compliant fire doors and compartmentation works in main basement with Essex Fire Brigade approval
- Installation of new upgraded AGSS ventilation systems to ADSU/Endoscopy building for compliance and safety Enabling works for new robot in Theatre 6 suite
- New site wide enlarged and new waste bin enclosures for compliance and segregation
- ED – general improvement works to comply with national standards including flooring, wall coverings and ligature safety, upgrade of dirty utility/fluid store and staff room enlargement.
- Maternity – upgrade of birthing pool room 1 to suit new larger pool
- Creation of a new Mental Health room in Charnley ward
- Light refurbishment works on clinical wards including staff and support areas and common areas working with Dementia Champion
- Minor upgrade works on Harvey ward to achieve Condition B in common and patient areas
- Upgrade works in Fleming ward to clean utility, critical store rooms, staff room and common areas
- Upgrade of Doctors Mess area to meet BMA guidelines.
- Installation of new metal fire doors to site wide plant room and roof top areas with access control
- Installation of new air handling units serving clean and dirty areas of CSSD
- Installation of new HTM compliant air handling units serving ADSU Theatres 3-4.
- New Public Address system installed into main ED and supporting areas
- New Vanguard eye theatre set up supporting role on site in car Park 2
- Completion of many projects within the Backlog Maintenance capital funding streams covering, Statutory Fire, HVAC, Drainage/Water, Environmental across site.
- Installation of site side new fully reporting emergency lighting systems
- Installation of new oxygen ring main to provide resilience and future proofing
- Creation of new external dementia and sensory gardens with Charity funding support for all users

Capital Investment support our amazing people

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

- Upgrade works to Oslo House offices
- New heating and cooling systems across site
- Upgrade of old safeguarding modular unit for agile working
- Upgrade of main kitchen for a more compliant working environment and achievement of 5* Food Safety Rating
- Installation of new upgraded AGSS ventilation systems to ADSU/Endoscopy building for compliance and safety
- Light refurbishment works on 7 No Care of the Elderly /Dementia Clinical wards
- Minor upgrade works on Harvey ward to achieve Condition B in common and patient areas
- Upgrade works in Fleming ward to clean utility, critical store rooms, staff room and common areas
- Upgrade of Doctors Mess area.
- ED – general improvement works to comply with national standards including flooring, wall coverings and ligature safety, upgrade of dirty utility/fluid store and staff room enlargement.

Annual Sustainability Report 2024-25

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 Trust 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.

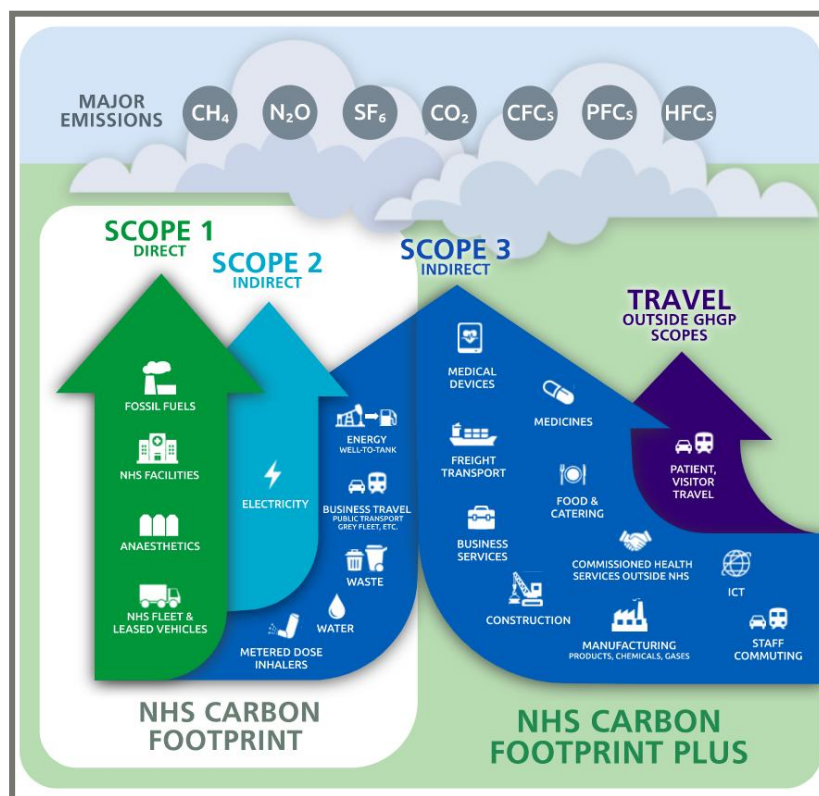


Figure 1: Green House Gas Protocol (GHGP) scopes in context of the NHS (Delivering a Net Zero National Health Service, 2020)

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. Our Green Plan will be updated this year, to run from 2025 to 2028.

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 2024/25.

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 Chief Finance and Infrastructure Officer (CFIO) is 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 has implemented a Sustainable Procurement Strategy in line with the NHS PPN06/20 and PPN06/21 policies on sustainable procurement.

Capital Projects

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

Progress made:

- The Trust received National Energy Efficiency funding of £359,000 plus VAT to complete the switch to LED at the main site, as well as add controls to our cooling systems to reduce energy usage. These will be installed in the first six months of 2025-26.
- Construction of the Community Diagnosis Centre is underway and has been designed to achieve a BREEAM "Excellent" rating throughout all stages of the build.

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 engaged an energy and sustainability consultancy to monitor, manage and audit activities to ensure our energy usage reaches the minimums required to operate effectively.
- 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).

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. Where items can be repaired to extend their life, such as chairs for waiting rooms this has also been undertaken.
- 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.
- The waste team have been investigating on site disposal of waste, to further reduce the carbon footprint associated with waste management, including new on-site processing options.

Carbon Emissions

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

Progress made:

- The Trust received National Energy Efficiency funding of £359,000 plus VAT to complete the switch to LED at the main site, as well as add controls to our cooling systems to reduce energy usage. These will be installed in the first six months of 2025-26 and is expected to yield a reduction of 53 tCO₂e, with full measurement and verification being conducted throughout 2025/26.
- To improve energy consumption data, upgrades are underway of the Building Management System (BMS) connectivity of the platform to meters and the installation of additional submeters.

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 now completed, expected to reduce the Trust waste of nitrous oxide by 60%.
- 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.

- In November 2023, a Green Travel Plan was published detailing the actions the Trust should undertake to achieve its goals, which has been implemented fully in the last year.
- A staff car salary sacrifice scheme has been implemented that encourages the procurement of 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.

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.
- The green spaces on our site have been protected from parking and damage, through use of car park monitoring to ensure the site remains as intended.
- We have successfully planted 130 trees and 2160 shrubs, generously provided by the Forestry Commission, into our natural landscape. This initiative not only enhances our natural environment and biodiversity, used by staff and patients but also contributes to long-term carbon sequestration.
- Work commenced in 2025 to construct a 'dementia garden'; a space that helps patients but will also in turn provide better outdoor spaces for staff to enjoy their local environment.

3.0 Energy

3.1 Gas and Electricity

The Trust has been committing to reducing its energy consumption over recent years; the impact of the increased fuel prices following the conflict in Ukraine in 2023 has placed a renewed focus on energy management and in this time, the Trust has entered into a partnership with an external management consultancy to mitigate costs.

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

There has been a 22% decrease in electricity and an 8% increase in gas usage from the previous year, resulting in an overall reduction of 27% in carbon emissions.

RESOURCE	Unit	2022/23	2023/24	2024/25
Gas	MWh	13,662	11,868	12,867
	tCO ₂ e	2,919	2,530	2,353
Electricity	MWh	11,341	13,198	10,357
	tCO ₂ e	2,966	3,600	2,122
Total Energy	MWh	25,003	25,066	23,224
Total Carbon Emissions	tCO ₂ e	5,885	6,130	4,475

Table 1: Gas and electricity consumption and carbon emissions 2022-23 – 2024-25

The graph below shows gas and electricity consumption between 2022-23 and 2024-25.

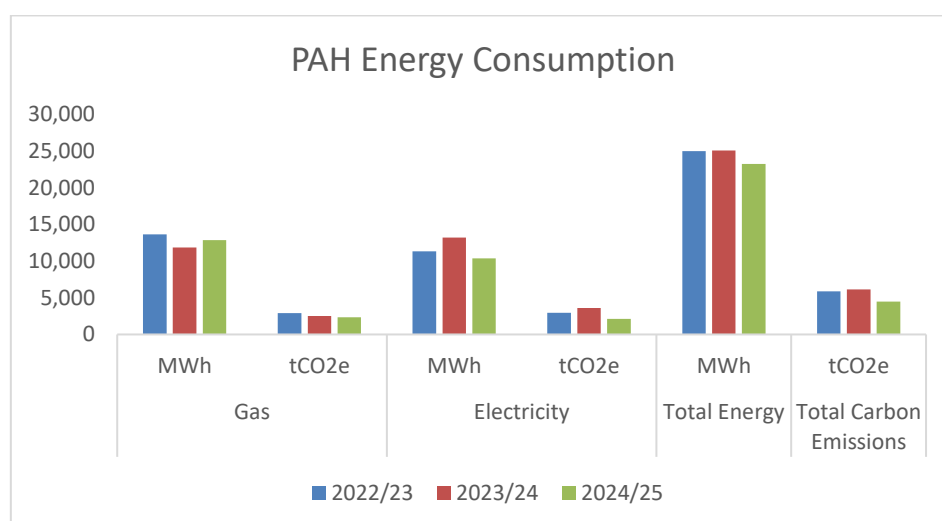


Figure 2: Gas and electricity consumption 2022/23 vs 2024/25

4.0 Waste

The Trust has been recording a comprehensive set of waste types since 2019 and reporting through the Estates Returns Information Collection (ERIC). This year we started to weigh food waste which now provides a more representative measurement.

We continue to invest resource to increase granularity and accuracy of our measurements to monitor our generation of waste and the effectiveness of waste reduction initiatives. There were segregation and measurement issues in 2023/24 which resulted the more Clinical Hazardous and significantly lower Clinical Non-hazardous waste measurements. Segregation issues have been addressed by training clinical and nursing staff in appropriate waste management principles.

FY 2022-23 - 2024-25			
Waste Type	22/23	23/24	24/25
General	657	569	645
<i>Recyclables</i>			
- Organic (food)	19	19	71
- Metals	8	8	11
- Cardboard	11	11	7
- Confidential	97	104	105
- Dry Mixed Recycling (DMR)	1	1	9
<i>Clinical Waste</i>			
- Clinical - Non-hazardous (offensive waste)	294	22	107
- Clinical - Hazardous	373	548	471
Total	1,458	1,281	1,426

Table 2: Waste by type 2022-23 to 2024-25

The graph below illustrates various types of waste streams.

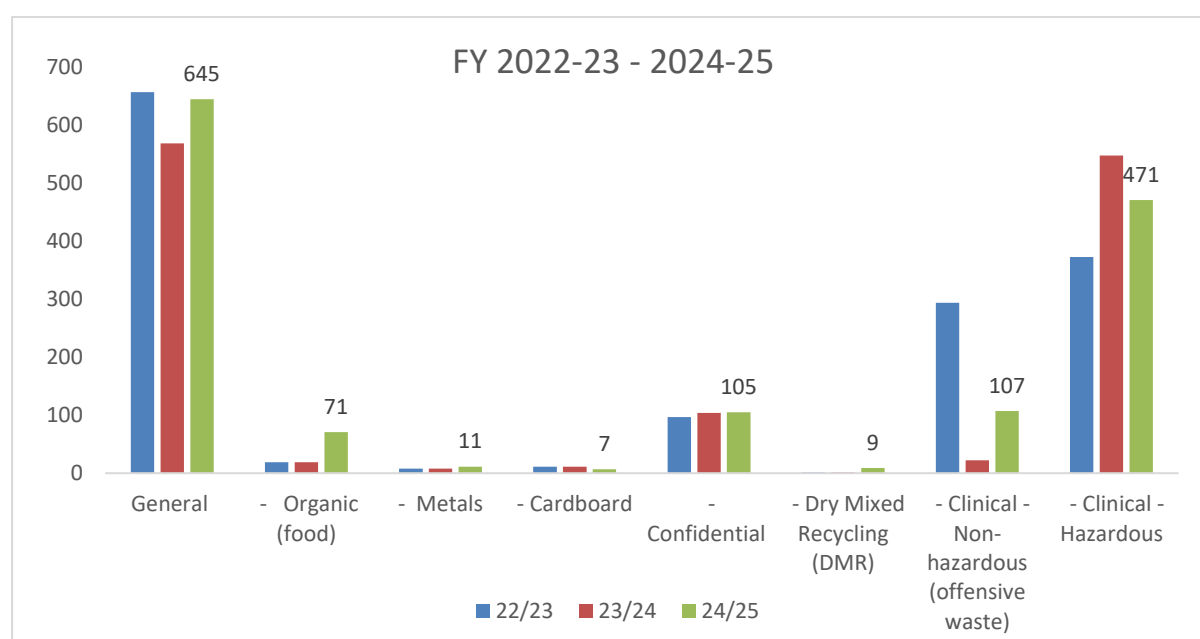


Figure 3: Volume of waste from 2022-23 – 2024-25

5.0 Water

The Trust used 128,562m³ of water in 2024/25. Whilst the consumption has risen from the previous year, the Trust have reduced water consumption by 21 million litres since 2021-22.

