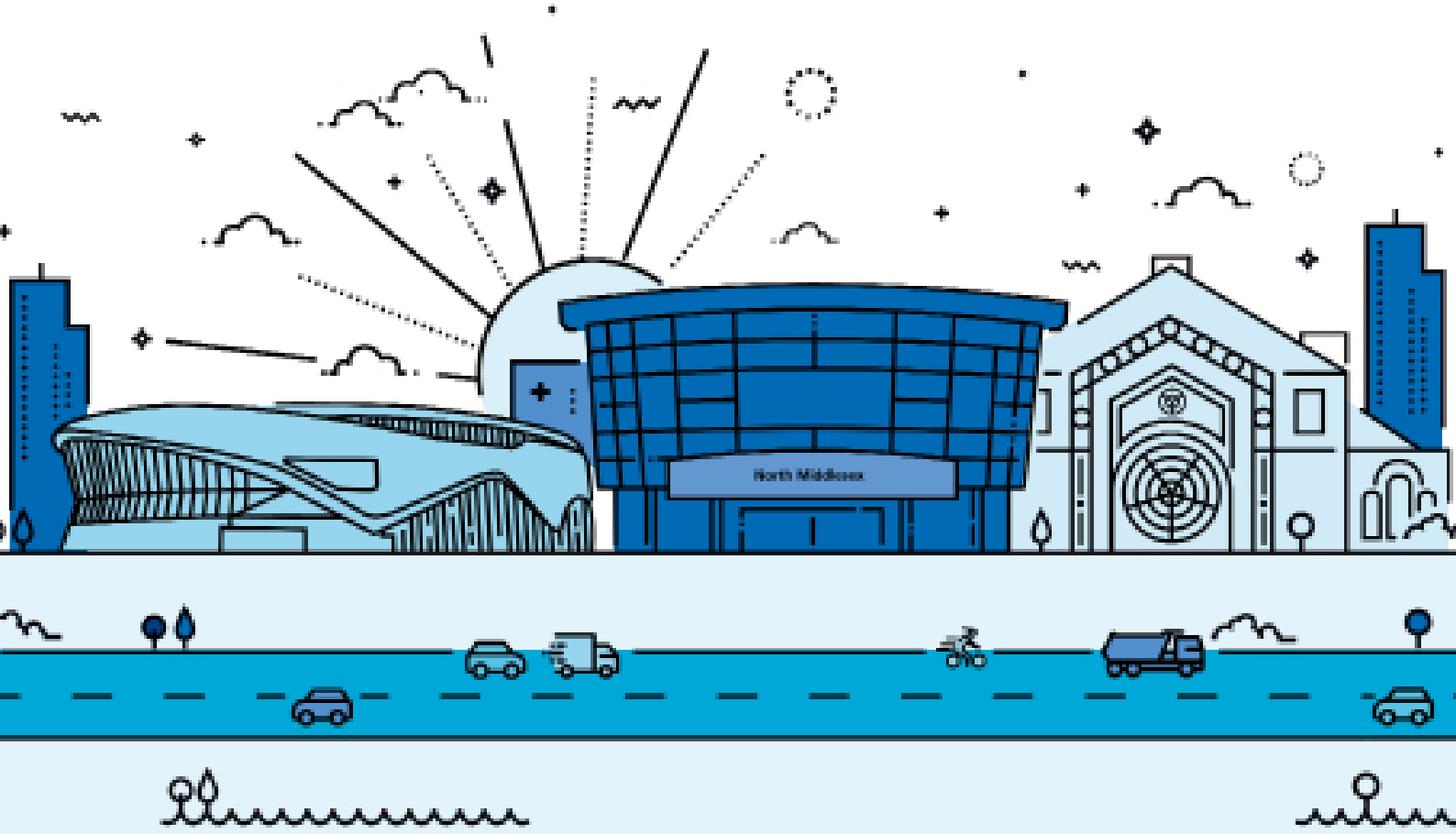
North Middlesex University Hospital NHS Trust

Patients, people, partners, progress

Our annual report for 2018-19



Welcome to our 2018-19 annual report

Last year saw a huge amount of progress and improvement at North Mid.

We redeveloped and expanded our A&E, increasing capacity both in our majors department where some of our sickest patients are cared for, and in our urgent care centre.

We regularly see 600 patients come through the doors of A&E every day, and the newly configured department supports our staff to provide care quicker than ever before.

This is as a result of changing how we work together. It's a combination of specialist teams working better together to put patients' care, experience, and valuable time, at the heart of what we do.

Our wonderful staff make this hospital what it is, providing care 24 hours a day, 365 days of the year. They are not only experts in clinical skills, patient care, and support services, but in knowing what makes North Mid tick, and what causes frustrations and bottlenecks. In 2018-19, we made sure that we listened carefully to what staff were saying - and, more importantly, followed up listening by taking action. Our Listening into Action programme has resulted in improvements throughout North Mid, including extended blood test opening hours for children, better coordination of transport arrangements for patients being discharged, and increased wellbeing support for staff to ensure they're healthy and able to work.

But North Mid is much more than the wards and clinics we provide patient care from.

We know people look to us as a key part of the local community, as an anchor organisation, one they can count on.

The early months of 2018-19 saw a series of almost unspeakable tragedies involving knife and gun violence in the local area surrounding North Mid. Our hospital is where far too many victims - and perpetrators - of this type of violence need to come for treatment. We've stepped up how we use our unique position in the community to reduce the violence, to protect local residents, especially children and young people, and to help them live their best lives.

We know that there is still a lot to do, but we are making progress - and fast.

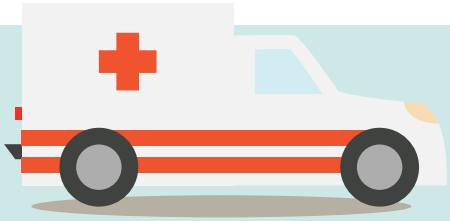
We believe that we can achieve more by working in close partnership with colleagues throughout the health and care system, and from across the local area. That's why we're showcasing some of our recent improvements in this annual report, and asking you to join with us to go further, faster, to help us continue to get better - for our patients, staff and local community. We have recently published our Forward View, which sets out the fundamental framework for what this Trust will do, and how we will do it, over the coming five years. We want to provide outstanding care for local people, work with partners, and support people to stay as healthy as possible throughout their lives. I would encourage you to take a look at it and to consider it alongside this report of the past year.

Thank you for reading our annual report for 2018-19. I look forward to hearing your views and comments.

Maria Kane

Chief Executive

The year in numbers:

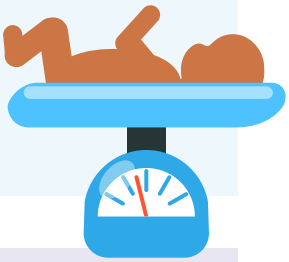


181,135 patients

through our A&E

4,564 babies

born in our maternity unit



Over **98%**

of new cancer patients treated **within 31 days** of decision to treat

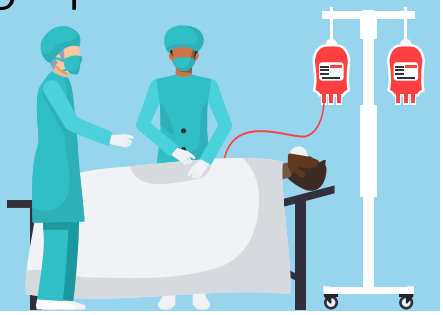
426,824 patients

attending outpatient clinic appointments

19 out of **20** patients

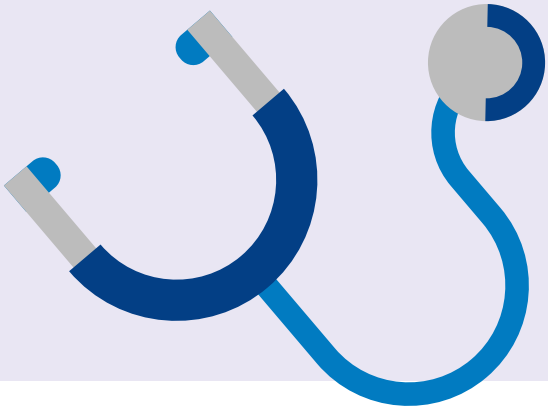
treated **within 18 weeks** of being referred to North Mid

40,445
patients
having operations



71,000
patients
referred to us by other health professionals

47,600
patients
referred by their GP



More than **99%**
of patients getting diagnostic test results **within six weeks**

And every one of them mattered to us as much as our own family.

In this section, we summarise what we planned to do during 2018-19, what we achieved, what went well and any problems which made it harder to achieve what we wanted to do. This is our performance report.

Our Trust has a clear vision: to provide outstanding care for local people.

To achieve this vision, we are committed to providing:

- Excellent outcomes for patients
- Excellent experience for patients and staff
- Excellent value for money

This is the progress we made in 2018-19.

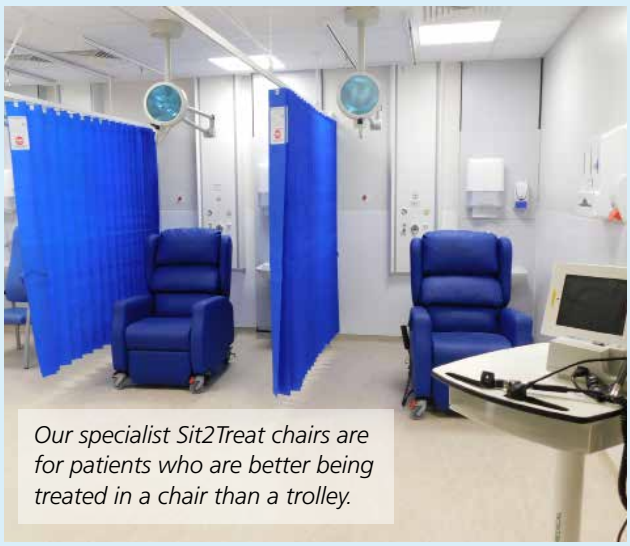
We provide more than 426,000 outpatient appointments every year.

Excellent outcomes for patients

Looking after people, treating patients who are unwell and helping local people get the best clinical outcome they can – that's what drives everyone at North Mid to do their very best, every day.

A spacious new layout in our A&E

More room for treating patients



Our specialist Sit2Treat chairs are for patients who are better being treated in a chair than a trolley.

Radical A&E improvement

Our A&E is one of the busiest in London. We regularly see nearly 600 patients in a day arrive at our A&E, who come for urgent treatment and care.

Last year, we fundamentally changed how we see patients in our A&E, in order to speed up how we provide safe, effective urgent care.

We worked closely with local and regional NHS partners and used the expertise of our senior doctors to develop a new model of clinical care. We involved clinical and support staff from throughout the Trust to help improve how quickly patients who arrive at A&E get seen and treated.

We introduced a Fast Initial Treatment (FIT) Zone, where patients get senior medical input within 15 minutes of arriving at A&E.

We started to use multiple queues (streams) to assess patients, so we can provide care quicker than ever before.

We created a dedicated area for patients who need complex treatment and can sit in a chair, called our Sit2Treat space. This reduces potential negative effects of patients being immobile on a trolley.

We improved how we use specialty assessment areas in other parts of the hospital, such as our surgical assessment unit and our Women's Ambulatory Day Unit. This means we can assess and provide care for patients faster and more conveniently.

By Summer 2018, we had reduced the amount of time patients wait to be seen by a nurse or doctor by one-third. Clinicians are seeing patients 30 minutes sooner and we have reduced the time it takes for ambulances to be able to hand over their patients by almost one-fifth.

A key part of our new clinical model is a change in how our nurses assess unwell patients. Our A&E nursing team has worked incredibly hard to incorporate this change into how they care for patients, building new skills and supported by a strong educational programme.

We have introduced classroom simulation sessions to support staff to develop their skills in the uniquely demanding environment of a very busy A&E.

More than 100 staff and contractors worked on our A&E redevelopment.

But the changes aren't only in A&E

Specialist teams from across the hospital, including surgeons, ultrasound technicians, occupational therapists, physiotherapists and speech and language therapists, work jointly as part of the new model to make sure patients get the care they need, faster.

In September 2018, the Government announced £145 million investment in the NHS to improve wards and A&Es in preparation for winter. North Mid was allocated £3 million of this funding to refurbish and reconfigure our A&E and urgent care centre.

We planned and delivered a major redevelopment of our A&E in just nine weeks, finishing in time for Christmas. We also improved the facility for caring for patients with mental health diagnoses which was completed by the end of January.

We expanded the space for treating our most unwell patients, increasing our capacity by 50%.

We increased space in our urgent care centre, where patients can be seen by GPs and emergency nurse practitioners.

We created a spacious Sit2Treat area where patients who don't need to be in a bed can get the care they need comfortably, without being immobile in a bed.

We installed new signage which explains what happens in each area of our A&E. Our partners at Healthwatch Enfield helped make sure this signage is clear for people who don't read English.

We built a specialised security hub and have increased security presence in A&E, in response to patients, visitors and staff saying they sometimes felt vulnerable and unsafe in the department.

The redevelopment of our A&E and urgent care centre involved more than 100 staff and contractors, working round the clock to finish the major project by the Christmas Eve deadline.

Healthcare support workers are vital members of our team.

From clinicians to construction workers, telephone engineers, porters, therapists, X-ray technicians, receptionists, electricians, medical gas specialists and volunteers, a huge team worked tremendously hard to make the tight turnaround a success.

We kept A&E fully open during all the building and refurbishment and saw about 58,000 patients during the period. A huge thank you to staff, contractors, patients and visitors for your patience and perseverance at a very busy time.

The redevelopment involved moving more than 1,000 tonnes of earth and rubble – more than 100 wheelie bins a day – to make room for our new mental health building, Horizon.

Our A&E sees an above average number of patients who need mental health support; Horizon is part of our continued commitment to providing outstanding care for local people.

We work with Barnet, Enfield and Haringey Mental Health NHS Trust who run a psychiatric liaison service in our A&E. This team works 24 hours, seven days a week and is the first in the UK to integrate peer support workers in a psychiatric liaison team in an emergency department.

Horizon is a purpose-built facility for A&E patients who need mental health support, with five safe, quiet spaces for people experiencing mental health crises.

In the first weeks of Horizon opening, we listened to feedback from mental health specialist staff and patients and responded by decorating Horizon's rooms and waiting area with supersized artworks depicting local calming scenes, produced by our talented Trust medical photographer, Harriet Armstrong.

This year, the number of nurses with specialist mental health training has increased and now a registered mental health nurse is working 24 hours a day, every day.

During 2018, we saw A&E attendance increase by 8%, and the number of ambulances coming to North Mid A&E rise by 30%. Despite this rising pressure, we have drastically improved our performance against the national four-hour standard, regularly reaching 90%. North Mid had been consistently in the bottom quartile of providers on this standard; by end of 2018-19, we were consistently in the top third in London.

The North Mid team includes therapists...

...nurses...

...doctors, and a whole range of specialist and support staff.

Developing our partnerships with local neighbours

During 2018, the Trust considered a proposal for closer convergence with the Royal Free London NHS Foundation Trust. We engaged widely with our local communities, staff and their representatives, as well as other stakeholders such as our statutory partners. The Trust Board considered a document entitled 'Case for Change' at the Trust Board meeting in October 2018.

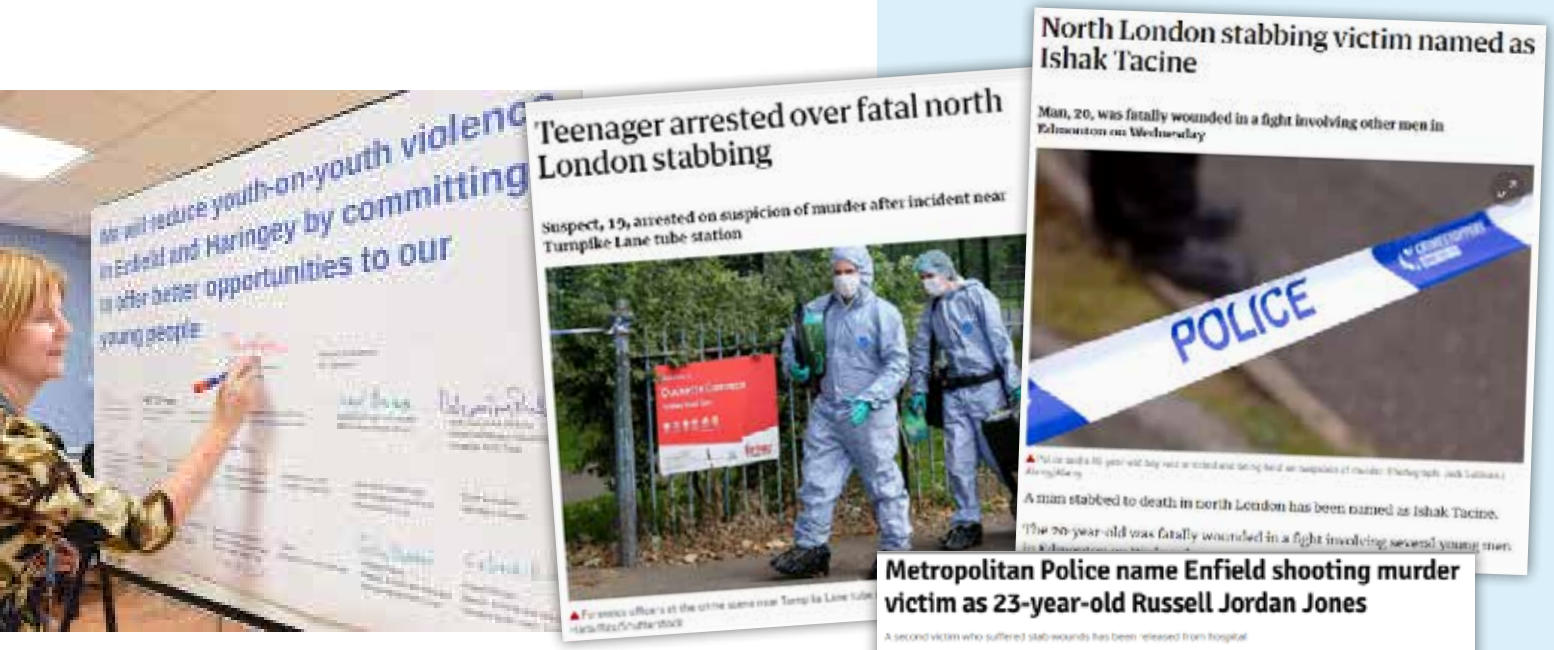
We heard from a wide range of stakeholders across the local area that they wanted North Mid to remain a central part of the local Enfield and Haringey community, to retain accountability through its own Board and to develop stronger relationships with partners in the local area, including those involved in supporting and looking after vulnerable people in the geographical area served by North Mid. Staff and patients were very clear about the importance of the hospital in delivering local services centred around the local population it serves.

We consistently heard that, although local people, staff and partners were supportive of the existing clinical partnership, they did not want us to move into full membership of the Royal Free London group. The Trust Board considered these views and the importance of local provision and decided not to proceed with full membership.

Throughout the extensive engagement which we carried out as part of considering the case for change, lots of individuals, groups and organisations told us that they wanted us to explore developing stronger partnerships with other local organisations. The key objective for 2019-20 is the development of a Forward View that considers the local improvement in services that will provide outstanding care for our population as well as the partnerships and collaborations that will make the hospital stronger and more resilient for the future.

We're proud to be embedded in busy north London.

We offer life-support training and first aid classes to help local families feel more confident in healthcare for children.



Leading work with local partners to reduce youth violence and knife crime

In 2018-19, there were more than 20 knife and gun fatalities in Enfield and Haringey, all involving teenagers and young people under 30.

Knife crime and youth violence is a significant challenge across London, but it is particularly acute in the area served by North Mid. In the 12 months to November 2018, Enfield and Haringey had the third and fifth highest volumes of serious youth violence in the capital.

North Mid responded to this series of tragedies by convening a roundtable of high profile senior leaders from across our two local boroughs and the wider north London area, leading work to create a step-change in reducing the violence and consequence for our local communities.

In October 2018, North Mid brought together MPs, council leaders and chief executives, the Metropolitan Police borough commander, youth service leaders, community activists, A&E doctors, psychiatrists and elected councillors, and secured their commitment to join forces to reduce the chances of young people being victims of youth-c youth violence.

Since our kick-starter 'roundtable' event, we have contributed to local anti-violence work, including the North Area Knife Crime and Serious Youth Violence Action Plan.

We have helped with the production of a ground-breaking film about knife crime by youth campaigner, Amani Simpson and supported its roll-out into schools and young people's groups.

*Trust Chief Executive Maria Kane (top left) signs her pledge to work with community leaders to reduce knife crime and youth violence in Enfield and Haringey. We are proud to have supported the production of *Amani*, a award-winning film for young people about knife crime dangers.*

We have also begun an innovative programme of outreach into primary and community schools in the local area, with our trauma and A&E doctors and a multi-agency team visiting schools like Park View Academy in Tottenham, Woodside High School in Wood Green, and St Francis de Sales Catholic Infant and Junior School in Tottenham, training teachers and safeguarding staff on how to spot and reduce the chances of children and teenagers being at risk of gangs, knife and gun crime and youth violence.

Our joint work with local police, councils, community and voluntary sector organisations is helping us make the most of our unique position as the local NHS acute hospital which often has to pick up the pieces following serious violence.

Thanking local MPs and other attendees who came to our youth-on-youth violence roundtable, Chief Executive Maria Kane said:

"We are such a central part of our local community and we want the very best for everyone in it. We want to use our position in the local system to support the changes that we know need to happen and I'm simultaneously delighted and grateful that so many local leaders have agreed to align efforts and expertise, in order to make a real difference for our local young people."