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 2.2 m³/m²/year. We aim to investigate technologies that can reduce water use even further.

Water	UNIT	2021/22	2022/23	2023/24	2024/25
Volume	m ³	149,484	141,485	116,108	128,562
Carbon Emissions	tCO ₂ e	55	52	39	42

Table 3: Water usage and carbon emissions 2021 - 2025

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

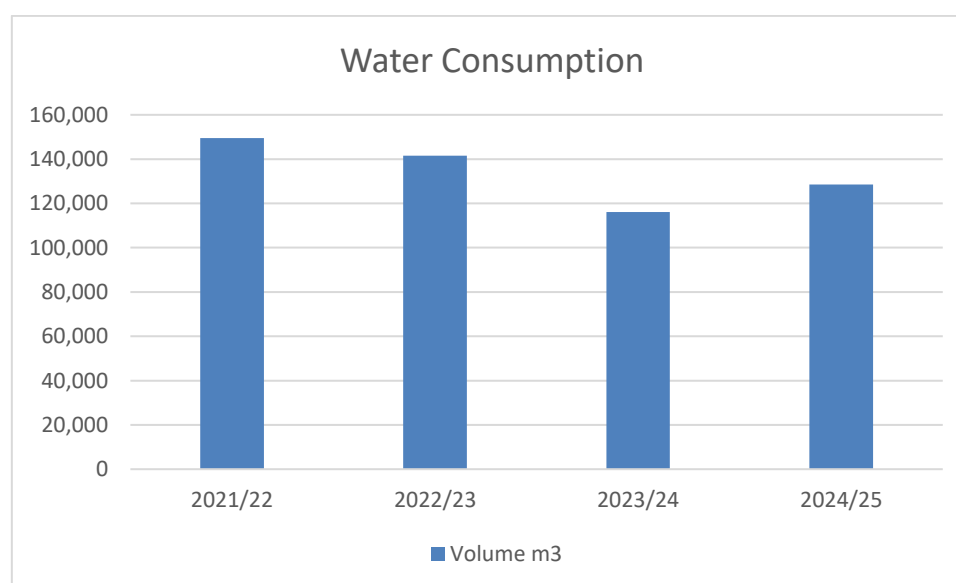


Figure 4: Water usage 2021 - 2025

While we remain committed to minimising our water usage, it should be acknowledged that we operate in an aged estate with compromised pipework and the issue of leaks has caused us issues historically. We have as a consequence invested hundreds of thousands of pounds in the pipework infrastructure in each of the last 3 years and continue to do so prospectively.

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. However, with the delay of our new site, which we expect to be built by 2035, the Trust have taken the strategy to use on site equipment to reduce carbon, instead of fully decarbonising before 2040. This ensures that our equipment is fully utilised, and improvements in carbon emissions are through minimal cost interventions instead of largescale capital equipment. The cost of decommissioning the steam heating system around which the Trust was constructed remains significant and it is not currently economically or operationally possible to install a modern system within the Trust.

7.0 Looking ahead to 2025-26

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 2025/26, 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 October 2025.
- The Heat Decarbonisation Plan will be reviewed an update by October 2025, the Trust will continue to work through the goals and actions laid out in the Plan to improve the efficiency and usage of 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 April 6th, 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 2024/25 is the second 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 and will be further detailed in our upcoming refresh. 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

- The Trust's commitment to managing climate change forms part of the Trust's overall strategy and has been discussed at the Trust's Strategic Transformation Committee (STC). We appreciate the environmental impact of our operations and take our green obligations seriously.
- The Trust Board delegates the reporting of adherence to the Trust's green plan to the Performance and Finance (PAF) committee; a sub-committee of the Trust Board. Reporting takes the form of a quarterly update and an annual report on the Trust's Sustainable Development Management Plan and Carbon Reduction and Sustainability Strategy.
- The Trust received the annual report on Sustainable Development at Executive Committees namely, the Trust's Strategic Management Team Meeting (which became Executive Board late in 2024/25) and ultimately this is the route through which it is reported prior to review at PAF.
- Wherever relevant, business cases are assessed against their environmental credentials and approved accordingly. One such example is the approval of the Trust's Inventory Management System (IMS) in 2024/25 which was in part approved due to its ability to minimise expiring stock and hence improve waste. A key objective from the implementation of the Trust's Electronic Health Record (EHR) was the reduction in the use of paper records and physical movement of large paper records between sites.
- The development of the green plan is the responsibility of the estates team reporting to PAF. Environmental concerns are considered as part of big strategic projects (such as the new hospital programme or community diagnostics centre) and an aspect of the estate's strategy work is included within the strategic planning for these projects. In addition, the Trust has re-commissioned a Six facet survey of the Trust's infrastructure in 2025/26 (commencing with the core 4 facets) and the outcome of any findings will be actioned in 2025-26.
- The Trust has a role for a dedicated sustainability manager within the team structure however in 2024/25, this role was unfilled with the responsibilities addressed through the employment of a dedicated external provider, Low Carbon Europe (LCE).

At Princess Alexandra Hospital, 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 Chief Finance and Infrastructure Officer (CFIO) and the Performance and Finance Committee (which meets monthly), has oversight of the Trust's Sustainability Plan, development of 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, which meets quarterly.

All of our current climate related policies are reviewed regularly, and reported through our PAM submission each year.

The above groups work to assess the climate related issues, including those covered by other premises assurance documentation such as fire, adverse weather and flood, and develop any changes to those policies.

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 has drafted a Business Impact Assessment which includes fire and flooding plans and details of a scenario analysis to identify the main transition risks and opportunities impacting the Trust. In the coming months, we will continue to develop our Risk Assessment Frameworks.

Risk Management

The Trust works with regional and national leads to manage a number of environmental risks including:

- Heat stresses for patients
- Air pollution (in line with the Green Plan for Harlow)
- Water supply
- Infrastructure vulnerability (including instances where there are catastrophic failures in supply e.g. water mains)
- Extreme weather events.

In all instances, our ability to respond is to some extent limited by the aged infrastructure within which we operate. However, we always proactively seek to mitigate any risks arising through our normal risk management procedures:

The Trust is assured through the work of the Trust's Risk Management Group which works with the health and safety committee to quantify and assess all known risks on a best practise, 5 x 5 scoring matrix. This includes the estates risk on the Board Assurance Framework which encompasses elements of the green plan.

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's Risk Management Group. Climate change risks that meet the threshold are then added to the Corporate and Trust-wide risk registers.

The field of climate risk is emerging and we are currently developing our approach to risk scoring with regard to specific climate risks in the Trust and hope to build on the outcomes of our impending Six facet survey in future years. .

We recognise that we need to do more in respect of the overall climate risks but can evidence significant measures taken to evidence progress in respect of our obligations.

Metrics and Targets

- The Trust implemented a new Electronic Health Record (EHR) in 2024/25. The new system has had impacts in respect of reporting capability within the Business Intelligence (BI) function but we are looking to develop a dedicated dashboard for the environmental domain in 2025-26 which individual services can drill into to assess their compliance against a suite of corporate objectives. The outcome of this new dashboard will be presented from 2025/26 onwards.
- As reported above, water and energy consumption (both gas and electric) are reported at a macro level along with waste volumes at a Trust level. We are looking to improve on recent years performance in the future.
- The new Associate Director for Estates and facilities is now in post; this is the first time the role has been permanently occupied since 2022/23 and they are looking more holistically at a suite of targets for 2025/26 and beyond.
- The Trust maintains a number of high level strategic objectives, linked to site transformation (e.g. the New Hospital) and has agreed the following objectives:

Attainment of net zero, in line with NHS guidance with:

- 80% reduction of controllable emissions from 2028-32.
- For influenceable emissions to reduce by 80% from 2036 – 2039
- With net zero achieved by 2045

Note: this is subject to any changes arising in line with the long term national objectives and / or 10 year plan.

- The Trust is designing its new hospital to be fully electric, using modern methods of construction and minimising energy wastage.
- The Trust has waste contracts in place which emphasise the importance of recycling and waste segregation with penalties for noncompliance assumed within the terms of each arrangement.
- The Trust is developing a green transport plan and is working with Local Authority partners on a green plan for Harlow. Measures have been taken early

in 2025/26 to disincentivise travel to the site by car through increased car parking charges at the main site.

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 keeps 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. The 2024/25 footprint will be included in our new Green Plan.

Tackling health inequalities

The Trust is committed to reducing health inequalities in line with its commitments under the NHS England 2024-25 Priorities and Operational Planning Guidance, the Hertfordshire and West Essex Integrated Care Board (ICB) priorities and as part of our local Health and Care Partnership. By leveraging our patient experience strategy —“Listening, learning, leading,” PAHT is improving communication, using technology inclusively, and fostering kindness and compassion.

Implementing the Core20PLUS5 Approach

Objective: Target the 20% most deprived populations, inclusion health groups, and five clinical areas (cancer, cardiovascular disease, respiratory disease, maternity, mental health) to reduce disparities.

- **Inclusion health group: Learning Disabilities:** PAHT Cancer Services partnered with Purple All Stars, Essex Partnership University NHS Trust, and others to host an inclusive cancer awareness event for people with learning disabilities. The event addressed low screening rates through dramatic re-enactments, interactive workshops, and sensory-friendly activities.
- **Inclusion health group: African men:** An event was held in partnership with the voluntary sector targeting the African community to support awareness of the symptoms of prostate cancer working
- **Inclusion health group: Black women:** The birthing experience of Black women has been an area of focus. The Trust partnered with FiveXMore to implement solutions developed by women to engage them better, using groups such as the Maternity and Neonatal Voices Partnership to involve ethnically diverse women.
- **Inclusion health group: The Deaf community:** PAHT Cancer services partnered with Anglia Ruskin University Masters in Illustration students to prototype new cancer information tailored to this health inclusion group. The students are now developing final versions of this information for publication.

- **Inclusion health group: BSL training for first responders:** Feedback identifies barriers to diagnosis including communication issues. BSL training (30 trainees) and sensory training are addressing access for underrepresented groups.
- **Targeting deprivation:** PAHT's Patient Panel has been supporting the ICB's priority to improve access in deprived areas through outreach events in Harlow, Epping, and Bishop Stortford, promoting access to primary and secondary care as well as resolving concerns through our PALS services. The voluntary services strategy emphasises co-design with vulnerable groups, using local knowledge to address health inequalities in Harlow's deprived communities.
- **Inclusion health group: Expectant mothers with high BMI:** HWEICB are working with our maternity team, Essex County Council and our Family centres to provide a health inequalities project that helps women with a high BMI to have a healthy pregnancy.
- **Patient safety:** Analysis of patient safety incident data using the core20plus identifiers (postcode, gender, age and ethnicity) to understand if the above groups are disproportionately affected. This has been published bi-annually for the last year.
- **Clinical strategy:** Currently undertaking a review of our clinical strategy which will include the requirement to describe how we will address health inequalities, service by service.

Reducing Inequalities in Access to Care

Objective: Ensure equitable access to elective, urgent, and emergency care for underserved groups, including ethnic minorities and socioeconomically deprived populations.

- **Elective care: A new surgical centre for elective Care:** The hub will support reductions in waiting times for elective care, aligned with the ICB's goal to prioritise deprived groups by supporting the establishment of the Herts and West Essex Surgical Centre in St Albans. 89% of surveyed patients in PAHT's catchment are willing to travel for earlier procedures.
- **Elective and urgent care: Epping Community Diagnostic Centre (CDC):** The CDC in Epping, which will be operating in the next financial year will speed up diagnostics like MRI scans, providing care closer to home.
- **Digital care: A new Patient Portal for digital inclusion:** The My Alex Health patient portal, launched in March 2025 had a 99% uptake to the first invitation to register. We now have nearly 2000 patients registered and are supported by a partnership with a local voluntary sector organisation, West Essex Community Action Network who helped us re-purpose electronic devices to combat digital exclusion in deprived areas.
- **Community Care:** The Hospital at Home project, highlighted at our Meet Your Hospital Leaders Event, uses technology to deliver care in patients' homes, reducing hospital visits for vulnerable groups.
- **Tele-Dermatology service in Harlow:** HWEICB are supporting better primary care integration with dermatology. In this service, a GP refers to the hospital, the team contacts the patient and arranges photography of the specific condition in

their local GP practice. Images and referral and history are reviewed by a consultant remotely and a decision on next steps made i.e. back to GP, into community or into the hospital. This results in shorter waiting times for the patient and means up to 80% of patients in some of our most deprived areas avoid a hospital appointment.