Our work with local partners across Enfield, Haringey and north central London to reduce violent crime and improve outcomes for young people in our communities builds on our successful work with the Oasis Trust, which sees dedicated youth workers embedded in our A&E. In early 2019, we expanded this service and are continuing to increase the provision of this vital and valuable service to support our local young people and families. In July 2018, as a result of positive impact of the service, the Mayor's Office for Policing and Crime (MOPAC) confirmed an extension of funding for this work.

Paediatric consultant, Dr Gayle Hann, who leads our work with Oasis Youth, won the London region NHS70 Parliamentary Award for urgent and emergency care for her work with Oasis.

Trauma director Dr Clara Oliver (bottom) leads joint safeguarding sessions with Met Police colleagues in local schools, which are the first of their kind in England.

Kids' Kits for children and young people

Dr Hann was also named as one of London's top 20 'leading lights' in health services by the Evening Standard for her work in developing 'Kids' Kits' - rucksacks filled with clothes, toiletries and toys for children going into emergency foster care. In 2018-19, North Mid's charitable fund financed the first full year of providing Kids' Kits, following the original small scale pilot in 2017. Dr Hann has now secured commercial sponsorship of the scheme.

Extending services and opening hours

Last year, we extended a number of our key services:

In September 2018, our children's blood testing service expanded from afternoons only to an all-day service, offering more convenience for local families. The service change was staff-led and prompted by the phlebotomy team wanting to respond to patient choice. The longer opening hours have improved access and reduced in-clinic waits.

And in early November 2018, we opened a third endoscopy room, expanding our capacity to be able to respond to increased demand prompted by national bowel screening and other health promotional activity. We spent £838,000 to convert and equip a clinical room into the new endoscopy facility, increasing capacity by one third, reducing waiting times for urgent cancer scopes and routine procedures.

Caring for people with dementia

There are more than 850,000 people living with dementia in the UK and this is expected to rise to more than one million by 2021. In response, we have developed a three-year strategy to focus on improving how we care for people with dementia.

In 2018, we introduced easy-to-use tools for staff to personalise the care they offer, including '10 important things about me' and additional signage on patients' notes and at their bedside.

We collaborated with Enfield Carers Centre, whose staff came to North Mid to train our team who have regular contact with people with dementia. Through this partnership, our staff who undertake the Enhanced Tier 2 Dementia training programme also heard from a carer who shared her first hand experiences of looking after a person with dementia and her insights about their hospital stay.

Through our Dragons' Den programme (modelled on the popular TV series), we have also invested in extra resources to help people with dementia. We have worked with local schools and colleges to develop culturally sensitive reminiscence toolkits, so that patients who grew up overseas can use memory prompts which are meaningful to their early lives and specialist clocks which help people with dementia orientate to time and place.

In 2018, North Mid joined John's Campaign, a charity which seeks to extend visiting rights for family carers of patients with dementia in hospitals, and are now providing flexible visiting hours for carers of people with dementia to stay with their loved ones.


Meet the A&E doctor awarded for saving the lives of London's knife victims

811

Left, Dr Gayle Hann

Right, Chief Executive Maria Kane and project manager Cathy Barns open our new endoscopy room in February 2019

Get up, get dressed, get moving

For patients over 80, 10 days in a hospital bed can age muscles by 10 years. One week in bed can cause 10% muscle loss.

In Spring 2018, we took part in the national End PJ Paralysis campaign, which aimed to increase the number of patients getting dressed in their own clothes and getting up and moving. It also maintains mobility, muscle tone, independence and confidence. This helps their recovery and can reduce the length of their stay in hospital.

When the 70-day campaign ended, we worked with multidisciplinary teams - ward managers, matrons, therapists and doctors - to continue the focus on increasing mobility and reducing 'pyjama paralysis' for our patients.

Helping patients stay mobile, maintain their independence and increase their confidence is a top priority for staff at North Mid.

Our occupational therapy teams run a breakfast club for patients who are recovering from strokes to ensure they are able and confident to make themselves tea, toast, and cereal when they are ready to leave hospital.

The physiotherapy team who work with patients on our medical wards won 'team of the month' in December 2018 for their work in ensuring patients are able to recover and improve their physical strength, balance and confidence. The team receive overwhelmingly positive feedback from patients - 100% of respondents said the team did a good job, with nearly 90% saying their work was 'very good' or 'excellent'.

Our therapists work with patients to recover core skills

Research and clinical trials

As a university hospital, North Mid has an extensive research programme, which helps ensure we're always giving patients and local people the very best opportunities for excellent clinical outcomes.

Research is a key element of NHS healthcare, providing evidence-based information to help us transform services and improve the current and future health outcomes of the people we care for.

Participating in clinical research also helps our staff stay at the forefront of medical science and healthcare developments, which contributes to our organisational knowledge and culture, as well as supporting retention and recruitment of high quality staff.

All of our research is approved by the National Institute for Health Research (NIHR) and we publish quarterly updates on the trials we are taking part in.

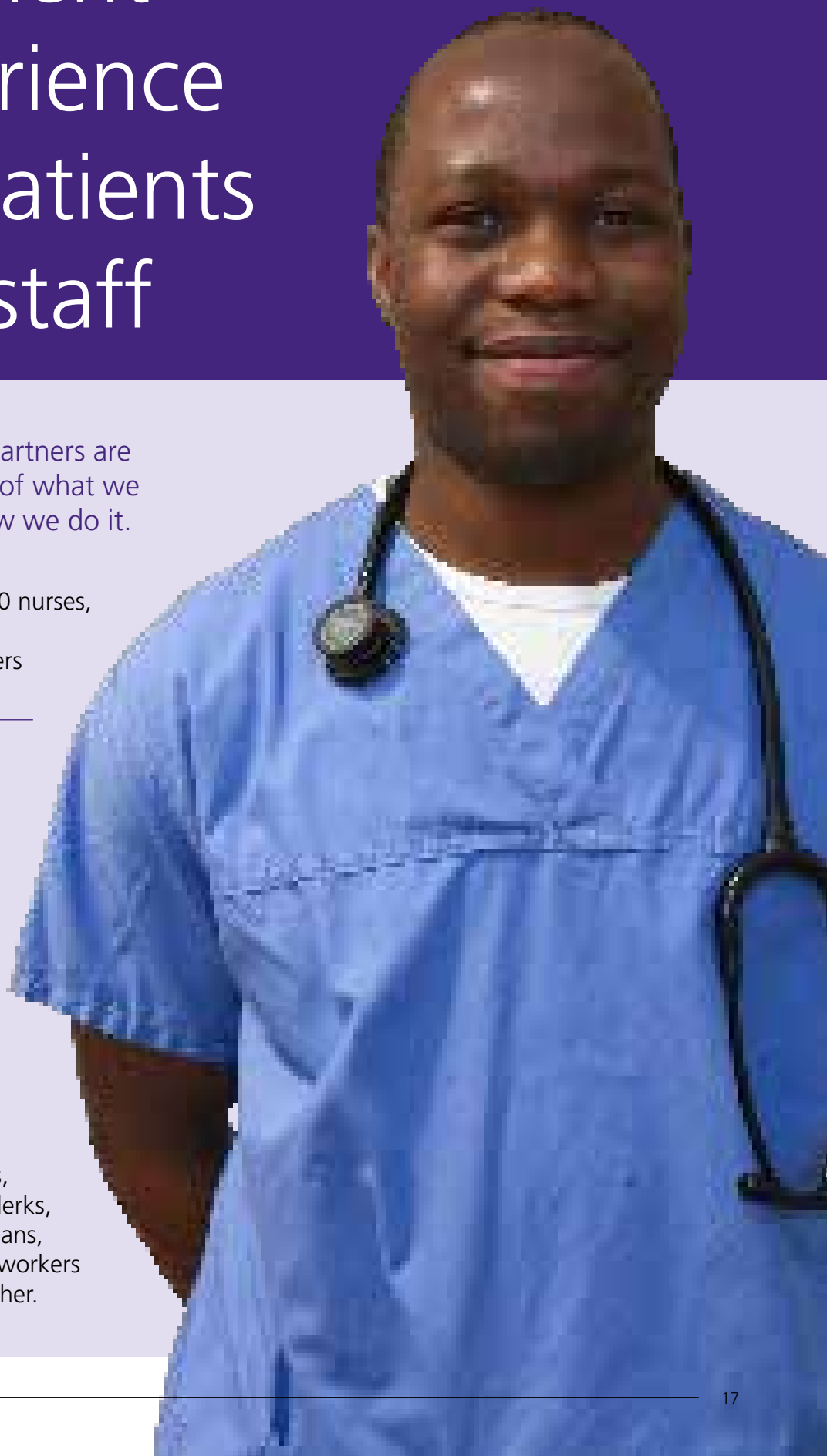
In March 2019, our clinical trials practitioner, Chloe van Someren, was awarded a prize for supporting high participation in NIHR's patient research experience survey. 100 per cent of patients who participated in clinical research said they had received all the information they needed about the study they took part in and 19 out of 20 said they had a good experience taking part in clinical research.

Everybody involved has been very helpful and supportive.

Good team, clear information, very reliable.

I was fully informed of what was going to be done and what I had to do.

Excellent experience for patients and staff



Our people and our partners are at the absolute heart of what we do, every day and how we do it.

We have more than 1,500 nurses, midwives, therapists and healthcare support workers at North Mid.

More than 500 doctors from orthopaedic surgeons to oncologists.

More than 400 scientists and technical staff, such as radiographers and pharmacists.

And a support team of receptionists, porters, medical secretaries, recruitment managers, cleaners, engineers, ward hosts and hostesses, admission and booking clerks, invoice payers, IT technicians, distribution and logistics workers and a medical photographer.

Ward manager Glenda Cagoyong (far right) and her team on one of our older people's wards

There are nearly 4,000 colleagues at North Middlesex University Hospital NHS Trust who make North Mid what it is.

And the range of roles in the NHS is much broader than you might think.

Raj Kistnareddy is a health records assistant and plays an essential role in ensuring patients are seen, treated and move onto the next stage of their care as quickly as possible. His role includes locating more than 50 sets of health records every day, for patients who arrive at our A&E and need admitting to hospital.

The NHS is the sum of all the people who work in it

The North Mid team works with patients day in, day out, who are the best people to make the changes and improvements which are going to have the biggest impact in improving how we care for and look after patients, visitors and our staff themselves.

In May 2018, we started a programme of work called Listening into Action.

Supporting staff to lead change

This involved asking every member of staff for their ideas about how to improve our hospital, what we needed to change to make things better for patients and patients and colleagues, and how we can 'unblock the way' to remove frustrations. The aim is to make North Mid continue to be a great place to work and be cared for.

We surveyed every member of staff in an initial 'pulse check' and heard from more than 1,500 individuals about what improvements were needed and how we should go about making them.

We identified and acted on a number of 'quick wins', including improvements for staff, such as a staff-only zone in the canteen at busy times so teams can share ideas over lunch or breaks, and extending out-of-hours parking for staff.

We have a strong team ethos at North Mid, and value the contribution of every member of the 'North Mid family'.

We also supported 12 teams to take forward improvements in their clinical services in direct response to what patients and families were telling them would make the service better.

These included:

- Introducing an all-day blood testing service for children
- Reducing aborted transport journeys for our A&E department so that there are fewer delays for patients being discharged from hospital
- Introducing a scoring system for frail patients who come to our A&E department to better determine the type of care they need

We also introduced new ways to support staff health and wellbeing, to support and show how much we value what the full range of diversity across our workforce brings to North Mid.

In preparation for our second year of our Listening into Action journey, we held a Pass It On event where all the teams involved in making improvements over the last year showcased what they achieved. The event was also an opportunity for staff from other departments to get ideas and advice on what they could do in their areas.

But the NorthMid family is much bigger than our staff

We have 99 volunteers who help direct visitors around the hospital site and help our patients give feedback on their care and experience. More than 60 have joined in the past year. Could you be another?

Our facilities service is provided by Medirest, who prepare and cook meals for patients, visitors and staff; clean our wards, corridors, toilets, day rooms, clinics and operating theatres; refill handtowels, cups, bed linen, gowns, alcohol gel; remove rubbish, clinical waste, dirty linen and other waste.

Last year, we got through nearly 21,000 big toilet rolls, 6,000 orange sacks for safely getting rid of clinical rubbish, 3,800 mop heads and provided over 377,000 meals to patients.

We supported nearly 82,000 patient journeys, using a mixture of patient transport service vehicles, local taxis and other transport.

Patient feedback is critical to our ongoing improvement.

We work closely with partners across the health and care system throughout the local area and north London and across the public sector like police, youth services, schools and social care.

During 2018-19, we have strengthened our valuable relationships with local stakeholders, ensuring that the expertise of statutory organisations like Healthwatch Enfield and Healthwatch Haringey help us identify where we need to focus improvement efforts and to ensure that we keep patients, carers and families at the heart of everything we do.

Patient feedback to drive improvement

We used the findings of research by Healthwatch Haringey and Healthwatch Enfield to improve how we do things in our A&E:

- We have increased the presence of volunteers in our A&E and urgent care centre waiting areas, in order to help patients waiting raise any concerns quickly
- We have worked with Enfield CCG and Haringey CCG to ensure patients get consistent accurate information about where they can get stitches removed and dressings changed
- We have installed better signage which is accessible to people with learning disabilities or who do not read English to help them know what happens in each area of the department and when and why they may have to wait
- We have increased training for clinical and reception staff about how to access Big Word, our translation and interpretation service

In Autumn 2018, we collaborated with Enfield Disability Association and our local Healthwatches to train outpatient and other staff in being able to communicate better with people with a range of sensory impairments and learning disabilities.

Patient experience strategy

In 2018, we co-produced a new patient experience strategy with Healthwatch Enfield and Healthwatch Haringey, based on what our patients told us really matters to them when they need to use North Mid's services. We used this information to agree seven 'Always Events', which our patients say are the cornerstone of a good North Mid experience and used these to form the core of our patient experience strategy. We were nominated for a Healthcare England award in recognition of being the first NHS trust to co-produce a patient experience strategy.

Carers support

One in eight people in England is a carer for family or friends, many of whom may use North Mid's services.

So it's vital that we work with carers to support them to support other people.

We offer carers discounts on hospital services like parking and refreshments, through a scheme called 'Carer's Passport' and ensure we offer flexible visiting for carers.

In 2018, we updated our carers' information booklet, which our matrons give out to families and friends of vulnerable patients.

PALS and complaints

During 2018-19, our Patient Advice and Liaison Service (PALS) dealt with 2,400 patient contacts. We have closed more than 1,900 of these and further work is ongoing to close the remaining contacts.

The top five themes which patients and families raised with PALS related to:

- Communication
- Ongoing treatment and future operations
- Being cancelled with short notice
- Information received from the Trust
- Waiting time

We received a total of 416 complaints and resolved just over half (53%) in the agreed timeframe. We know this is not a good enough proportion and that we need to improve it significantly in order to ensure patients and their families get the service they expect and deserve when things go wrong.

The number of complaints relating to our A&E reduced by more than one-third and we also received fewer complaints relating to car parking than in the previous year.

The top themes for formal complaints we received were:

- Clinical treatment
- Attitude of staff
- Delays or cancellations of outpatient appointments
- Written or verbal information given to patients
- Arrangements with patient admissions, discharges, or transfers

We also took part in national patient surveys relating to maternity services, inpatient care, emergency care and care for children and young people, using the findings to agree what we need to focus on to improve the care and experience we offer.

Our Patient Advice and Liaison Service (PALS) team help patients and families resolve issue.

CQC inspection and follow-up

In May and June 2018, the Care Quality Commission (CQC) visited North Middlesex University Hospital NHS Trust to carry out a full inspection of our core services.

Inspectors spent six days interviewing staff, patients and local people and collected feedback from patients, visitors and Enfield and Haringey community groups.

They found more than a dozen examples of outstanding practice at North Mid which they included in their report:

- Our continued commitment to learning from excellence, as well as from incidents, so that we share and celebrate good practice and embed it in all our services
- Our focus on patients, including our creative and individual ways of ensuring we personalise services and care, protect patients' dignity and meet the full range of their health needs, including caring for dementia patients who undergo surgery.
- Our commitment to carers, including practical and emotional support, such as our carers' passport and open visiting hours
- Our award-winning services and staff, including bereavement midwifery, child protection and nursing leadership

The overall inspection report was published in September 2018 and rated the Trust as 'requires improvement' overall, with a 'good' rating in response to the question 'are services caring?'

Three of the Trust's eight core services are also now rated 'good' overall – surgery, critical care and maternity, compared to just one service following our previous inspection in 2016. Additionally, a table of results showing five different ratings for each of the eight services shows that more than half – 21 out of a total of 40 – are rated 'good', the second highest possible rating.

The inspection team had particular praise for our maternity service, which it rated 'good' overall. Inspectors found the service

The CQC described our maternity service as "especially caring and responsive".

"especially caring and responsive" and that there is "a positive culture", with staff who are "committed and proud" of working at North Mid.

The report also included a detailed list of areas for improvement, including one which related to the Trust as a whole and 11 'must dos' which related to individual services.

We have used the report to develop detailed improvement plans for our services and systems to ensure we are focusing our efforts on the necessary improvements and that we are making progress faster and further, to achieve our vision of providing outstanding care for local people.

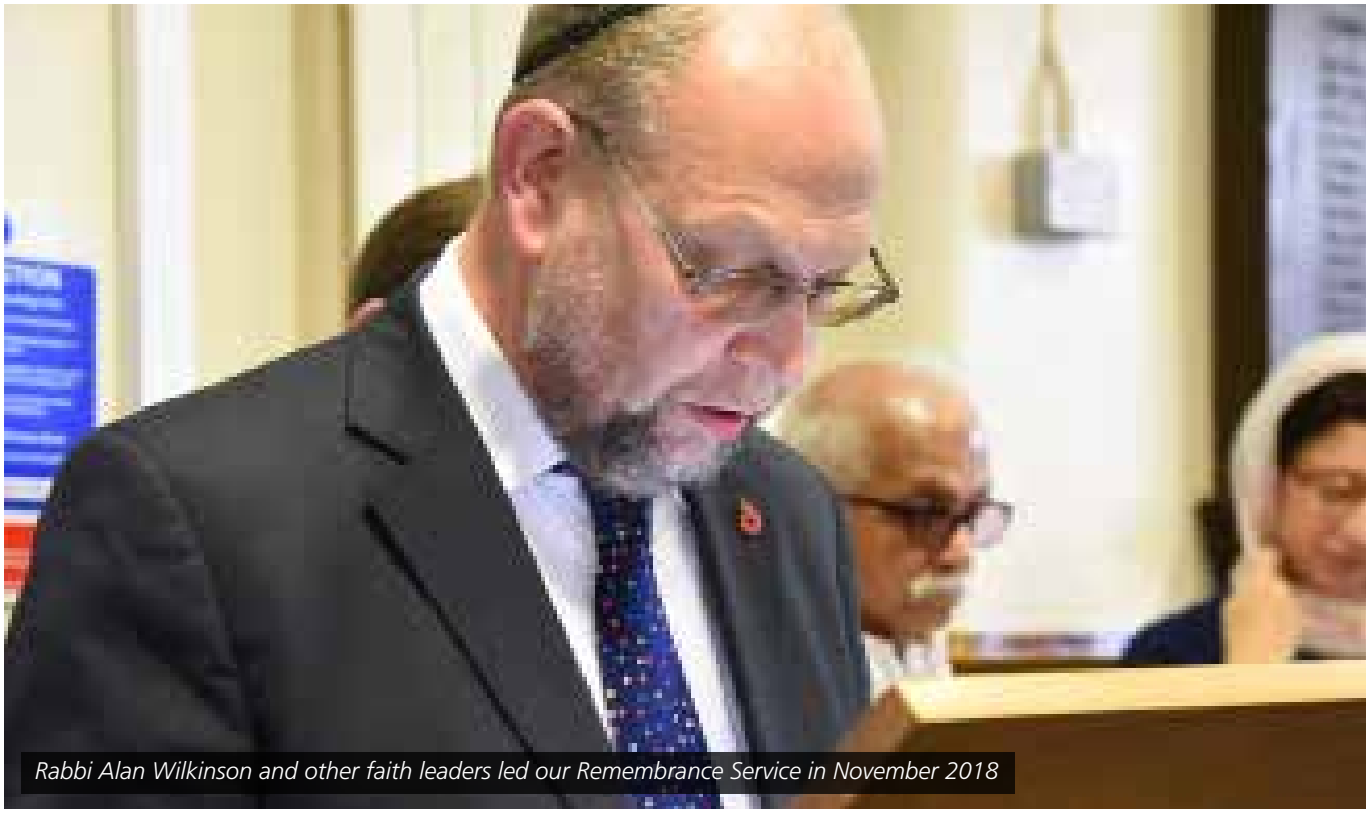
Faith/spiritual care

Our spiritual care team includes three members of staff – a part-time Anglican priest, a Free Church chaplain and a business support apprentice – plus a wide number of faith leaders representing Greek Orthodox, Hindu, Jewish, Muslim, Roman Catholic and Sikh communities. With their leadership and support from volunteers we maintain a strong spiritual care offering for our patients, visitors, carers and staff, as well as extensive links with our local community.

We support people of all religions and beliefs (including those for whom this is not important); we have Jumma prayers led by our Imam, and hold weekly secular mindfulness-based meditation.

The Trust's Multi-Faith Belief Network meets quarterly and acts as a reference group for the spiritual care team to shape a programme of events and activities which are relevant for North Mid, its patients, staff and local community.