Enabling patients and families' involvement in care

Objective: Support the roll-out of communication and knowledge of marginalised groups, including tools such as Martha's Rule and Oliver McGowan Training to ensure standardised escalation of care concerns.

- **Martha's rule campaign:** Working jointly with the Surgery and Critical Care division the patient experience team helped design and deliver a new campaign enabling out of hours access to a second opinion, using the skills of our Critical Care Outreach Teams (CCOT).
- **Communication Training:** 1,076 nursing, midwifery, and AHP staff completed SAGE and THYME communication training, with doctors starting in 2025-26. This enhances staff ability to respond to low level mental health concerns.
- **Responding to concerns:** Patient Advice and Liaison Services responded to 4,729 concerns in 2024-25, a 7.2% increase on 23-24, enabling targeted support for deprived populations.
- **Case Study Learning:** All divisions in the hospital are asked to present their learning from complaints at bi-monthly patient experience committee meetings. The Surgery and Critical Care Division presented a case study of a cancer patient's family concerns highlighted poor clinical engagement. Actions included independent consultant reviews, a new clinical communication clinic and surgical audit discussions to improve escalation processes.

Increasing Dementia Diagnosis Rates, involving carers

Objective: PAHT aligns with the ICB's 2023–2028 strategy, embedding dementia pathways in frailty and mental health services to improve diagnosis rates, focussed on deprived or underrepresented communities to close diagnosis gaps.

Integrated Dementia and Delirium Strategies: The Trust has implemented comprehensive dementia and delirium strategies with key performance indicators, including pathways for assessment and referral, person-centred care via 'This is Me' documentation, and monitoring harm-related incidents. These strategies, supported by national audit recommendations, aim to reduce health inequalities by improving care quality for dementia patients, who often face disparities in hospital settings due to complex needs.

45-52 referrals per month to a Dementia Clinic: The Admiral Nurse role, supported by Dementia UK, provides clinical expertise and community outreach through clinics at PAH, addressing service gaps for dementia patients and carers. With 45-52 monthly referrals, this initiative tackles health inequalities by extending

support to underserved groups, including family carers and community members, ensuring equitable access to specialised dementia care.

Weekly Well-being and Music Therapy: Weekly music therapy sessions, introduced to combat social isolation and enhance well-being, have shown positive outcomes like improved appetite and reduced delirium-related anxiety. By prioritising emotional and physical health for dementia patients, this program addresses inequalities in hospital care, where such patients often experience neglect of their psychosocial needs.

Delirium Management and Training: New delirium pathways, guidelines, and mandatory training, including Tier 1 and 2 dementia training and simulation programs, enhance staff competence in managing high-risk conditions like delirium, which carries a 40% mortality risk in dementia patients. These efforts reduce health inequalities by ensuring consistent, high-quality care for vulnerable patients across the Trust.

Namaste Care and Carer Support: The Namaste Care programme, delivered with St. Clare's Hospice, offers compassionate care for advanced dementia, while initiatives like the Carers Passport and Action for Family Carers provide tailored support for carers. These programs address inequalities by recognising and supporting carers' roles, ensuring better care coordination and access to resources for dementia patients.

A New Sensory Garden: The development of a sensory garden and planned upgrades to ward environments aim to create dementia-friendly settings, reducing distress for patients. The Alex Health electronic records system and My Alex Health patient portal, launching in 2025, will improve carer identification and care coordination, addressing inequalities by enabling proactive adjustments and better access to healthcare services for dementia patients and their families.

Beyond CORE20PLUS5

In addition to this a variety of teams are addressing challenges around health inequalities through work on:

Joint working across the place-based geography: Advocating for work to address the social determinants of health (e.g., housing, education, income). A key example of this is the intention of the main health and care provider, The Princess Alexandra Hospital NHS Trust to become the host provider for community services in 2025-26.

Intersectoral Collaboration: Partnerships with non-health sectors (e.g., education, transportation, urban planning) to create environments that support health, like safe spaces for exercise or access to nutritious food. An example of this is memorandum of understanding (MOU) signed by PAHT last year (2024) with Harlow College to align them as strategic partners for a purpose-built Health and Science Academy, based at Harlow College, using the Stansted Airport College as a model.

Addressing Structural Inequities: We are tackling systemic racism, gender disparities, and other forms of discrimination in healthcare through targeted interventions, such as bias audits and inclusive care protocols.

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.

A handwritten signature in black ink, appearing to read 'Thomas Lafferty', with a stylized, sweeping flourish at the end.

Thomas Lafferty

Chief executive officer

The Accountability Report 2024-25

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 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 2 areas set out below. Both areas were addressed in year but were not in place from 1 April 2024:

Section C, 4.1	
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. They must also have no issues of	The Trust's policy and process for complying with the additional requirements in the revised Fit and Proper Persons guidance was approved by the Trust Policy Group during 2024-25. Fit and proper persons checks are carried out prior to appointment and a 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.

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.	
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 was included in the Trust's Governance Manual during 2024-25. No non-audit services have been purchased from the Trust's external auditors during 2024-25.

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	Summary	Section
Section A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships.	Annual Governance Statement and West Essex Health and Care Partnership arrangements

	The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	
Section A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Annual Governance Statement and People Performance section
Section A 2.8	The board of directors should describe in the annual report how the	Annual Governance Statement and West

	interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Essex Health and Care Partnership
Section B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business	Included in Corporate Governance section

	relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance- • related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive	
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	director is independent, it needs to be clearly explained why.	
Section B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Included in Corporate Governance section
Section C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Included in Corporate Governance section
Section C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Annual Governance Statement
Section C 4.13	The annual report should describe the work of the nominations committee(s), including: the process used in relation to appointments, its approach to succession planning and how both	Included in Corporate Governance section

	support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	
Section D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee	Include in Corporate Governance section

	considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	
Section D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a	Included in accounts pages 1 -59

	whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	
Section D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Governance Statement
Section D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report.	Annual Governance Statement
Section D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this	Page 16 Annual Report and included in accounts pages 1-59

	assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	
Section E 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Included in Remuneration report

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: [Our reports | Princess Alexandra Hospital \(pah.nhs.uk\)](http://www.pah.nhs.uk)

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 2024-25. 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 2024-25.

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, staff health and wellbeing 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, training 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 statutory and regulatory requirements relating to workforce are met.
- Maintain oversight of the implementation of the communications strategy and delivery of communications to patients, staff, the media and stakeholders.

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.

Leadership Management Team (transitioned into the Executive Board in February 2025)

The Executive Board is the executive decision-making committee of the Trust, its purpose being to make management decisions on issues within the remit of the executive directors and divisional directors, to support delivery of their delegated responsibilities by providing a forum for briefing, exchange of information and decisions on issues relating to finance, quality and operational matters. Authorised to approve business cases up to £500k and to review those exceeding £500k before submission to PAF and Trust Board.

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 and left the Trust at the end of March 2025 to take up a new role as Chair of Essex Partnership University Trust (EPUT).

Hattie has extensive experience as chair of NHS organisations, having chaired Hertfordshire Partnership Foundation Trust (HPFT) and Buckinghamshire Health NHS Trust. She is the Co-Chair 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 worked predominantly in the commercial sector and has a successful track record in strategic planning, financial management, effective team development and corporate governance.

As an experienced Finance Director with extensive leadership experience at Board level, she was also responsible for Human resources, Operations and Facilities.

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. Following Hattie's appointment as Chair of EPUT, Darshana was appointed as the Trust's Acting Chair from 1 April 2025.



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 Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) as a non-executive director and chaired the Finance Committee and was 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.



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) role 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.

Dr Oge Austin-Chukwu, 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 the Quality and Safety Committee (QSCI), a member of the People Committee and was appointed as a non-executive director in September 2024.



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. In 2020, Anne was appointed as the Commonwealth Nations Special Envoy for Inclusion and Equality in Sports. 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 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. Rob left the Trust on 5 September 2024.

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.

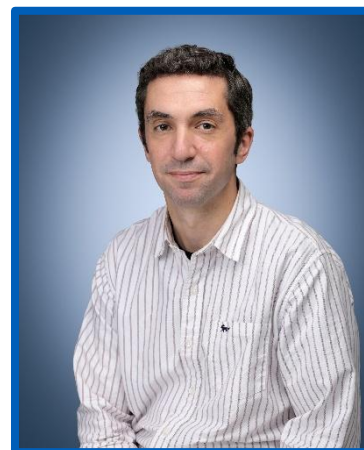
Now semi-retired, Rob was the chair of West Essex Clinical Commissioning Group for nine years and has taken on the role of chair of Stellar Healthcare, a GP provider company covering Harlow and Epping Forest.



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

Ralph Coulbeck, associate non-executive director

Ralph has a background of over 20 years in healthcare, currently he is the chief executive of Haven House children's hospice. Previously, he was CEO of Whipps Cross Hospital where he also led the Waltham Forest Healthcare Partnership, bringing together primary care, community service and the voluntary sector to deliver improved services for local residents. Ralph has significant leadership experience in working across the NHS.



Ralph is the Chair of the Quality and Safety Committee (QSCII) meeting (maternity) effective from November 2024 and a member of the Quality and Safety Committee (Part I)

Bolanle Johnson, NExT non-executive director

Bolanle Johnson is an award-winning senior manager and Certified Risk professional, who brings a wealth of extensive expertise from within the banking and finance sector.

Bolanle has successfully integrated teams and processes, enhancing risk management and compliance. She is incredibly passionate about continuous improvement.

She is also a senior leader who is committed to achieving strategic objectives and promoting proactive risk management best practices.

Bolanle joined the Board as part of the NHSE NExT Director scheme in 2024.



Bolanle was a member of the Performance and Finance Committee for part of the year and joined the People Committee in March 2025.

Dr Ben Molyneux, associate non-executive director

Dr Ben Molyneux joined the Board as an associate non-executive director in March 2025.

He has 20 years NHS experience, and works clinically as a GP in London with a special interest in urgent care. Ben is also Associate Medical Director of NHS North East London, responsible for the primary care needs of 2.4million local residents.

Dr Molyneux has previously chaired two national British Medical Association (BMA) committees and in that time led and participated in national contract negotiations for UK doctors. He has additional regulatory experience having worked with both the GMC and CQC.

Ben brings a combination of system, commissioning, primary and secondary care NHS experience to the Board.

Ben joined the Board as an associate non-executive director in March 2025.



Dr Parag Jasani, associate non-executive director

Dr Jasani is a highly accomplished consultant haematologist with over 20 years of experience in clinical practice, research, and leadership within the NHS. He is currently the divisional clinical director of a large division at the Royal Free London NHS Foundation Trust. He is recognised as a leader in his clinical specialist area with a strong track record in clinical trials, patient care, and service development.

Parag joined the Board as an associate non-executive director in March 2025.



Executive directors

Lance McCarthy, chief executive (left 1 August 2024)

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.



Lance was appointed as the Chief Executive Officer of Frimley Health NHS Foundation Trust and left the Trust in August 2024.

Thom Lafferty, chief executive (joined 4 November 2024)

Thom joined The Princess Alexandra Hospital NHS Trust (PAHT) in November 2024 from Kingston Hospital NHS Foundation Trust and Hounslow and Richmond Community Healthcare (HRCH), where he was deputy chief executive and director of strategy. Previous to that, Thom was the director of strategy at Royal Cornwall Hospitals NHS Trust and has over 12 years of Board experience in areas including strategy, transformation and corporate governance.

Thom has worked with or for the NHS his whole career in a wide range of roles. He has particularly led on strategy and transformation.



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. Her portfolio includes ensuring the highest possible professional standards of our doctors, the delivery of high quality medical education, patient safety and quality, learning from deaths and leading the risk management strategy for PAHT.

Fay is the Trust's Caldicott Guardian and Responsible Officer. Fay is passionate about PAHT as an anchor institution to improve the quality of health and care for our community, enabling the delivery of high quality patient care and improving the daily lived experience of our people.



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, chief finance and infrastructure officer

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 had over 25 years' experience working in HR in the NHS, during which time she delivered strategic and operational HR initiatives and on the organisational development agenda. Ogechi was passionate about improving staff health and wellbeing and driving forward staff and leadership development.

Ogechi sadly died in July 2024.



Giovanna Leeks, interim chief people officer

Giovanna has 20 years of experience and knowledge of people-led initiatives including recruitment; workforce and performance management; staff wellbeing and employee relations, from both private and NHS organisations.