During 2018-19, the team worked with a North Mid junior doctor on a project to develop better understanding of cultural and religious perspectives at end of life. 'Bridging the gap' aims to increase understanding of both clinicians and faith leaders around each other's perspectives on issues such as 'do not resuscitate' declarations, advanced care planning and end-of-life care.



Rabbi Alan Wilkinson and other faith leaders led our Remembrance Service in November 2018

Being a good employer

North Mid is a major employer in the local Enfield and Haringey area and we are committed to ensuring we offer our staff and our community the very best employment and career development opportunities.

During 2018-19, we recruited more than 100 apprentices, bringing our current apprenticeship workforce to 186, working in roles ranging from health and care, IT, business administration and pharmacy.

Daniel:

I had heard that North Mid is a very good hospital for training and also that the Trust is good at training and developing new staff from within, helping you on your career path.

I joined North Mid in November 2017 in the radiology department and am working through my apprenticeship with a view to increasing my knowledge and experience and taking on more responsibility, so I can go for promotion.

I have already passed my first course with a distinction, but as an apprentice, you learn much more about working in a hospital which would be difficult to learn from a book.

Keisha:

I had been doing admin in my previous job for five years and always wanted to be able to progress and also get a qualification. I picked North Mid because I knew there were many opportunities on offer. The fact that North Mid paid its apprentices a decent wage was also an important factor, because I needed that financial stability too.

Mohammed:

In 2016, I was unemployed and was desperately searching for a job. I came across an advert for an apprenticeship at North Mid and as I read through the post details, I could see myself thriving in the role.

I was quite sceptical that I would be turned away without a second look, but within a few weeks I had been invited for an interview. From the minute I arrived, I could see the Trust values in every single member of staff I met.

I am currently working in the ophthalmology team and working towards my level 3 business administration.

If I could choose my ideal position, I would be a service manager, so I can use the skills I've gained over the years to provide a better service for our patients.

I've been here two years and sometimes I look back and see how far I've come. And I will carry on until I achieve my ambition.

I honestly feel like I am surrounded more by family than work colleagues and I am extremely proud to say that I am working at North Mid.

Medical recruitment

Our medical workforce team recruited 17 new clinical consultants in 2018, reducing our medical vacancy rate to below four per cent by the end of 2018-19.

The small in-house team has worked with clinical leaders at North Mid and at neighbouring trusts to develop innovative split posts working across specialties, helping to improve staff and patient experience while making the roles highly desirable to potential candidates.

Trainee doctors have described North Mid as an extremely friendly, welcoming and supportive place to train.

From consultant surgeons to student nurses, we're committed to offering everyone the career development that's right for them.

You can develop your career at any level and any direction at North Mid and you'll get encouragement and support from your colleagues:

New roles in nursing

In February 2019, the first members of North Mid staff who had trained as nursing associates – a new role in the NHS nursing team – took up their roles in our surgical wards and on our oncology ward.

We currently have a further cohort of 14 staff training as nursing associates and are expanding to take on two cohorts each year.

Our joint work with Health Education England on workforce transformation is ensuring that we make full use of the potential of this new role in the nursing team, both as a standalone role and for staff who wish to use it as a stepping stone to becoming a registered nurse.

Our award-winning preceptorship programme

North Mid has one of the highest retention rates for newly qualified nurses making the bridge from student nurse to staff nurse, as part of our preceptorship programme, which has been awarded a Capital Nurse Quality Mark for meeting high standards.

In summer 2018, we expanded our preceptorship programme across clinical disciplines, resulting in more than 100 people joining the programme in November 2018.

As individuals thrive and progress in their careers, we see whole teams developing and moving ahead together.

The team on our Surgical Assessment Unit supports each other's professional and career development.

Andrew:

I started at North Mid in 2014, first as a domestic and then working as a porter. I'm a caring person and I felt that I had more to give, so I spoke with Sucad, the ward manager on the Surgical Assessment Unit and she encouraged me to speak with HR and here I am – an apprentice health care support worker on SAU!

I enjoy caring for patients and building relationships with them while they are on the ward and it is always a joy to see them go home feeling much better than when they first came in. Doing this job has made me feel more passionate and I am considering nursing as a further career development.

Jean:

I joined this team as a ward clerk and was encouraged to go for the bed manager role by my ward manager. It's an extremely challenging role, but she was very supportive with the application and said I would be very well suited to it.

There has been a lot to learn and there is pressure, but when you've achieved the performance you're aiming for at the end of the day, it makes it a good day. The whole team is passionate about caring for patients.

Carla:

I worked here for four years as a healthcare support worker on the Surgical Assessment Unit. I love looking after people so my colleagues encouraged me to join the nursing programme. And here I am, in my first year of nurse training!

I'm back at North Mid on placement – it's also my local hospital – and I'm enjoying every minute.

Sucad:

I have worked at North Mid for more than 10 years. It's important to me to try to motivate people to join the most rewarding profession for them. From the domestic assistant who helps maintain cleanliness in the department to the matrons, we all 'think big' and work hard to make the most of the opportunities North Mid has to offer.

Our diversity is one of our key strengths

This Trust serves one of the most diverse and vibrant areas of England. It's important to us that we reflect the diversity of the communities and population we serve. As a Trust, we work hard to promote and celebrate what diversity of all types offers to the NHS, from frontline clinical staff to the Board, and we're proud of recent improvements.

Workforce Race Equality Standard (WRES) data published in January 2019 showed our Trust Board had the greatest increase in representation of people from Black and Minority Ethnic (BME) backgrounds in the previous year, from 23% to 40%. The Trust as a whole continues to strive for better representation in all services. For example, nearly half of the finance team (46%) at North Mid are from a BME background, compared to 18% nationally and 39% in our local population.

Nevertheless, we are keen to ensure that our local population is represented at all levels of the Trust workforce, including in senior management roles. We know that like many NHS organisations we have much further to go.

Our new equality, diversity and inclusion lead took up her role in early 2019. We have refreshed our Black and Minority Ethnic (BME) network, as well as launched a new Women's Network on International Women's Day (8 March 2019). In 2019, we have launched two further networks to support and celebrate the contributions made by LGBT+ and disabled colleagues.

Supporting our staff to stay healthy, physically and mentally

Published in March 2018, our 2017 annual staff survey results showed a higher response rate than ever for this Trust. The results put us in amongst the top number of acute trusts for staff saying they are motivated to come to work and for staff saying they are pleased with the quality of work and care they can offer.

The results also identified some issues we committed to addressing, particularly in relation to staff health and well-being and bullying and harassment. We were determined to address these challenges with clear and visible actions:

Staff support officers

We have appointed a network of staff support officers from teams and services across the Trust, who were recruited and trained to talk through and support staff with any issues around bullying and harassment. Staff support officers are not there to solve a situation that is reported to them but they will provide a listening ear and a confidential conversation to support those who have been affected.

Workplace mediation

Our network of mediators hold a national, external qualification and are fully trained to provide support for workplace mediation, which is a voluntary process for resolving disputes and re-establishing effective working relationships.

We launched our Women's Network on International Women's Day 2019, and were joined by national NHS leader Yvonne Coghill (far right)

Helping staff to speak up

Last year, we committed to appointing an additional Freedom to Speak Up Guardian, and we were delighted that Sharnette Wallace-Mailor took up this role in Spring 2018, joining our existing F2SU Guardian Frances Evans.

By appointing Sharnette, we have significantly expanded capacity for staff to be able to raise in confidence any concerns they may have about patient safety.

Sharnette and Frances have increased the presence, availability and awareness of this important role throughout the Trust, supported by a tailored internal communications campaign.

Schwartz Rounds

Following the model overseen by the Point of Care Foundation, we run monthly Schwartz Rounds, which provide an opportunity for all staff to reflect on the emotional aspects of their work.

Serious incident aftercare

We offer a serious incident aftercare service to help support staff who have been involved in serious incidents. The service consists of a team of North Mid staff who have been specially trained as peer debriefers and who offer evidence-based, structured group interventions for staff teams who have been involved in stressful or traumatic incidents in the workplace.

We hold regular Schwartz Rounds.

Mental health awareness training

We offer mental health training and wellbeing workshops for all staff which offer attendees the chance to gain skills and information to best manage their mental health, as well as sessions specifically for managers to help them identify when staff may be experiencing issues with their mental health.

Fast-track physiotherapy

In 2018 we expanded our capacity to give staff fast-track access to physiotherapy to help them return to work more quicklya following musculoskeletal injuries.

Sharnette Wallace-Mailor took up a new role as our second Freedom to Speak Up Guardian in Spring 2018.

Staff awards

The North Mid family is diverse, welcoming, compassionate and committed to providing outstanding care for local people.

Individuals and teams regularly go the extra mile for patients, families, carers and colleagues. Throughout the year we recognise some of these 'above and beyond' efforts culminating in an awards ceremony, which in 2018 was held at Alexandra Palace supported by kind donations to the Trust's charitable fund and by local sponsorship.

In 2018, we received more than 200 nominations for individuals and teams, across 14 categories. Winners included:

- Outstanding contribution to patient care – North Mid @Home team (team award)
- Outstanding contribution to patient care Kay Frances, HIV midwife (Individual award)
- Volunteer of the year - Selma Esseghir
- Improvement award - mental health liaison team based in A&E
- Unsung hero trust - Kelly Eaton, estates and facilities project manager
- Unsung hero partner - accident and emergency porters
- Educator of the year – critical care practice development team (team award)
- Educator of the year – Joan Mendez, chief pharmacy technician (individual award)
- Promoting equality, diversity and inclusion - Maria Kalotichou, staff engagement officer
- Improving patient experience - Michelle Lynch, bereavement midwife
- Clinical team of the year - urology team
- Community partnership - Helen Joyce matron, discharge
- Non-clinical team of the year - service improvement and transformation team
- Apprentice of the year - Shannon Boyram, admin officer to the paediatric diabetic service
- Chief Executive award - Frances Evans, associate medical director and one of the hospital's freedom to speak up guardians

Ten members of staff, each of whom have worked continuously for 25 years or more at the hospital, also received long service awards for their dedicated care to patients:

- Liaqat Ali, senior operating department practitioner – joined 1 May 1991
- Velma Arnold, ante natal screening co-ordinator – joined 1 September 1992
- Meriel Clarke, matron - joined 22 June 1992
- Anna Engqvist, bed manager – joined 3 March 1993
- Kay Francis, specialist midwife for infectious diseases & haemoglobinopathies – joined 1 September 1992
- Geraldine Lambe, head of workforce resourcing – joined 20 September 1993
- Karen Madgwick, specialist practitioner – joined 27 May 1992
- Nalini Mandora, senior orthoptist – joined 1 December 1991
- Kathleen O'Farrell, oncology research data co-ordinator – joined 19 May 1993
- Anita St Louis, administrator and co-ordinator – joined 8 April 1991

Our monthly 'staff stars' during 2018-19 were:

- Clara Kwentoh
- Justine Brown
- Lou Jeffery
- Debbie Encisa
- Raj Kistnareddy
- Sarah Johnson
- Judy Hill
- Tony Hudgell
- Chris Kelly
- Rainbow ward team
- Anticoagulation clinic
- Haematology and oncology clinical nurse specialists
- Paediatric day assessment unit
- Radiology clerical team
- Chemotherapy day unit nursing team
- Medical wards physiotherapy team
- Preceptorship programme education team

Excellent value for money

For patients, for staff and for taxpayers, it's vital we spend every penny wisely and ensure we get full value out of the public money which funds the NHS.