She started her NHS human resources (HR) career as the first head of HR for NHS England (NHSE) Midlands and East in 2013. She has since undertaken a variety of contracts in the NHS across London and the east of England including at Kingston Hospital, Royal Free London Group, Hertfordshire Community Trust and Lewisham and Greenwich NHS Trust, with contracts in the private sector including FTSE100 and small and medium-sized enterprises (SME) organisations.



With a commitment to high quality services for our people and patients, Giovanna is delighted to have joined the Trust in October 2023 as the deputy chief people officer, taking up the interim chief people officer role in July 2024.

Michael Meredith, chief strategy officer

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, chief clinical transformation officer

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 2024-25								
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
Non-executive directors		Attendance (actual/maximum)						
George Wood	15/16	5/5	N/A	N/A	11/11	N/A	N/A	5/5
Colin McCready	11/16	3/5	N/A	N/A	10/11	N/A	3/4	4/5
Darshana Bawa	16/16	5/5	N/A	N/A	9/11	6/6	N/A	5/5
Elizabeth Baker	14/16	N/A	N/A	N/A	N/A	N/A	3/4	5/5
Oge Austin Chukwu	14/16	N/A	11/11	11/11	N/A	6/6	N/A	5/5

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
Associate non-executive directors		Attendance (actual/maximum)						
Anne Wafula-Strike	12/16	N/A	2/6	3/6	N/A	2/6	N/A	3/5
Ralph Coulbeck	13/13	N/A	7/10	9/10	N/A	N/A	3/4	4/4
Bola Johnson	5/6	N/A	N/A	N/A	4/5	N/A	N/A	1/1
Ben Molyneux	N/A	0/0	1/1	1/1	N/A	N/A	N/A	N/A

(from 10.03.25)								
Parag Jasani (from 10.03.25)	N/A	N/A	0/1	0/1	0/1	N/A	N/A	N/a

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
Executive directors		Attendance (actual/maximum)					
Sharon McNally *	14/16	N/A	6/11	6/11	N/A	4/6	N/A
Stephanie Lawton	14/16	N/A	9/11	8/11	10/11	5/6	N/A
Fay Gilder	15/16	5/5	11/11	10/11	N/A	N/A	2/4
Tom Burton	16/16	5/5	N/A	N/A	11/11	N/A	4/4

Ogechi Emeadi	4/6	N/A	N/A	N/A	N/A	1/1	N/A
Michael Meredith	16/16	N/A	N/A	N/A	8/11	N/A	3/4
Phil Holland	15/16	N/A	N/A	N/A	9/11	N/A	4/4
Giovanna Leeks *	9/10	N/A	N/A	N/A	N/A	5/5	N/A
Giuseppe Labriola *	4/4	N/A	8/11	8/11	N/A	1/3	N/A

* Sharon McNally was appointed as Interim Chief Executive Officer from 01.07.24 – 04.11.24

Giovanna Leeks was appointed as Interim CPO from 08.07.24 to present date

Giuseppe Labriola was appointed as Interim Chief Nurse from 01.07.24 – 04.11.24

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:



Chief Executive

Date: 30 June 2025

The Princess Alexandra Hospital Annual Governance Statement 2024-25

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 2025 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,
- five non-voting associate non-executive directors and one NExT non-executive director,

- five voting executive directors (chief executive officer, chief finance and infrastructure officer, medical director, chief operating officer and chief nurse/deputy chief executive) and four further executive directors without voting rights; the chief people officer, chief strategy officer, chief transformation officer and the chief information officer.

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

- Elizabeth Baker, associate non-executive director was appointed as a non-executive director on 1 April 2024.
- Rob Gerlis, associate non-executive director left the Trust on 5 September 2024.
- Oge Austin-Chukwu, associate non-executive director was appointed as a non-executive director on 1 September 2024.
- Ralph Coulbeck was appointed as an associate non-executive director on 17 May 2024.
- Bolanle Johnson commenced her placement with the Trust as a NExT non-executive director on 1 November 2024. The NExT Director Scheme is a development programme created and designed to support talented people from groups who are currently under-represented on NHS boards into non-executive roles.
- Ben Molyneux and Parag Jasani were both appointed as associate non-executive directors on 10 March 2025.

The following appointments/changes were made to the executive team in year:

- Ogechi Emeadi, chief people officer sadly died in July 2024 and Giovanna Leeks was appointed as the interim chief people officer on 8 July 2024.
- Lance McCarthy, chief executive officer left the Trust on 1 August 2024 and Sharon McNally, chief nurse was appointed as the interim chief executive officer, in shadow initially from 1 July 2024.
- Giuseppe Labriola, deputy chief nurse acted up as chief nurse during this period until 17 November 2024.
- Thomas Lafferty joined the Trust as chief executive officer on 4 November 2024.

Attendance at Board and Committee meetings throughout 2024-25 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
- Leadership Management Team Meeting (LMT). In February 2025 the Executive Board was established and replaced the LMT 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 2024-25:

The chief nurse and deputy chief executive officer 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 chief finance and infrastructure officer (CFIO) 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. From February 2025 the CFIO also took on responsibility for managing the operational estates and facilities function as well as health and safety.

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 chief people officer 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 chief transformation officer has delegated responsibility for managing the Trust's transformation, improvement and modernisation programmes as well as the Quality First team.

The chief strategy officer has delegated responsibility for managing the development of the new hospital and the strategic estates function.

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 deployment of Alex Health, the Trust's new electronic health system.

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 the Executive Board meetings
- A Corporate Risk Register, Trust wide Risk Register and Board Assurance Framework, all of which are reviewed by the Risk Management Group, Executive Board 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 in 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. All departmental risk leads review their risks regularly at divisional board and corporate departmental governance meetings, with oversight by senior corporate and divisional leads. Trust wide risks are discussed and monitored through relevant Trust wide groups.

Once a risk is approved locally, those with a current score of 15 to 25 and those exceeding the risk appetite for their category will be escalated to the Risk Management Group (RMG) for discussion. RMG meets on a monthly basis to review risks across all divisions as well as corporate departments. RMG will consider if the risk should be added to the Corporate Risk Register and make a recommendation to the Executive Board based on its deliberations. This process is embedded into practice.

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.

At the end of 2024-25 there were 11 principal risks defined on the Board Assurance Framework.

Nine of the 11 BAF risks were red-rated (scoring 15 and above) at the end of the financial year:

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

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

1.4 EHR: There is a risk to the delivery of safe and high quality care caused by the stabilisation of Alex Health post go live

1.5 Cyber: There is a risk of Trust-wide loss of IT infrastructure and systems from Cyber attack

2.3 Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust

3.1 Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & 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

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

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

Two of the 11 risks on the BAF were amber-rated (scoring between 8 and 12)

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.

5.1 Risk that the Trust will fail to meet the financial plan

During 2024-25 three BAF risks were closed:

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

4.3 Industrial action: There is a risk that patient safety will be impacted by further industrial action

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.

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 2024-25 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 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 three Never Events in 2024 -2025:

- Two incidents of wrong site surgery (wrong site nerve block): 2 patients received wrong site nerve block on hip, one incident was investigated and closed, the second case

- relates to incorrect reporting of X-ray site which was identified after the incorrect nerve block was given. Both patients did not require any additional hospital stay or treatment.
- Retained foreign object (retained swab following C-section): this investigation is in progress.

All completed patient safety incident investigations generate a sharing the learning report which is presented locally within each team, across divisional teams and when appropriate, shared across all divisions. A report is presented to the Patient Safety Group and the Quality and Safety Committee.

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.

In July 2024 the Board completed a self-assessment against the new CQC single assessment framework and the four point rating scale.

A high level 2 rating (*quality is evident but not fully embedded*) with elements of 3 and 4 was assigned. A further self-assessment will be undertaken during 2025.

Compliance with NHS Provider Licence

No principal risks have been identified to compliance with NHS provider licence condition 4. This condition covers the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the Board, its committees and the executive team.

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
- 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 Care Quality Commission (CQC) inspected the Trust 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)

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:

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 four Information Governance (IG) data security breaches to the Information Commissioners Office (ICO) during 2024-25:

The first breach related to a patient being given a discharge summary for another patient in error. The ICO closed this case with no action required.

The second breach related to a member of staff from an agency who received a false letter allegedly from the PALS office. The ICO has not responded however the investigation has been closed locally with no evidence of any inappropriate staff behaviour.

The third breach related to correspondence received from a supplier regarding a possible cyber incident related to processing patient personal identifiable data. The ICO closed this case with no further action required.

The fourth breach related to a patient discharged with documentation relating to two other patients. The ICO closed this case with no further action required.

Data quality and governance

Data quality reports are produced and reviewed at the Data Quality Steering Group. 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.

Following the implementation of Alex Health in November 2024, there is an ongoing focus on improving data quality and reporting.

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 daily in the Patient Tracker List (PTL) meetings, chaired by the performance manager. Pathway trigger points are reviewed and remedial actions taken, if required. The PTL meetings report to the weekly Senior Operational Group and fortnightly into NHSE Tiering meetings. The senior operational meeting also reviews

RTT data quality reports and determines actions to ensure there are processes to maintain accurate data recording. Data quality and operational performance reporting is an ongoing area of concentrated work following the implementation of Alex Health, the Trust's new electronic health record.

The Trust's Operational Board receives a summary report of performance against the national constitutional standards including actions being taken to support patient care and outcomes. Quality and Safety Committee (QSC) receives a summary highlight report on the quality and safety elements of delivery against the Trust's annual operating plan.

NHSE and ICB colleagues meet regularly with the senior operational and clinical teams to review recovery actions against plans and trajectories. Reporting against all statutory access reports including data quality is an area of increased focus following implementation of Alex Health.

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 role of internal audit is to provide an opinion to the Board, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from BDO, the Trust's internal auditors provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by the firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period.

The Head of Internal Audit Opinion (HoIA) on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2025 as reported by BDO is:

‘Overall, we provide **Moderate** Assurance that there is a sound system of internal controls, designed to meet the Trust’s objectives, that controls are being applied consistently across various services’.

BDO completed a total of eleven reviews (ten assurance audits and one advisory review). Limited opinions were assigned to Consultant Job Planning and Medical Devices Management. These were known areas of risk identified by the Trust which the auditors were directed to.

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 2025 (and beyond); these issues are also reflected on the Board Assurance Framework:

Urgent and emergency care

The Trust has continued to make sustained incremental improvement in the care and treatment of patients attending the emergency department within 4 hours. The Trust agreed a trajectory for performance improvement with the ICB and NHSE in 2024-25 which demonstrated ongoing improvement in flow and performance. The trajectory was achieved at the end of the year and has provided a strong platform for progress over the next year.

The Trust wide urgent and emergency care improvement plan is overseen and driven by clinical and operational senior leads across all divisional teams in the Trust. Supported by quality improvement colleagues, ongoing improvements in pathways are a key focus of activity over the year.

Elective recovery programme: 78 weeks and cancer waits

The Trust has reduced the number of long waiting patients over 78 weeks with zero patients waiting over 78 weeks at the end of the year. The number of patients waiting over 65 weeks has significantly improved throughout the year with a small number of patients remaining at the end of March 2025. Robust oversight and plans are in place to support ongoing improvements across the year ahead.

The Trust has continued to make incremental improvements in delivery of diagnostic standards with strong performance in radiology. Cancer care and treatment standards have remained challenged throughout the year with recovery trajectories in place across all tumour sites.

Finance:

The Trust achieved its revised 2024-25 forecast outturn position of a £1.1m deficit. This was achieved through a number of non-recurrent measures along with sustained reduction in agency staffing spend. The planned position for 2025-26 is breakeven which includes delivering a cost efficiency programme of £26.2m. The 2024-25 forecast outturn position and the 2025-26 planned position include non-recurrent support from our ICB. We believe this links to our recurrent structural issues that we have sought funding for recurrently. The scale of the efficiency requirement is a risk to the Trust in 2025-26.

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 2024-25 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.



Thomas Lafferty, Chief Executive

Date: 30 June 2025

Remuneration and staff report

Background

This report includes details regarding “senior managers” remuneration in accordance with paragraphs 3.68 to 3.125 of the DHSC (Department of Health and Social Care) Group Accounting Manual 2024/25. 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 chair and meets at least annually. Membership of the committee consists of Trust chair and all non-executive directors with the chief people officer 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 (subject to audit)

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 2024/25 (and 2023/24), these were:

	2024/25		2023/24 Restated	
	Highest paid director	Employee average	Highest paid director	Employee average
Salary & Allowances	0.0%	4.0%	7.4%	17.9%
Performance pay & 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 2024-25 was £215-£220k (2023-24, £215-£220k). In 2024-25, 12 (2023-24, 23) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £220,000 to £360,000 (2023-24 £220,000- £405,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2024/25	25th Percentile	Median	75th Percentile
Total Remuneration	31,469	42,354	56,114
Salary component of total remuneration	31,469	42,354	56,114
Pay Ratio Information	7:1	5:1	4:1

2023/24 Restated	25th Percentile	Median	75th Percentile
Total Remuneration	28,976	41,611	54,769
Salary component of total remuneration	28,976	41,611	54,769
Pay Ratio Information	8:1	5:1	4:1

Consultancy and professional services spend

Total consultancy and professional services expenditure in 2024/25 were £1,898k (2023/24 £3,002k).