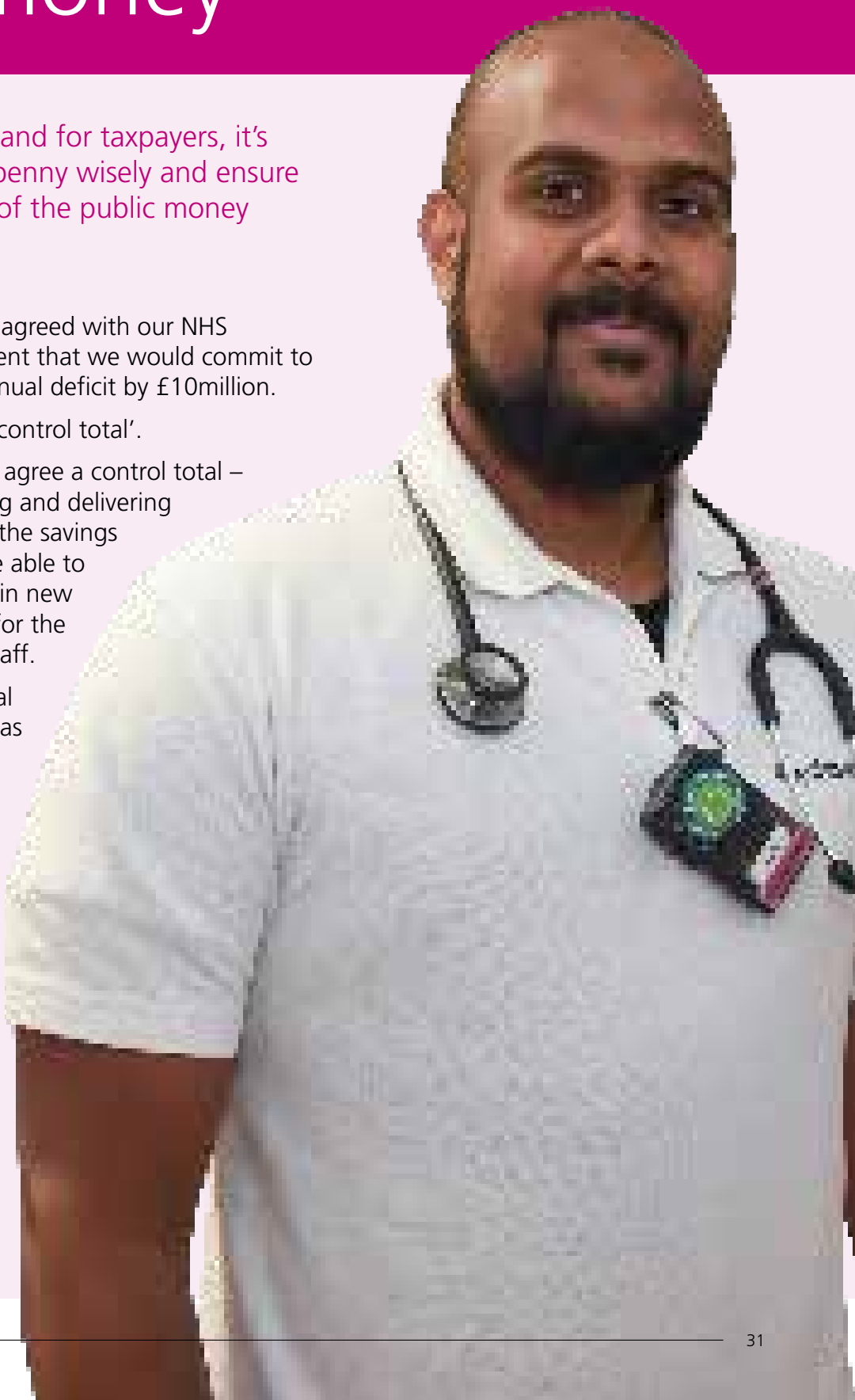
In April 2018, North Mid agreed with our NHS regulator NHS Improvement that we would commit to reducing our ongoing annual deficit by £10million.

This is called agreeing a 'control total'.

NHS organisations which agree a control total – which includes developing and delivering on robust plans to make the savings necessary to meet it – are able to release funding to invest in new facilities and equipment for the benefit of patients and staff.

By agreeing a control total in 2018-19, North Mid was able to 'unlock'

- £3 million to redevelop our A&E and urgent care centre
- £2 million to invest in a new linear accelerator
- £5 million to invest in new digital technology for clinical staff to speed up access to patient notes, test results and other essential information



Saving money and improving patient experience

We see more than 50 patients every day in our anti-coagulation clinic. For many this means monthly visits to hospital, which can sometimes take the best part of a day, especially if you're dependent on patient transport each way.

Consultant haematologist Dr Chris Mitchell, matron Noeleen Behan and service manager Penny O'Hara worked with service improvement colleagues to redesign how the anticoagulation clinic operates, making things better for patients and reducing how much we need to spend running it.

The team said: "The starting point was making sure we provide an excellent anticoagulant service. That's non-negotiable.

"An excellent service means making sure patients get the best treatment possible for them. Four out of five of our anticoagulation patients take warfarin and need monthly blood tests to monitor their health. We worked with patients to explore other possible treatments which could be more suitable for them."

One option was for patients to use direct oral anticoagulant medications, which would mean being discharged after one follow-up appointment. This means less time coming to hospital and more time going about daily lives.

Dr Mitchell said: "We trained all of our staff on how to provide this treatment and counsel patients. There are now 300 more patients using this treatment, which means fewer coming to hospital – the hours we've given back to patients is phenomenal.

"We've also started to give patients their medications in clinic, so they don't have to go to the hospital pharmacy any more – it saves them time, reduces pressure on the pharmacy team and improves the overall hospital experience for lots of people."

Saving money and helping save the planet

Deputy theatres manager, Theo Ellina, is committed to reducing the impact we have on the environment.

She said: "I tell colleagues 'think about the planet our children will live in – and the planet their children will live in'. We want it to be the best it can be."

Theo worked with our procurement team to find ways which the theatres team can 'go green', without impacting on the quality of care they give patients.

And in the first six months of making changes, they saw big improvements – not just to the amount of waste they produce but also in the money they save.

The team now uses off-white 100% recycled paper to print theatre lists, which reduces the team's carbon footprint and saves them more than £2 each purchase.

Matron Noeleen Behan helped redesign how our anticoagulation clinic works

Superintendent radiographer Rob Lythgoe spotted an opportunity to save time for patients and staff

By reviewing standard blood test sets, we have saved patients' time, and saved money

Patients can use a self check-in kiosk in our radiotherapy department if they choose

Saving money and speeding up test results

When a patient comes to A&E, it's normal at many hospitals for clinicians to order a standardised set of blood tests for some of the most common conditions seen in the A&E. These 'standard order sets' can help reduce variation and make submitting test orders quicker.

Our A&E team, pathology department and service improvement colleagues reviewed the standard order sets and found that a small number of tests weren't normally clinically necessary. Removing them from the standard order set – while keeping them fully available when clinically appropriate – saved money and speeds up the processing of blood tests, so patients and clinicians get the information they need faster and have to spend less time waiting in A&E. It's a win-win-win!

Saving time for patients and staff in radiotherapy

In November 2018, we installed new equipment in our radiotherapy department to allow patients to check-in themselves when they arrive.

The radiotherapy team has recently extended its opening hours, so it can see and treat more patients at more convenient times.

The new self check-in kiosks are faster, reducing the time patients spend queuing to tell clinic staff they have arrived.

Superintendent radiographer, Rob Lythgoe, who helped lead the project to procure and install the new kiosks, using funding from our Dragons' Den scheme in early 2018, said: "It frees up time for our administrative staff to continue managing the clinic and helps our radiographers know when out-of-hours therapy patients have arrived so that we can meet them sooner".

Reducing how much we spend on agency staff

One of the biggest challenges facing many NHS organisations is recruiting and retaining staff. For North Mid, it's one of our top five challenges.

We know that many clinicians and support staff like the advantages which flexible working can offer and it helps NHS trusts to have a degree of flexibility in staffing to manage changing demands.

By developing a strong and responsive staff bank, we are able to maintain flexibility while reducing unnecessary spend on agency fees and premiums.

In 2018, we introduced a new staff bank, operated by Bank Partners – an organisation with more than 20 years' experience in providing bank staff and a strong reputation for helping NHS organisations reduce their agency usage and spend. In November 2018, we went live with medical bank staff via Bank Partners and in January 2019, we extended to all other staff groups.

Whilst our overall agency spend has increased in the year, the new arrangement has helped us reduce agency spend in the last quarter of the year. We need to continue this reduction further and faster through our new workforce strategy, which includes a targeted focus on improving recruitment and retention.

Modernising our medical photography

Medical photography is a vital support service for clinical teams and patient care. In 2018, we developed and implemented a secure system which reduces the time between taking pictures and clinicians being able to view the images. With secure digital storage, clinicians are also able to refer to previous images without needing to keep hold of individual printed photos, cutting down waste and reducing the chance of photos being misplaced.

By jointly developing the system in-house, our medical photographer and IT team saved the Trust needing to outsource our image management, which can cost more than £50,000 a year. It's also saved time for clinical and support staff and means patients' assessments and diagnostics can happen faster.

Medical photographer Harriet Armstrong has improved turnaround times for clinical photography, and reduced printing costs

Performance standards

Table 1

North Middlesex University Hospital Key Figures	2016/17	2017/18	2018/19	16/17 - 17/18	17/18 - 18/19	Compound Annual Growth Rate 16/17 -18/19
A&E Attendance	167,021	175,167	181,135	5%	3%	8%
Outpatient Attendances	376,348	401,072	426,824	7%	6%	13%
Admissions	83,804	79,608	83,432	-5%	5%	-0.4%
Operation/ Procedures	39,193	37,642	40,445	-4%	7%	3%
Babies Born	5,047	4,707	4,564	-7%	-3%	-10%

Summary of activity and growth

In 2018-19 our attendances in A&E grew by 8%. This is following growth during 2017-18 of 5%. There was also significant growth in the number of outpatient attendances, which reflected a similar significant growth during 2017/2018, and reached a highest ever level of attendances at over 426,000. We continued to see a drop in the number of babies born at the Trust by 10% which also reflects a drop in the previous year. This is of concern to the Trust, and there has been a significant amount of work to improve the care and outcomes for mothers as part of a maternity improvement programme. The Trust will continue to strive to improve the patient experience and hopes to see a turnaround of the reductions over the last two years.

Table 2			
Indicator	**Target 18/19**	**Performance 18/19**	**Status**
A&E 4 hour performance (all types)	>95%	85.82%	
18 week referral-to-treatment incomplete pathways	>92%	94.20%	
2WW - 2 week wait - suspected cancer	>93%	90.75%	
2WW - breast symptomatic	>93%	73.62%	
31 day decision to treat to treatment	>96%	98.03%	
31 day subsequent - other subsequent treatment	>98%	97.99%	
31 day subsequent - radiotherapy	>94%	97.08%	
31 day subsequent - surgery	>94%	98.08%	
62 day referral to treatment	>85%	75.35%	
62 day specialist screening service to treatment	>90%	88.17%	
Diagnostic waiting times	>99%	99.30%	
Operations not rebooked within 28 days	0	26	
Maternity bookings within 13 weeks referrals received within 13 Weeks	>80%	89.66%	
Clostridium difficile (aged 2+) - hospital acquired / received	33	26	
MRSA bacteraemias - hospital acquired	0	1	
Mortality (SHMI) rolling 12 months	<100	88.1	Oct 16 – Sep 18
Mortality (HSMR) rolling 12 months	<100	99.8	Jan 17 – Dec 18

The Trust has prepared its 2018-19 annual accounts on a going concern basis. The Board has sought assurance that this basis of preparation is appropriate. Further detail can be found in the going concern accounting policies note in the annual accounts. This is also referenced in the auditor's report.

Key performance measures

Overall we met nine of the 17 standards.

Emergency care

As described above, the Trust has made significant progress in improving performance against the four hour performance indicator while still not achieving the 95% standard. Performance has improved by 5% in 2018-19 compared to the standard achieved 2017-18. Nationally, many Trusts continue to struggle to deliver 95% or above performance. The introduction of a new model of care along with significant capital investment has led to sustained improvements. The Trust continues to work with colleagues across the system to deliver reduced waiting times in order to achieve the four hour performance standard.

18 week wait times

The Trust continues to have some of the best performance in England for referral from GPs to initial treatment. We have performed consistently this year and historically against this standard.

Cancer treatment waiting times

The Trust did not achieve on five of the eight cancer standards.

In particular, the Trust is focusing on recovering performance against the 62 day standard from GP referral to first treatment. Poor performance against this standard is driven by shared breaches with other providers who on occasion do not refer patients to the Trust in a timely manner, or where other providers are unable to commence treatment despite a timely referral from the Trust. The Trust also has a number of internal delays, particularly in urology and colorectal services that it is addressing through improvement and streamlining pathways.

The Trust did not achieve the two week wait standard for suspected cancers or for breast symptomatic patients. This was due to poor performance in the last quarter of the year as a result of a breakdown of the mammography diagnostic machine. The Trust approached other providers for support as far as possible who were able to provide some additional capacity.

Diagnostic waiting times

Ensuring that patients receive any diagnostic tests within six weeks is vital to ensure the GP referral to treatment (RTT) is met. The Trust exceeded the 99% target by 0.3%. This is partly reflective of the investment in endoscopy facilities described elsewhere in the annual report that provides additional capacity to scope patients both to support cancer diagnosis and elective treatments.

Infection control

- Clostridium difficile

  NHS Improvement assesses us against a threshold, or maximum number of 33 infections. Up to the year end, there were 26 cases of CDI identified. All these cases have been reviewed with North East London Commissioning Support Unit (NEL CSU) to identify whether there were any lapses in care which the Trust can learn from. Following a review of the 26 cases, it was identified that in 23 cases there were to be found no lapses in care. This is a reduction in cases of Clostridium difficile compared to the number recorded in 2017-18.

- MRSA

  The objective for all Trusts in England in 2018-19 was to have no avoidable MRSA bacteraemia. There was one MRSA bacteraemia assigned to the Trust.

Mortality rates

The table above shows the Trust summary hospital-level mortality indicator (SHMI) and the hospital standardised mortality ratio (HSMR). HSMR excludes deaths that are coded in particular ways, for example palliative care. SHMI includes all deaths. For both indicators, the expected level of mortality is 100, with scores between 90 and 110 representing statistically expected levels of mortality. Scores below 90 represent better than expected levels of mortality, and above 110 worse than expected. The Trust's HSMR for the 12 month period to December 2018 was 99.8. This is above the national average however and is showing a nine month trend downwards. The Trust's SHMI for the 12 month period to September 2018 was 88.1 which is better than the statistically expected level of mortality, and significantly below the national average.

Improving the quality of our services

Our quality account provides an in-depth analysis of quality issues and is available on our website.

Patient experience

Improving patient experience remains a key focus of our work in 2018-19. Patients provide feedback on their experiences of care in a range of ways, including providing compliments, making complaints, by contacting our patient advice and liaison service (PALS), completing the Friends and Family Test (FFT) using hand-held devices as well as kiosks or online through our website. Comments are also posted on social media, including NHS Choices, Care Opinion, Facebook and Twitter. Our monthly FFT results in outpatients, inpatients, maternity and A&E are shown in table 3.

Sustaining positive feedback from our patients remains a key challenge for the Trust to achieve. The Trust has only seen an improvement in scores in A&E; however these remain well below where the Trust would aspire to be. FFT scores across all other domains have remained broadly static or dipped. This is of concern to the Trust particularly as access standards have improved in a number of areas. The Trust is undertaking a number of staff engagement initiatives during 19/20, as well as building on its Listening into Action programme with an anticipated partnership with a quality improvement organisation in order to drive improvements in these scores during 2019/2020.

We also believe that a number of the other areas of improvement described in this annual report will also support delivery of improvements for patients that will be reflected in improved scores during 2019/2020.

Table 3

Category	Indicator Name	Benchmark	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Patient FFT	A&E - FFT % Positive	National	60.0%	60.0%	71.0%	70.0%	77.0%	65.6%
	I/P- FFT % Positive	National	96.0%	85.0%	87.0%	84.0%	84.0%	90.2%
	Maternity- FFT % Positive	National	97.0%	75.0%	79.0%	78.0%	73.0%	74.8%
	Outpatients - FFT % Positive	National	90.0%	75.0%	76.0%	76.0%	75.0%	75.4%

Anti-corruption and anti-bribery matters

The Trust is absolutely committed to maintaining an honest, open and well-intentioned atmosphere, so as to best achieve our values and the wider objectives of the NHS. It is, therefore, also committed to the elimination of bribery and corruption and to the rigorous investigation of any such allegations. The Trust has in place adequate procedures to prevent bribery, and procures goods and services ethically and transparently.

The Trust will not engage in any form of bribery, and we expect all employees, suppliers and other associated persons to comply with the Bribery Act 2010 at all times.

Environmental matters and sustainability

Sustainability and energy efficiencies

In 2018-19 our total energy consumption increased by 2.7% to 34.3 million kWh (kilowatt hours). Within this total, electricity consumption was 5.7% higher at 15.0 million kWh, whilst gas consumption rose by 0.5% to 19.3 million kWh. Solar panels contributed 60,800 kWh to this. The Trust continues to try to reduce its carbon footprint in order to comply with the government's carbon reduction commitment. However, our carbon dioxide emissions increased slightly during 2018-19 from 8,958 tonnes to 9,284 tonnes. This is mainly due to the additional cooling and ventilation provided during the long hot summer of 2018. Water consumption increased by 9% to 155 million litres.

The Trust continues to progress towards reducing the level of carbon emissions generated by its operations. The expectation is to achieve the NHS carbon reduction targets by 2020. This will be achieved by a combination of developments that have already taken place – the replacement of the hospital's older buildings with new energy-efficient buildings – as well as on-going energy efficiency projects that are described elsewhere in this document.
A major investment in energy efficiency measures, funded by the Mayor of London's Energy Efficiency Fund, is expected to be approved by the end of 2019 and be implemented by the end of 2020. As well as achieving substantial cost savings, this is expected to deliver an annual reduction of around 9% of current carbon dioxide emissions.

To the best of my knowledge and belief, the 2018-19 performance report is fair, true and accurate.

Signed 

Date: 22 May 2019

Maria Kane

Chief Executive

Our therapists work with patients to help them recover physical skills and regain independence.

Financial performance summary in 2018-19

Director of finance's report

Although North Middlesex University Hospital NHS Trust improved its financial performance in 2018-19, the financial year has again proven challenging for the Trust and the wider north central London health economy.

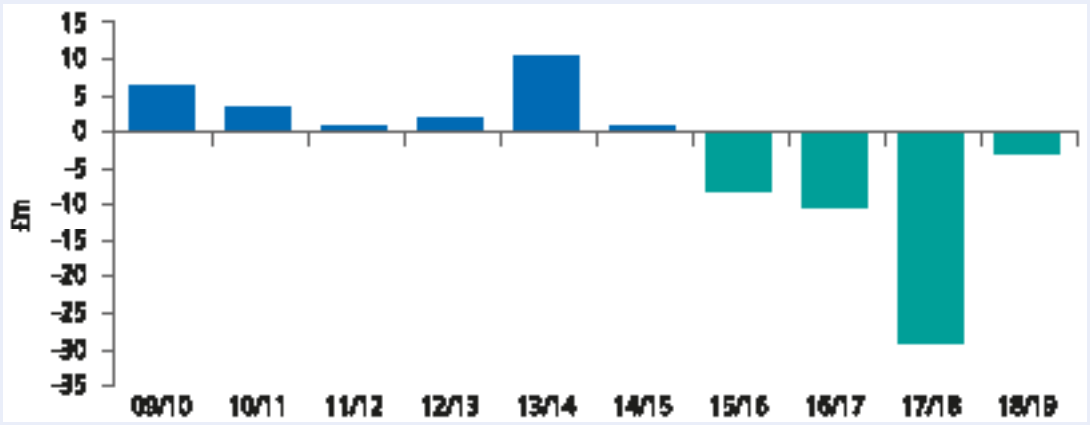
In the year ending 31 March 2019, the Trust reported a retained income and expenditure (I&E) deficit of £3.2m, compared to £29.0m in the prior year.

Whilst the reported deficit has improved significantly, the I&E position includes £14.4m of central provider sustainability funding. The Trust continues to face challenges relating to the demands on its emergency services and the impact of pressures within the wider health and social care economies. The Trust experienced an increase in its reliance on agency staff, with costs increasing by 18% from 2017-18. Initiatives to improve recruitment and retention of staff are underway to manage the need for temporary staff, and the vacancy rate has shown signs of improvement.

The Trust's operating costs continue to be incurred mainly through the delivery of patient treatment activity within the framework of service level agreements (SLAs) with local clinical commissioning groups (CCGs) (principally Enfield CCG and Haringey CCG) and specialist commissioners, which are financed from resources voted annually by Parliament.

The Trust generally finances its capital expenditure from budgets generated internally, however the Trust's acceptance of a control total and improved financial management in 2018-19 resulted in significant external capital being made available to the Trust through Public Dividend Capital (PDC). Key schemes include the replacement of a linear accelerator to improve the provision of radiotherapy treatment for cancer patients, and new and replacement IT systems through the three year Global Digital Exemplar programme, sponsored by NHS Digital. The Trust also received £3m PDC funding to redesign the A&E department around the new clinical model, which has supported improvements in patient pathways and performance against the 4-hour wait standard.