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	0.7 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.

First Column	Figures
Provide the total cost of facility time	£32,017
Provide the total pay bill (£'000)	£287,182
Provide the percentage of the total pay bill spent on facility time, calculated as: £287182.00	 0.01%

(total cost of facility time ÷ total pay bill) x 100	
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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: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	68%
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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 2025	31 March 2024
	Number	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 2024 and 31 March 2025, for more than £245⁽¹⁾ per day

	31 March 2025	31 March 2024
	Number	Number
No. of temporary off-payroll workers engaged between 1 April and 31 March 2025	-	-

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 2024 and 31 March 2025

	31 March 2025	31 March 2024
	Number	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)

On the 29th July 2024, The Government announced the 2024/25 pay award for staff under the remits of the NHS Pay Review Body (NHS PRB) and Doctors' and Dentists' Review Body (DDRB). All pay uplifts were backdated to take effect from the 1st April 2024.

A 5.5% consolidated uplift for all Agenda for Change staff on NHS terms and conditions, and a 6% For doctors and dentists, applying to the following:

- Consultants
- Specialty and specialist (SAS) doctors
- Doctors and dentists in training who will also receive an uplift of £1,000
- Salaried dentists, including those working in community dental services and public dental services
- Contractor general medical practitioners
- Salaried general medical practitioners pay ranges
- Pay element of dental contracts

There will be no uplifts in Local Clinical Excellence Awards as these remain. These additional uplifts have been included in 2024/25 Salary and remuneration.

Employee benefits (subject to audit)

Gross expenditure	Permanently employed	Other	2024/25 Total	2023/24 Total
	£000's	£000's	£000's	£000's
Salaries and wages	195,587	761	196,348	169,809
Social security costs	21,090	-	21,090	18,693
Apprenticeship levy	969	-	969	882
Employer's contributions to NHS pensions	36,999	-	36,999	28,931
Pension costs – other	24	-	24	28
Temporary Staff	-	39,166	39,166	48,358
Total employee benefits	254,669	39,927	294,596	266,699

Less: Employee costs capitalised	6,876	272	7,148	3,568
Redundancy	266	-	266	300
Total employee benefits excl. capitalised costs	247,793	39,655	287,448	263,131

Average staff numbers

	Permanent Number	Other Number	2024/25 Total	2023/24 Total Restated tbc
Medical and dental	302	293	595	544
Ambulance Staff	-	-	-	-
Administration and estates	1,018	91	1,109	1,040
Healthcare assistants and other support staff	538	25	563	588
Nursing, midwifery, and health visiting staff	1,202	39	1,241	1,145
Nursing, midwifery, and health visiting learners	-	-	-	-
Scientific, therapeutic, and technical staff	241	16	257	239
Healthcare science staff	83	6	89	96
Social care staff	-	-	-	-
Other	-	-	-	-
Total	3,384	470	3,854	3,652

Staff engaged on capital projects (included in above)	159	11	170	108
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In preparing this report the Directors identified that the average staff numbers for the prior period had been reporting incorrectly. They do not believe this to be material but have restated prior period figure.

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 TBC](#)

Ill Health Retirements	2024/25	2023/24
	Number	Number
Number of persons retired early on ill health grounds	5	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	107	172

Reporting of compensation schemes - exit packages 2024/25 (subject to audit)

There was one exit package provided in 2024/25 (£0k 2023/24).

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	1	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total	-	-	-

Total resource cost (£)	-	-	-
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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 2023/24 (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	1	-	-
£100,001- £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total	-	-	-
Total resource cost (£)	-	-	-

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

	2024/25	2023/24
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	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)

		2024/2025							2023/2024						
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 payment s (taxable) to nearest	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 ⁽²⁾	Trust Chair	01/04/24-28/03/25	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 ⁽³⁾	Associate Non-Executive Director	01/04/24-05/09/24	05-10	-	-	-	-	05-10	All Year	10-15	-	-	-	-	10-15
Helen St Claire Howe ⁽¹⁾	Non-Executive Director	All Year	05-10	-	-	-	-	10-15	All Year	10-15	-	-	-	-	10-15
John Russell Keddie ⁽³⁾	Non-Executive Director	-	-	-	-	-	-	-	01/04/23 – 30/06/23	00-05	-	-	-	-	00-05
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) ⁽³⁾	Non-Executive Director	-	-	-	-	-	-	-	01/04/23-28/02/24	10-15	-	-	-	-	10-15
Ralph Coulbeck ⁽²⁾	Associate Non-Executive Director	17/05/24 - 31/03/25	10-15	-	-	-	-	10-15	-	10-15	-	-	-	-	10-15
Liz Baker ⁽¹⁾	Non-Executive Director	All Year	10-15	-	-	-	-	10-15	All Year	05-10	-	-	-	-	05-10
Dr Ogesomekwu Austin-Chukwu ⁽¹⁾	Non-Executive Director	All Year	10-15	-	-	-	-	10-15	04/09/23 – 31/03/24	00-05	-	-	-	-	00-05
Ben Molyneux ⁽²⁾	Associate Non-Executive Director	10.03.25 - 31.03.25	00-05					00-05	-	-	-	-	-	-	-
Parag Jasani ⁽²⁾	Associate Non-Executive Director	10.03.25 – 31.03.25	-	-	-	-	-	-	-	-	-	-	-	-	-

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.

Table of salaries - executive directors (subject to audit)

		2024/2025							2023/2024						
Name	Title	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performan ce 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
Thom Lafferty ⁽²⁾	Chief Executive	04/11/24- 31/03/25	80-85	-	-	-	-	80-85	-	-	-	-	-	-	-
Lance McCarthy ⁽²⁾	Chief Executive	01/04/24 - 01/08/24	85-90	-	-	-	-	85-90	All Year	210-215	-	-	-	0-2.5	210-215
Sharon McNally ⁽¹⁾	Chief Nurse & Deputy Chief Executive	All Year	160-165	-	-	-	12.5-15.0	175-180	All Year	150-155	-	-	-	0-2.5	150-155
Stephanie Lawton ⁽¹⁾	Chief Operating Officer	All Year	155-160	-	-	-	7.5-10.0	165-170	All Year	150-155	-	-	-	0-2.5	150-155
James McLeish ⁽¹⁾	Chief Clinical Transformation Officer	All Year	125-130	-	-	-	-	125-130	All Year	120-125	-	-	-	0-2.5	120-125
Michael Meredith ⁽¹⁾	Chief Strategy Officer	All Year	135-140	-	-	-	25.0-27.5	160-165	All Year	130-135	-	-	-	32.5-35.0	165-170
Ogechi Emeadi (RIP) ⁽²⁾	Chief People Officer	01/04/24 - 05/07/24	50-55	-	-	-	-	50-55	All Year	125-130	-	-	-	0-2.5	125-130
Phil Holland ⁽¹⁾	Chief Information Officer	All Year	120-125	-	-	-	45.0-47.5	165-170	All Year	105-110	-	-	-	0-2.5	105-110
Thomas Burton ⁽¹⁾	Chief Finance & Infrastructure Officer	All Year	155-160	-	-	-	15.0-17.5	170-175	All Year	145-150	-	-	-	32.5-35.0	180-185
Giuseppe Labriola ⁽²⁾	Interim Chief Nurse	01/08/24 - 15/11/24	35-40	-	-	-	-	35-40	-	-	-	-	-	-	-
Giovanna Leeks ⁽²⁾	Interim Chief People Officer	08/07/24- 31/03/25	105-110	-	-	-	-	105-110	-	-	-	-	-	-	-
Fay Gilder ⁽¹⁾	Medical Director & Caldicott Guardian	All Year	215-220	-	-	-	-	215-220	All Year	205-210	-	-	-	0-2.5	205-210

- 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.

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 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024 (£000's)	Real increase in Cash Equivalent Transfer Value (CETV) (£000's)	Cash Equivalent Transfer Value at 31 March 2025 (£000's)	Employee's contribution to stakeholder pension (£000's)
Thom Lafferty ⁽²⁾	Chief Executive	2.5-5.0	0-2.5	35-40	-	453	14	541	10
Lance McCarthy ⁽²⁾	Chief Executive	0-2.5	0-2.5	80-85	215-220	1,747	-	1,840	2
Sharon McNally ⁽¹⁾	Chief Nurse and Deputy CEO	0-2.5	0-2.5	70-75	195-200	1,609	32	1,768	19
Stephanie Lawton ⁽¹⁾	Chief Operating Officer	0-2.5	0-2.5	65-70	170-175	1,316	16	1,440	20
James McLeish ⁽¹⁾	Chief Clinical Transformation Officer	0-2.5	0-2.5	35-40	90-95	80	24	125	16
Michael Meredith ⁽¹⁾	Chief Strategy Officer	2.5-5.0	0-2.5	25-30	15-20	434	32	512	17
Ogechi Emeadi RIP ⁽²⁾	Director of People, Comms & OD	0-2.5	0-2.5	0-5	0-5	1,183	-	-	5
Fay Gilder ⁽¹⁾	Medical Director	0-2.5	0-2.5	65-70	195-200	1,620	8	1,741	4
Tom Burton ⁽¹⁾	Chief Finance & Infrastructure Officer	0-2.5	0-2.5	35-40	0-5	463	7	520	20
Giuseppe Labriola ⁽²⁾	Interim Chief Nurse	0-2.5	-	-	-	-	-	-	-
Giovanna Leeks ⁽²⁾	Interim Chief People Officer	0-2.5	0-2.5	0-5	0-5	-	-	-	-
Phil Holland ⁽¹⁾	Chief Information Officer	2.5-5.0	0-2.5	30-35	75-80	591	42	688	15

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.

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

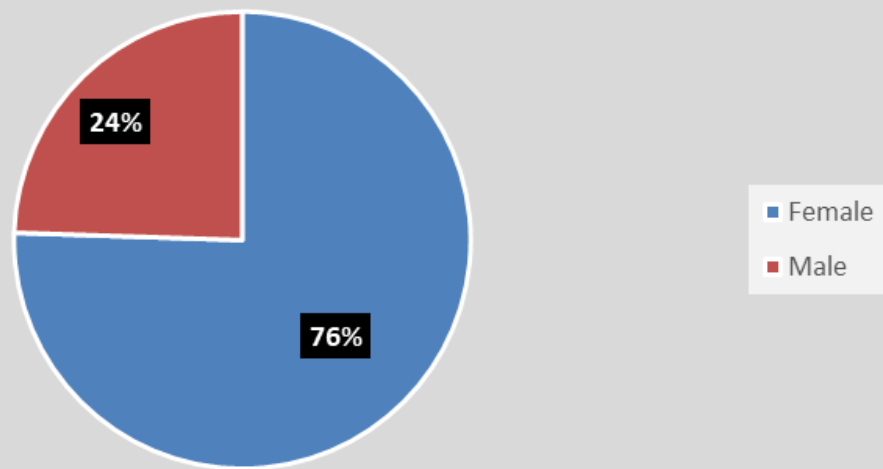
March 2025 staff composition	Male	Female
Executive directors	5	4
Other employees	1010	3137
Total	1015	3131

Turnover rate

Turnover rate	2023/24	2024/25
Voluntary turnover	11.63%	9.50%
Overall staff turnover	13.60%	13.34%

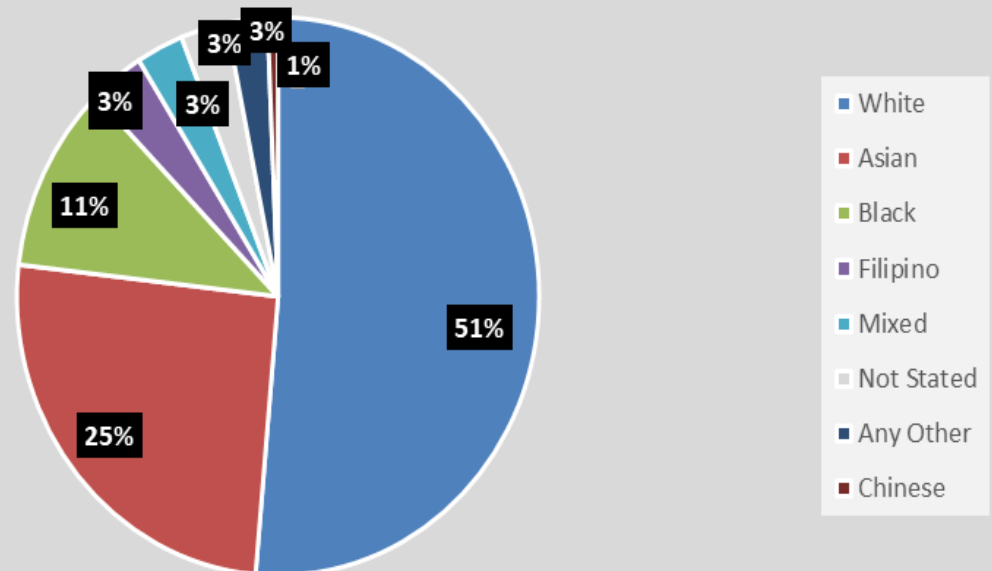
Our workforce – gender profile

Workforce Profile by Gender



Our workforce – ethnic profile

Workforce Profile by Ethnicity



Equality diversity and Inclusion

Our EDI compliance

In February 2024 we published our EDI strategy that will support engagement with external partners and adherence to our commitment to diversity as a core value.

In 2024 we developed our EDI Delivery Plan 2024 -2025 setting out the delivery of our Strategy. This includes a Governance framework timetable to meet our regulatory reporting responsibilities. We are committed to improving the quality and extend our data and information in relation to protected characteristics. This will inform the development of equality actions and activity within the delivery plan.

The EDI Delivery Plan details the actions we are taking to deliver the following reporting requirements:

- EDI Annual Report – (EDI goals and objectives)
- NHSE EDI Improvement Plan
- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- Gender Pay Gap Report
- Ethnicity Pay Gap Report
- Equality Delivery System
- East of England Anti-racism Strategy
- Health Inequalities (from 2025 - 2026)

The outcome of the Delivery Plan will be reviewed along with new activity to create our EDI Delivery Plan for 2025 - 2026.

The EDI Steering Group (EDISG) is now responsible for the monitoring of our EDI Delivery Plan and Governance framework. The EDISG consists of a diverse range of representation from teams and departments across the Trust. The main aim of the group is to help shape the organisation's strategies and policies to improve the experience of staff and patients with protected characteristics.

The Trust also actively participates in the ICS-wide EDI network. Strong relationships have been developed with the other participants in the ICS and PAHT is working collaboratively on a number of diversity initiatives including recruitment, leadership development, and anti-racism awareness.

Improving accessibility

A plan was developed by the patient engagement team alongside the patient panel and other stakeholders, to make some improvements to the required access to services by patients. Through our membership of the Disability Forum we are in the process of preparing a disability audit to examine and improve policies and practices across the organisation. Further work is underway in partnership with our volunteers. Progress will be reported in our EDI Delivery Plan for 2025-26.

In addition, plans are being devised alongside our Estates and Facilities team, for our New Hospital and PAHT2030 strategy, to support the improvement of accessibility for all. A plan for all year round communications is being devised. We are also utilising our membership with the Business Disability Forum, to improve accessibility of information, throughout our communication platforms.

Growing our Staff Networks

We have reviewed our staff networks in line with the NHS Guidance for Staff Networks 2024. The Trust currently has three staff networks; the Disability and Wellbeing Network (DAWN), the Race Equality & Cultural Heritage (REACH) staff network and the Alex Pride (LGBTQ+) staff network.

The **REACH** network has supported the organisation to move forward on race equality with a focus on its three primary objectives:

1. The promotion of *Psychological Safety*
2. Support for *Continuing Professional Development*
3. Achieving our goals through *Allyship* with other networks.

The **DAWN** network has been operating for just over a year and formed in response to feedback from staff and review of staff survey findings. The purpose of the network is to be an independent and effective voice for staff with long term health conditions and disabilities. We want to ensure that the organisation recognises and responds to the needs of all its staff, thereby increasing staff morale and improving the patient experience.

The **LGBTQ+** staff network re-established its name to **Alex Pride**. The network has invited members of the LGBTQ+ community to meetings to share learning and as an opportunity to inform trust policies and practices. The network is linked in with the East of England LGBTQ+ network.

In the coming year the Trust intends to develop two more staff networks, to represent Faith & Belief and Women.



Thomas Lafferty
Chief executive

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)

Clinical 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 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

Enterovirus – a common cause of infection in people of all ages

Escherichia coli (E.coli) bacteraemia - 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 galvanize 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 and Incident Response Framework (PSIRF) -

Patient, Quality & 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

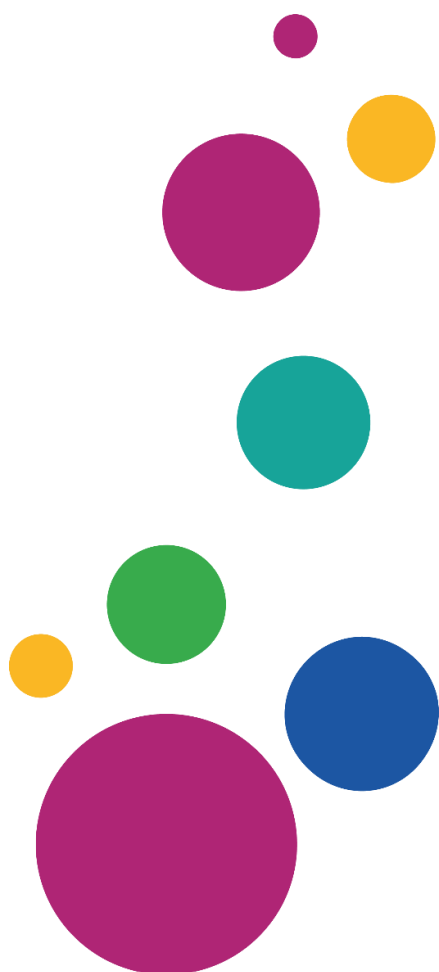
TIMS (This is Me System) – a learning and performance platform/system

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 diseases

The Princess Alexandra Hospital NHS Trust

Annual accounts for the year ended 31 March 2025



INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF PRINCESS ALEXANDRA HOSPITAL NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Princess Alexandra Hospital NHS Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the directors' conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to

commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve financial performance targets delegated to the Trust by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the majority of the funding provided to the Trust during the year and that the Trust's contracted income relates to the financial year in which it is billed. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified fraud risk related to expenditure recognition, particularly in relation to year-end accruals. The Trust is set a financial performance target by NHS England and there is a risk that non-pay expenditure may be manipulated in order to report that the control total is met.

In determining the audit procedures we took into account the results of our evaluation of some of Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted at the end of the year which improve the Trust's position.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Testing a sample of invoices of expenditure, in the period just after 31 March 2025 to determine whether expenditure has been recognised in the correct accounting period and whether accruals are complete.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards), and discussed with the directors the policies and procedures regarding compliance with laws and regulations

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

We are required to make a referral to the Secretary of State, and notify NHS England of the matter under section 30 of the Local Audit and Accountability Act 2014 if we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would

involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

As outlined in the section of this report dealing with other legal and regulatory matters, we made a Section 30(1)(b) referral to the Secretary of State on 25 June 2025 relating to the Trust's failure to comply with its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws and employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The directors are responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 148, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of

its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 104 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in these aspects.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 104 the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(2A) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the Trust under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 25 June 2025 we made a section 30(1)(b) referral to the Secretary of State in respect of the Trust's breach of its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006. We have nothing else to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of Directors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of the of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.



Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London E14 5GL

30 June 2025

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 policies 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



30 June 2025
Chief Executive



30 June 2025
Finance Director

Statement of Comprehensive Income

		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	2	379,134	342,014
Other operating income	3	50,854	41,748
Operating expenses	5,6	(433,338)	(390,263)
Operating surplus/(deficit) from continuing operations		(3,350)	(6,501)
Finance income	8	1,202	1,378
Finance expenses	9	(395)	(309)
PDC dividends payable		(5,331)	(4,357)
Net finance costs		(4,524)	(3,288)
Other gains / (losses)	9.1	(378)	(3,688)
Surplus / (deficit) for the year from continuing operations		(8,252)	(13,477)
Deficit for the year		(8,252)	(13,477)

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 £1,097k in 2024-25. A reconciliation from the accounting deficit to this figure is provided in [note 29](#)"

Statement of Financial Position

		31 March 2025 £000	31 March 2024 £000
	Note		
Non-current assets			
Intangible assets	10	32,138	20,135
Property, plant and equipment	11	189,054	179,127
Right of use assets	13	43,098	41,698
Receivables	15	1,081	1,073
Total non-current assets		265,371	242,033
Current assets			
Inventories	15	4,185	5,035
Receivables	15	10,094	14,953
Cash and cash equivalents	16	28,628	28,242
Total current assets		42,907	48,230
Current liabilities			
Trade and other payables	17	(45,098)	(51,215)
Borrowings	19	(2,718)	(2,402)
Provisions	21	(1,189)	(918)
Other liabilities	18	(549)	(246)
Total current liabilities		(49,554)	(54,781)
Total assets less current liabilities		258,724	235,482
Non-current liabilities			
Borrowings	19	(40,202)	(39,218)
Provisions	21	(1,012)	(932)
Total non-current liabilities		(41,214)	(40,150)
Total assets employed		217,510	195,332
Financed by			
Public dividend capital		384,555	356,329
Revaluation reserve		13,782	11,394
Income and expenditure reserve		(180,827)	(172,391)
Total taxpayers' equity		217,510	195,332

The notes on pages 9 to 59 form part of these accounts.

The financial statements on pages 2 to 8 were approved by the Board on 26 June 2025 and signed on its behalf by:



Name : Thomas Lafferty

Position: Chief Executive Officer

Date: 30-06-2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	356,329	11,394	(172,391)	195,332
Surplus/(deficit) for the year	-	-	(8,252)	(8,252)
Revaluations	-	2,388	-	2,388
Public dividend capital received	28,226	-	-	28,226
Other reserve movements	-	-	(184)	(184)
Taxpayers' and others' equity at 31 March 2025	384,555	13,782	(180,827)	217,510

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £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	-	-	(179)	(179)
Taxpayers' and others' equity at 31 March 2024	356,329	11,394	(172,391)	195,332

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

		2024/25	2023/24
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		(3,350)	(6,501)
Non-cash income and expense:			
Depreciation and amortisation	5	16,193	14,661
Net impairments	5.2	6,815	2,931
(Increase) / decrease in receivables and other assets		4,852	(1,178)
Decrease in inventories		850	107
Decrease) in payables and other liabilities		(1,581)	(3,407)
Increase / (decrease) in provisions		342	(301)
Net cash flows from / (used in) operating activities		24,121	6,312
Cash flows from investing activities			
Interest received		1,202	1,378
Purchase of intangible assets		(17,660)	(10,262)
Purchase of PPE and investment property		(26,973)	(17,639)
Net cash flows from / (used in) investing activities		(43,431)	(26,523)
Cash flows from financing activities			
Public dividend capital received		28,226	15,393
Capital element of lease rental payments		(2,813)	(2,236)
Interest paid on lease liability repayments		(386)	(296)
PDC dividend (paid) / refunded		(5,331)	(3,601)
Cash flows from (used in) other financing activities		-	(3)
Net cash flows from / (used in) financing activities		19,696	9,257
Increase / (decrease) in cash and cash equivalents		386	(10,954)
Cash and cash equivalents at 1 April - brought forward		28,242	39,196
Cash and cash equivalents at 31 March	16	28,628	28,242

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 2024/25 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 2025/26 - 2028/29 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 2024/25 financial year, the Trust achieved an adjusted control performance of £1.1m deficit against a reforecast plan of £5.0m 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.

For 2025/26, 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 ICB's for continuing delivery of NHS acute services in West Essex for 2025/26 and beyond. We are leading on the development of Place within the system and will in 2025/26, assume lead provider status for the provision of adult community services and are progressing with developments on Host Provider arrangements. We feel this will cement our ability to address some of the structural issues set out above.

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 affects 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:

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. 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, £2.5m in 2025/26 in preparation for Land Purchase.

Since the announcement in 2019, the Trust has been part of the New Hospital Programme with an initial expected delivery date of 2030. However, in January 2025, the Secretary of State for Health & Social Care announced a revised implementation plan for the 40 'new hospital' schemes. This revision has adjusted the anticipated start date for construction at The Princess Alexandra Hospital NHS Trust to 2032-2034.

In response to this announcement, the Trust has conducted a thorough review of the costs incurred to date, which are currently held as Assets Under Construction (AUC). This review focused on planning and preparatory work, including business cases, consultancy, and architectural services. The assessment identified costs associated with work that will need to be redone due to the change in the expected construction date. Consequently, an impairment of £2.0m has been recorded in the accounts. This impairment does not affect our control totals.

Additionally, the Trust has undertaken a detailed assessment of the costs incurred to date in relation to the Electronic Health Records (EHR) project and has evaluated the extent to which these costs would be replicated in a comparable future deployment. Based on this analysis, it has been determined that certain efficiencies and cost savings could reasonably be expected in any subsequent implementation. These savings primarily relate to streamlined governance processes and reduced staff deployment time, owing to the retention of internal expertise and institutional knowledge. However, it has also been concluded that a significant proportion of the costs incurred represent near full-cost outlays that would likely be required again in a future deployment. As a result of this assessment, an impairment charge of £3.2m has been recognised in the financial statements. This impairment reflects the portion of costs not expected to yield future economic benefit and has been accounted for accordingly.

It is important to note that this impairment does not impact the Trust's control totals.

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 has determined that the lease term for the Heart and West Essex PFI Lease is 42 years, based on recent discussions with the lessor, NHS Property Services Ltd. This decision is pending the finalisation of the formal legal agreement.

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 2024. 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 2024/25 the majority of the Trust income is in the form of a fixed payment and a variable element. The Trust earned variable 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 (pass-through) incurred.

In 2024/25, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets. Income earned from the fund is accounted for as variable consideration. During 2024/25 the Trust agreed a fixed payment with HWEICB for the period November 2024 to March 2025 for Elective Recovery Fund income to mitigate the income risk resulting from the Electronic Health Record implementation.

We implemented a new Electronic Health Record System in 2024/25. While this has given us some initial challenges on reporting in 2024/25, we feel longer term, it will assist in our ability to capture, report and bill for income. Local arrangements around de facto block income in 2024/25 safeguarded against some of the reporting risks set out above.

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 1.6 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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.7 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 1.8 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 1.9 Property, plant and equipment

Note 1.9.1 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 1.9.2 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 (i.e. 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 2025 with the valuation date being 31 March 2025. 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.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.9.3 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 1.9.4 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.

Note 1.9.5 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 Years	Max life Years
Land	-	-
Buildings, excluding dwellings	15	30
Dwellings	-	-
Plant & machinery	5	15
Transport equipment	3	7
Information technology	5	8
Furniture & fittings	5	15

Note 1.10 Intangible assets

Note 1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets 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, e.g. application software, is capitalised as an intangible asset.

Note 1.10.2 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 1.10.3 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	10
Software licences	3	7

Note 1.11 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.

Between 2020/21 and 2023/24 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. Distribution of inventories by the Department ceased in March 2024.

Note 1.12 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 1.13 Financial assets and financial liabilities

Note 1.13.1 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 1.13.2 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 1.13.3 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 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 24.45% of outstanding receivables is included - was previously 23.07% in 2023/24).

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 1.13.4 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 1.14 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 1.14.1 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 are in the process of signing Mottos for most of our right of use leased buildings with other DHSC groups for a term 25 years where there were 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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.

Note 1.14.2 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 head lease.

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.

Note 1.15 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's discount rates effective from 31 March 2025. The discount rate used by the Trust for Early Retirements is 2.40% in real terms (2023/24 rate was minus 2.45%):

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 22 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 1.16 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 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 23, 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 1.17 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 dividend. 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 1.18 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 1.19 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 1.20 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 1.21 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 1.22 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 accruals 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 1.23 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 sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations

The Trust has reviewed all new accounting standards, amendments, and interpretations issued but not yet adopted as at 31 March 2025. In line with the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and HM Treasury's Financial Reporting Manual (FReM), the Trust has not early adopted any of the following standards:

IFRS 16 – Amendments – Lease Liability in a Sale and Leaseback: Provides guidance on accounting for leasebacks. Not expected to significantly affect the Trust's financial statements.

IFRS 17 – Insurance Contracts: Effective from 1 January 2025. Not expected to impact the Trust, as it does not issue insurance contracts¹.

IFRS 18 – Presentation and Disclosure in Financial Statements: Introduces a new structure for financial statements. The Trust will assess its impact once adopted by the FReM.

IFRS 19 – Subsidiaries without Public Accountability: A simplified standard for certain entities. Not currently applicable to NHS Trusts.

IAS 1 – Presentation of Financial Statements (Amendments): Clarifies classification of liabilities and disclosure of material accounting policies. The Trust is reviewing the implications for future reporting.

The Trust will continue to monitor developments and adopt these standards in accordance with national guidance when required.

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)	2024/25	2023/24
	£000	£000
Income from commissioners under API contracts - variable element*	74,465	59,253
Income from commissioners under API contracts - fixed element*	248,011	247,907
High cost drugs income from commissioners	19,337	18,858
Other NHS clinical income	20,132	5,784
Patient transport services income	208	-
Private patient income	374	462
National pay award central funding***	936	157
Additional pension contribution central funding**	14,906	8,887
Other clinical income	765	706
Total income from activities	379,134	342,014

*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/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 2.2 Income from patient care activities (by source)

	2024/25	2023/24
	£000	£000
Income from patient care activities received from:		
NHS England	32,515	36,776
Integrated care boards	345,468	304,062
Department of Health and Social Care	12	8
Non-NHS: private patients	374	462
Non-NHS: overseas patients (chargeable to patient)	207	167
Injury cost recovery scheme	551	539
Non NHS: other	7	-
Total income from activities	379,134	342,014
Of which:		
Related to continuing operations	379,134	342,014

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	207	167
Cash payments received in-year	39	36
Amounts added to provision for impairment of receivables	358	105
Amounts written off in-year	1	37

Note 3 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	729	-	729	656	-	656
Education and training	11,649	970	12,619	11,095	955	12,050
Non-patient care services to other bodies	33,455		33,455	27,341		27,341
Income in respect of employee benefits accounted on a gross basis	2,279	-	2,279	-		-
Charitable and other contributions to expenditure		-	-		57	57
Revenue from operating leases		152	152		101	101
Other income	1,620	-	1,620	1,543	-	1,543
Total other operating income	49,732	1,122	50,854	40,635	1,113	41,748

Of which:

Related to continuing operations	50,854	41,748
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The Princess Alexandra Hospital NHS Trust as lessor

Note 4 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	152	101
Total in-year operating lease income	152	101

Note 4.1 Future lease receipts

	31 March	31 March
	2025	2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	152	101
Total	152	101

Note 5 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,316	6,798
Purchase of healthcare from non-NHS and non-DHSC bodies	6,027	6,355
Staff and executive directors costs	287,182	262,831
Remuneration of non-executive directors	162	172
Supplies and services - clinical (excluding drugs costs)	28,404	22,993
Supplies and services - general	5,743	6,396
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	27,752	26,256
Consultancy costs	1,898	3,002
Establishment	3,346	2,632
Premises	18,715	15,729
Transport (including patient travel)	435	514
Depreciation on property, plant and equipment	13,776	11,660
Amortisation on intangible assets	2,417	3,001
Net impairments	6,815	2,931
Movement in credit loss allowance: contract receivables / contract assets	468	(144)
Change in provisions discount rate(s)	18	-
audit services- statutory audit	190	153 **
Internal audit costs	102	128
Clinical negligence	14,629	13,591
Legal fees	435	568
Insurance	132	122
Education and training	3,714	2,604
Variable lease payments not included in the liability	544	-
Redundancy	266	300
Car parking & security	1,751	1,181
Hospitality	22	41
Losses, ex gratia & special payments	184	118
Other services, eg external payroll	637	440
Other	(742)	(109)
Total	433,338	390,263

Of which:

Related to continuing operations 433,338 390,263

The audit fee for KPMG shown above of £190k (Excluding VAT the audit fee is £140k) is inclusive of VAT which is not recoverable and includes variation fees for 2023-24. (2023-24: £128K)

Note 5 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2023/24: £1 million).

Note 5.2 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	2,048	-
Changes in market price	4,767	2,931
Total net impairments charged to operating surplus / deficit	6,815	2,931
Impairments charged to the revaluation reserve	-	139
Total net impairments	6,815	3,070

Note 6 Employee benefits

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	196,348	169,809
Social security costs	21,090	18,693
Apprenticeship levy	969	882
Employer's contributions to NHS pensions	36,999	28,931
Pension cost - other	24	28
Temporary staff (including agency)	39,166	48,356
Total gross staff costs	294,596	266,699
Of which		
Costs capitalised as part of assets	7,148	3,568

Note 6.1 Retirements due to ill-health

During 2024/25 there were 5 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £107k (£172k in 2023/24).

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 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by 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 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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 2024/25 was 3% (2023/24 3%).

Note 8 Finance income

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	1,202	1,378
Total finance income	1,202	1,378

Note 9 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	386	296
Total interest expense	386	296
Unwinding of discount on provisions	9	10
Other finance costs	-	3
Total finance costs	395	309

Note 9.1 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Losses on disposal of assets	(378)	(3,688) ***
Total other gains / (losses)	(378)	(3,688)

As of the financial year ending 31 March 2025, the Trust has derecognised a lease and disposed of certain Plant & Machinery. These actions were undertaken in alignment with the Integrated Care System (ICS) strategic plan for our system, specifically during the Trust Pathology transfer.

Note 10 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	-	10,890	16,044	11,388	38,322
Additions	217	-	17,443	-	17,660
Impairments	-	-	(3,240)	-	(3,240)
Reclassifications	798	410	10,180	(11,388)	-
Valuation / gross cost at 31 March 2025	1,015	11,300	40,427	-	52,742
Amortisation at 1 April 2024 - brought forward	-	3,154	15,033	-	18,187
Provided during the year	69	1,473	875	-	2,417
Amortisation at 31 March 2025	69	4,627	15,908	-	20,604
Net book value at 31 March 2025	946	6,673	24,519	-	32,138
Net book value at 1 April 2024	-	7,736	1,011	11,388	20,135

Note 10.1 Intangible assets - 2023/24

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023 - as previously stated	-	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 - as previously stated	-	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 11.1 Property, plant and equipment - 2024/25

	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 2024 - brought forward	7,723	122,871	28,334	47,577	303	34,963	1,332	243,103
Additions	-	759	20,984	402	-	562	21	22,728
Impairments	(140)	(1,387)	(2,048)	-	-	-	-	(3,575)
Revaluations	-	2,388	-	-	-	-	-	2,388
Reclassifications	-	7,821	(9,130)	1,309	-	-	-	-
Disposals / derecognition	-	-	-	(1,882)	-	-	-	(1,882)
Valuation/gross cost at 31 March 2025	7,583	132,452	38,140	47,406	303	35,525	1,353	262,762
Accumulated depreciation at 1 April 2024 - brought forward	-	8,239	-	31,309	217	23,013	1,198	63,976
Provided during the year	-	4,796	-	3,632	26	2,746	17	11,217
Disposals / derecognition	-	-	-	(1,485)	-	-	-	(1,485)
Accumulated depreciation at 31 March 2025	-	13,035	-	33,456	243	25,759	1,215	73,708
Net book value at 31 March 2025	7,583	119,417	38,140	13,950	60	9,766	138	189,054
Net book value at 1 April 2024	7,723	114,632	28,334	16,268	86	11,950	134	179,127

Note 11.2 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 - as previously stated	8,054	110,830	24,026	44,005	303	29,870	1,332	218,420
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2023 - restated	8,054	110,830	24,026	44,005	303	29,870	1,332	218,420
Transfers by absorption	-	-	-	-	-	-	-	-
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 - as previously stated	-	4,054	-	28,054	188	20,512	1,180	53,988
Accumulated depreciation at 1 April 2023 - restated	-	4,054	-	28,054	188	20,512	1,180	53,988
Transfers by absorption	-	-	-	-	-	-	-	-
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 11.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under constructio	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,583	119,417	38,140	12,730	60	9,766	138	187,834
Owned - donated/granted	-	-	-	1,220	-	-	-	1,220
Total net book value at 31 March 2025	7,583	119,417	38,140	13,950	60	9,766	138	189,054

Note 11.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under constructio	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 12 Donations of property, plant and equipment

The Trust did not received any Property, plant and equipment donation in the year 2024-25

Note 13 Revaluations of property, plant and equipment

The trust appointed Newmark Gerald Eves (GE) LLP, independent firm of professional valuers, to provide a report on the movement in building costs and land values during 2024/25 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 (December 2024 edition) published by the Royal Institution of Chartered Surveyors (RICS), except as otherwise stated below. We refer in this report to those Global Standards and the national standards and guidance set out in the UK national supplement (October 2023 edition) collectively as “the Standards”.

Basis of Valuations

Basis of Valuation for NHS Trust Properties

In preparing the property valuations as at 31 March 2025, Newmark (formerly Gerald Eve) has undertaken the work in accordance with the relevant professional and regulatory standards. Specifically, the valuations have been carried out in compliance with:

International Financial Reporting Standards (IFRS), with particular reference to:

- IAS 16 – Property, Plant and Equipment
- IAS 40 – Investment Property
- IFRS 13 – Fair Value Measurement

The Department of Health Group Accounting Manual 2024/25 and HM Treasury Financial Reporting Manual (FRM) 2024–25.

Valuation Methodology

For the valuation of the Trust’s hospital sites, the **Depreciated Replacement Cost (DRC)** method has been adopted. This approach has been applied to each site in its entirety, recognising that while certain elements—such as office accommodation, ancillary buildings, or car parking—may not be specialised in isolation, they are considered integral to the operation and service delivery of the healthcare estate. These components are therefore treated as inseparable from the specialised healthcare facilities for valuation purposes, as their presence enhances the overall utility and value of the site.

Replacement Cost Assessment

The replacement build cost rates used in the DRC assessments have been primarily derived from the **Building Cost Information Service (BCIS)** and other published cost data. These have been supplemented, where appropriate, by the valuers’ knowledge of recent construction projects undertaken by the Trust, covering both general and specialised healthcare accommodation.

For this update valuation, conducted in year four of the Trust’s standard five-year revaluation cycle, the construction cost rates have been **rebased using current BCIS cost data**, rather than applying indexation to previous figures. This ensures that the valuation reflects prevailing market conditions.

The applied build costs have been further adjusted to reflect a **location factor** specific to the Trust’s geographical area. Within this approach, the valuers have assumed an **instant build scenario**, excluding finance costs and contingency allowances. All DRC figures are inclusive of professional fees.

Infrastructure directly associated with buildings (e.g. drainage, service connections) has been accounted for through an uplift to the base construction cost rates. Roads, car parks, and other site infrastructure have been treated as **separate assets**.

Plant, Equipment and Capital Enhancements

The valuations include the value attributable to items of plant and equipment that are integral to the buildings and necessary for the provision of normal building services.

In preparing the valuation as at 31 March 2025, the valuers have also taken into account the cost of significant capital improvements completed since the previous valuation (as at 31 March 2024), where such improvements can be clearly allocated to specific assets

In addition, the Trust has advised the valuers of a number of site-wide capital projects completed during the year. The Trust has supported the allocation of these expenditures to specific buildings or blocks through a series of approximate apportionments, which have been reflected in the valuation.

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 13.1 Right of use assets - 2024/25

	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 2024 - brought forward	42,187	3,320	191	45,698	32,458
Additions	3,922	-	-	3,922	3,246
Remeasurements of the lease liability	191	-	-	191	109
Disposals / derecognition	(154)	-	-	(154)	(154)
Valuation/gross cost at 31 March 2025	46,146	3,320	191	49,657	35,659
Accumulated depreciation at 1 April 2024 - brought forward	2,765	1,235	-	4,000	1,151
Provided during the year	1,914	581	64	2,559	1,041
Accumulated depreciation at 31 March 2025	4,679	1,816	64	6,559	2,192
Net book value at 31 March 2025	41,467	1,504	127	43,098	33,467
Net book value at 1 April 2024	39,422	2,085	191	41,698	31,307
Net book value of right of use assets leased from other DHSC group bodies					33,467

Note 13.2 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	30,207	3,320	125	33,652	20,951
Remeasurements of the lease liability	15,668	-	66	15,734	15,195
Disposals / derecognition	(3,688)	-	-	(3,688)	(3,688)
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 13.3 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 19.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	41,620	27,943
Lease additions	3,922	-
Lease liability remeasurements	191	15,734
Interest charge arising in year	386	296
Early terminations	-	179
Lease payments (cash outflows)	(3,199)	(2,532)
Carrying value at 31 March	42,920	41,620

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 is £0k and is included within revenue from operating leases in note 4.

Note 13.4 Maturity analysis of future lease payments

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,718	1,065	2,402	1,074
- later than one year and not later than five years;	11,265	5,808	10,868	5,858
- later than five years.	33,602	29,678	33,467	30,534
Total gross future lease payments	47,585	36,551	46,737	37,466
Finance charges allocated to future periods	(4,665)	(1,552)	(5,117)	(4,660)
Net lease liabilities at 31 March 2025	42,920	34,999	41,620	32,806
Of which:				
Leased from other DHSC group bodies		34,999		32,806

Note 14 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	1,086	1,265
Consumables	2,963	3,607
Energy	136	163
Total inventories	4,185	5,035
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £57,060k (2023/24: £36,763k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

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. Distribution of inventory by the Department ceased in March 2024.

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 15.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	6,111	12,075
Allowance for impaired contract receivables / assets	(2,075)	(2,251)
Prepayments (non-PFI)	2,658	2,794
VAT receivable	3,399	1,829
Other receivables	1	506
Total current receivables	10,094	14,953
Non-current		
Contract receivables	575	576
Other receivables	506	497
Total non-current receivables	1,081	1,073
Of which receivable from NHS and DHSC group bodies:		
Current	3,171	9,353
Non-current	506	497

Note 15.2 Allowances for credit losses

	2024/25	2023/24
	Contract	Contract
	receivables	receivables
	and contract	and contract
	assets	assets
	£000	£000
Allowances as at 1 April - brought forward	2,251	2,395
New allowances arising	807	664
Reversals of allowances	(339)	(808)
Utilisation of allowances (write offs)	(644)	-
Allowances as at 31 Mar 2025	2,075	2,251

Note 16 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.

	2024/25	2023/24
	£000	£000
At 1 April	28,242	39,196
Net change in year	386	(10,954)
At 31 March	28,628	28,242
Broken down into:		
Cash at commercial banks and in hand	211	124
Cash with the Government Banking Service	28,417	28,118
Total cash and cash equivalents as in SoFP	28,628	28,242
Total cash and cash equivalents as in SoCF	28,628	28,242

Note 16.1 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	31 March
	2025	2024
	£000	£000
Bank balances	22	22
Total third party assets	22	22

Note 17 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	15,366	7,581
Capital payables	5,365	9,610
Accruals	16,793	21,829
Social security costs	2,456	2,604
Other taxes payable	1,764	2,436
Pension contributions payable	2,961	2,725
Other payables	393	4,430
Total current trade and other payables	45,098	51,215
Of which payables from NHS and DHSC group bodies:		
Current	4,039	2,632
Non-current	-	-

Note 18 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	549	246
Total other current liabilities	549	246

Note 19 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Lease liabilities	2,718	2,402
Total current borrowings	2,718	2,402
Non-current		
Lease liabilities	40,202	39,218
Total non-current borrowings	40,202	39,218

Note 19.1 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2024	41,620	41,620
Financing cash flows - payments and receipts of principal	(2,813)	(2,813)
Financing cash flows - payments of interest	(385)	(385)
Additions	3,922	3,922
Lease liability remeasurements	191	191
Application of effective interest rate	385	385
Carrying value at 31 March 2025	42,920	42,920

	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

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 2024	385	475	300	690	1,850
Change in the discount rate	18	-	-	(5)	13
Arising during the year	62	660	266	18	1,006
Utilised during the year	(71)	(43)	(100)	(24)	(238)
Reversed unused	-	(416)	-	(49)	(465)
Unwinding of discount	9	-	-	26	35
At 31 March 2025	403	676	466	656	2,201
Expected timing of cash flows:					
- not later than one year;	69	627	466	27	1,189
- later than one year and not later than five years;	277	-	-	73	350
- later than five years.	56	49	-	557	662
Total	402	676	466	657	2,201

Note 22 Clinical negligence liabilities

At 31 March 2025, £116,176k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of No trust selected (31 March 2024: £119,478k).

Note 23 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(14)	(14)
Employment tribunal and other employee related litigation	(145)	(188)
Gross value of contingent liabilities	(159)	(202)
Net value of contingent assets	-	-

Note 24 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	6,150	3,728
Intangible assets	141	3,489
Total	6,291	7,217

Note 25 Financial instruments

Note 25.1 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 25.2 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2025		
Trade and other receivables excluding non financial assets	4,612	4,612
Cash and cash equivalents	28,628	28,628
Total at 31 March 2025	33,240	33,240

	Held at amortised cost £000	Total book value £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

Note 25.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025		
Obligations under leases	42,920	42,920
Trade and other payables excluding non financial liabilities	33,907	33,907
Total at 31 March 2025	76,827	76,827

	Held at amortised cost £000	Total book value £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

Note 25.4 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 2025 £000	31 March 2024 £000
In one year or less	36,625	44,421
In more than one year but not more than five years	11,265	10,868
In more than five years	33,602	33,467
Total	81,492	88,756

Note 26 Losses and special payments

	2024/25		2023/24	
	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	1,467	444	1,082	83
Stores losses and damage to property	23	175	12	33
Total losses	1,490	619	1,094	116
Special payments				
Compensation under court order or legally binding arbitration award	1	7	6	15
Ex-gratia payments	5	2	5	70
Total special payments	6	9	11	85
Total losses and special payments	1,496	628	1,105	201
Compensation payments received				

Details of cases individually over £300k

There was no case exceeding £300k during the 2024/25 financial year, (2023/24 £0K).

Note 27 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

Other NHS Providers

NHS Hertfordshire and West Essex ICB

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

NHS Property Services

HM Revenue and Customs
NHS North East London ICB
Local Authorities

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 £534k (unaudited) to the trust (2023/24 £392k, audited)

Note 28 Better Payment Practice code

	2024/25	2024/25	2023/24	2023/24
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	52,201	182,340	60,823	194,383
Total non-NHS trade invoices paid within target	49,396	166,392	57,051	180,326
Percentage of non-NHS trade invoices paid within target	94.6%	91.3%	93.8%	92.8%
NHS Payables				
Total NHS trade invoices paid in the year	1,922	19,503	1,901	48,358
Total NHS trade invoices paid within target	1,683	17,995	1,830	47,644
Percentage of NHS trade invoices paid within target	87.6%	92.3%	96.3%	98.5%

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 28.1 Capital Resource Limit

	2024/25	2023/24
	£000	£000
Gross capital expenditure	47,884	45,698
Less: Disposals	(551)	(3,688)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	3,688
Charge against Capital Resource Limit	47,333	45,698
Capital Resource Limit	47,333	46,304
Under / (over) spend against CRL	-	606

Note 29 Breakeven duty financial performance

	2024/25	2023/24
	£000	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(8,252)	(13,477)
Remove impairments scoring to Departmental Expenditure Limit	6,815	2,931
Remove capital donations / grants / peppercorn lease i&E impact	283	316
Remove net impact of DHSC centrally procured inventories	57	417
Remove Loss on modification of lease liability	-	3,688
Breakeven duty financial performance surplus / (deficit)	(1,097)	(6,125)

Note 30 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		511	415	461	122	(16,403)	(21,998)	(37,714)	(26,715)
Breakeven duty cumulative position	1,536	2,047	2,462	2,923	3,045	(13,358)	(35,356)	(73,070)	(99,785)
Operating income		172,171	179,388	180,790	184,568	177,739	190,478	196,124	209,742
Cumulative breakeven position as a percentage of operating income		1.2%	1.4%	1.6%	1.6%	(7.5%)	(18.6%)	(37.3%)	(47.6%)
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
		£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(28,435)	(16,542)	418	1,816	1,110	(13,049)	(6,125)	(1,097)
Breakeven duty cumulative position		(128,220)	(144,762)	(144,344)	(142,528)	(141,418)	(154,467)	(160,592)	(161,689)
Operating income		213,231	236,700	288,491	315,122	355,856	361,581	383,762	429,988
Cumulative breakeven position as a percentage of operating income		(60.1%)	(61.2%)	(50.0%)	(45.2%)	(39.7%)	(42.7%)	(41.8%)	(37.6%)

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

			2024/25	2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	195,587	761	196,348	169,809
Social security costs	21,090	-	21,090	18,693
Apprenticeship levy	969	-	969	882
Employer's contributions to NHS pension scheme	36,999	-	36,999	28,931
Pension cost - other	24	-	24	28
Temporary staff	-	39,166	39,166	48,356
Total gross staff costs	254,669	39,927	294,596	266,699
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	254,669	39,927	294,596	266,699
Of which				
Costs capitalised as part of assets	6,876	272	7,148	3,568

Average number of employees (WTE basis)

			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number Restated
Medical and dental	302	293	595	544
Administration and estates	1,018	91	1,109	1,040
Healthcare assistants and other support staff	538	25	563	588
Nursing, midwifery and health visiting staff	1,202	39	1,241	1,145
Scientific, therapeutic and technical staff	241	16	257	239
Healthcare science staff	83	6	89	96
Total average numbers	3,384	470	3,854	3,652
Of which:				
Number of employees (WTE) engaged on capital projects	159	11	170	108

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
£50,001 - £100,000	1	-	1
Total number of exit packages by type	1	-	1
Total cost (£)	100	£0	£100

Reporting of compensation schemes - exit packages 2023/24

There was no exit packages in 2023/24