The following graph illustrates how the financial performance of the Trust has changed over the last 10 years.



The Trust is required to achieve five statutory financial duties. Owing to the reported deficit, the Trust did not achieve the break-even duty. The other four key indicators are set out below:

- to manage cash flows within the limits set by the Department of Health and Social Care (the External Financing Limit - EFL). This determines how much more (or less) cash can be spent by the Trust compared to that which is generated from its operations. The Trust is required to maintain net external financing within its approved EFL.
- to achieve a 3.5% return on assets (the cost of capital absorption duty), in other words the total dividends paid on PDC must be 3.5% of the average net relevant assets.
- to limit capital expenditure within the limit set by the Department of Health and Social Care (the Capital Resource Limit - CRL). The CRL determines the amount which can be spent by the Trust each year on capital purchases, such as building works, IT infrastructure and medical equipment. Capital expenditure on an accruals basis (rather than cash outflow on capital spend), and the limit must not be exceeded.
- to pay 95% of invoices within 30 days of receipt of the invoice or goods (the Better Payment Practice Code).

Performance against these metrics is shown in table 4:

Table 4

Financial performance targets, 2014-15 to 2018-19

Target	14/15	15/16	16/17	17/18	18/19
External financing limit	Met	Met	Met	Met	Met
Cost of capital absorption duty	Met	Met	Met	Met	Met
Capital resource limit	Undershoot	Undershoot	Undershoot	Undershoot	Undershoot
Better payment practice code	86%	79%	76%	73%	73%
Breakeven duty	Met	Met	Met	Not met	Not met

Ongoing financial issues

The Trust Board continues to scrutinise the delivery of its agreed financial objectives. The lessons learnt from the financial improvement programme and strengthened transformation team have supported the Trust in managing the financial position in-year and will continue to ensure that the Trust is in a strong position from the onset of the new financial year to deliver yet another challenging efficiency programme, amounting to £12m for 2019-20.

Close working with commissioners and local partners as part of the Sustainability and Transformation Plan will support the wider health economy in ensuring that our patients receive high quality care for the best possible value. We are now working more closely with local partners in the health and care system to generate better value from local funding given the financial constraints on all parties.

I would like to conclude by expressing my sincere thanks to the finance team, whose professionalism and commitment have been a constant theme during a year of relentless focus.

Overall financial arrangements

The Trust operates within the regulatory framework determined by the Department of Health and Social Care. Risk management is monitored through the Trust's Board assurance framework and risk registers, as described in the annual governance statement.

Directors are members or attendees of the Trust Board and the Chief Executive has put in place systems that provide information and assurance for the Trust Board, including a substantial internal audit programme which is monitored by the Trust's audit committee.

In addition, as confirmed via the annual letter of representation to the Trust's external auditors, there is no relevant audit information of which the Trust's auditors are unaware. This letter is signed by the Chief Executive, the director of finance and the non-executive chair of the audit committee. The directors have taken all the steps they ought to as a director in order to make themselves aware of any relevant audit information and to ensure that the external auditor is aware of that information.

The full annual governance statement and the letter of representation relating to 2018-19 can be obtained at the following address: Director of finance, North Middlesex University Hospital NHS Trust, Sterling Way, Edmonton, London N18 1QX.

Financial statements

The full accounts and notes to the accounts are included at the end of this report and are also available on the Trust's website at: www.northmid.nhs.uk/About-Us/Corporate-Documents/Annual-Reports or by contacting the Trust at the following address: Director of finance, North Middlesex University Hospital NHS Trust, Sterling Way, Edmonton, London N18 1QX.

The Trust's appointed external auditors are Grant Thornton; external audit fees for the 2018-19 year were £54,000. Fees payable to Grant Thornton and BDO for non-audit work totalled £11,000.

Signed _____

Date: 22 May 2019

David Stacey

Director of finance

Accountability report

Corporate governance report

North Middlesex University Hospital NHS Trust is a medium-sized hospital in Edmonton, north London, providing emergency, general and specialist services for people in Enfield and Haringey – about half in each.

We provide a full range of services for adults and children and our specialists treat strokes, HIV and sickle cell disease and thalassemia, for which we are a leading centre. We offer radiotherapy and a dedicated clinic treats female genital cutting.

Most of our services are provided at Sterling Way, where we have been based for more than a century, but we also run clinics and services in the community, at partner hospitals and in collaboration with local GPs and mental health service providers.

We are a major local employer with 3,376 staff (March 2019). In 2018-19 we had a total annual income of £320.7 million.

2.1.1 Directors' report

The Trust Board

The role of the Trust's Board of directors is to consider the strategic, managerial standards, performance, governance and financial targets. NHS Trust boards are required to consist of full-time executive directors and part-time non-executive directors, who collectively make up a unitary board of directors which functions as a corporate decision-making body. The executive directors are responsible for the day-to-day running of the organisation and work with the non-executive directors to translate the Trust's strategic vision into day-to-day operational practice. The role of non-executive directors is to provide an independent view on strategic issues, performance, key appointments and to hold the executive directors to account.

NHS Trust boards are required to have more non-executive members than executive members. Our Board is made up of a Chair and five non-executive directors, the Chief Executive and four voting executive directors. The executive directors are the medical director, the director of nursing and midwifery, the director of finance and the director of strategic development.

Our Board is also supported by the chief operating officer and the director of human resources and organisational development, both of whom are non-voting members of the Board. During the past year, the Board also included two associate non-executive directors, who were also non-voting members of the Board.

The Board held seven meetings during 2018-19, which were open to the public. The Trust also held its annual general meeting on 6 September 2018, at which we presented our annual report, our annual accounts and our quality account for 2017-18. The minutes and reports from Trust Board meetings are published on the Trust's web-site: http://www.northmid.nhs.uk/About-Us/Trust-board-meetings.

Board members have a wide range of skills and bring experience gained from other NHS bodies, as well as public and private sector organisations. Due consideration is given to the composition of the Board in terms of the protected characteristic groups in the Equality Act 2010. Each member is appointed for their experience, business acumen and their relationship with the community.

The Chair and non-executive directors are appointed by NHS Improvement. The Chief Executive and the executive directors are appointed by members of the remuneration committee, which is composed of the non-executive directors and the Chair.

Trust Board members

The members of the Trust's Board, as at 31 March 2019, were:

Dr Peter Carter OBE

Interim chair

Current term of office:
20 February - 31 October 2019

Peter was Chief Executive at the Royal College of Nursing (RCN) from January 2007 to August 2015. Prior to his role at the RCN, he was Chief Executive of the Central and North West London NHS Foundation Trust for 12 years. Now an independent healthcare consultant, Peter was awarded an OBE for services to the NHS in 2006.

Alan Palmer

Non-executive director and vice chair / Chair of the audit committee and senior independent director

Current term of office: 1 April 2019 - 31 March 2020 (first appointed 31 October 2016)

Alan has a background in finance, investment and banking in the City and is a fellow of the Institute of Chartered Accountants in England and Wales, and a fellow of the Association of Corporate Treasurers. He was until recently on the board of Swan Housing Association and a non-executive director at East London NHS Foundation Trust. He has also been a non-executive director at the Kent Reliance Building Society and of Moat Homes Limited, and a trustee of the British Humanist Association. He served as secretary to the Lord Chancellor's Strategic Investment Board, which advised the Ministry of Justice on investment funds held in court for vulnerable adults and children.

Professor Aine Burns

University nominated non-executive director
Current term of office: 1 May 2018 and ended on 30 April 2019

Aine is a consultant nephrologist and director of post-graduate medical education. She qualified in Ireland in 1983 and was awarded an MD in 1991 for bench research conducted at the Royal Postgraduate Medical School, Hammersmith. She has spent almost 30 years working as a clinical nephrologist and honorary senior lecturer at the University College London's centre for nephrology at Royal Free London Foundation Trust. She has been the director of postgraduate medical education since 2004 and in 2017 she was promoted to professor of postgraduate medical education and nephrology at University College London.

Mehboob Khan

Non-executive director /
Chair of the quality committee

Current term of office: 1 April 2019 - 31 March 2020 (first appointed 31 October 2016)

Mehboob is a political adviser to London Councils, and works closely with the Mayor to ensure London government secures the resources and powers it needs to deliver for Londoners. Previously he was leader of Kirklees Council in West Yorkshire for six years.

Mehboob has held many senior leadership positions in local government: Kirklees Council leader, chair of West Yorkshire Fire Authority, and a national lead for the sector on crime and community safety. He has substantial experience of turn-around failing organisations, managing change and community co-production, leading on a council restructuring programme saving £120m per annum and increasing customer satisfaction.

Sarah Rapson

Non-executive director /
Chair of the finance, performance and planning committee

Current term of office:
1 January 2019 – 31 December 2020

(first appointed as an associate non-executive director 1 September 2017 – 31 December 2018)

Sarah has been director of authorisations at the Financial Conduct Authority since 2016. She is responsible for ensuring there is a rigorous gateway for firms and individuals wishing to operate in the UK financial system. She joined from the Home Office where, from 2013-16, she was the director general of UK visas and immigration; from 2010-14 she was registrar general for England and Wales and from 2005-13 she worked at the Identity and Passport Service, latterly as CEO. Before joining the civil service in 2005 Sarah's career was in retail financial services and included management positions at American Express, Barclays and Woolwich plc. She graduated in mathematics from Lancaster University and has an MBA from London Business School. Sarah lives in London with her husband and young son. She is a member of the gender leadership group of Business in the Community.

Dr Surendra Deo

Non-executive director /
Chair of the workforce committee

Current term of office:
1 January 2019 – 31 December 2020

(first appointed as an associate non-executive director 1 September 2017 – 31 December 2018)

Surendra grew up in Edmonton and attended local schools. He graduated in medicine from the Royal Free Medical School and trained as a GP at North Middlesex Hospital, as it was then called. He practised as a GP and forensic physician in Enfield and Haringey for 25 years. He is a past Fellow of the Royal College of General Practitioners and chaired its north east London faculty which he represented at college council. He remains a Fellow of the Royal College of Physicians and the Higher Education Academy. He has extensive experience in professional regulation: as an adjudicator for the Solicitors Regulation Authority, a case examiner and as an employer liaison advisor for the General Medical Council. He was also an associate dean for Health Education England in North London. He currently chairs a community charity and is vice president of a healthcare charity.

Maria Kane

Chief Executive

In post since 18 December 2017

Maria joined the Trust in December 2017, after ten years as chief executive of Barnet, Enfield and Haringey Mental Health Trust, which delivers local community and mental health services to our local population. Previously, she was responsible for strategy and planning and, latterly, corporate development, communications and public engagement at the strategic health authority in London. Before this, Maria held a variety of senior roles in corporate and strategic development for the Royal College of Midwives, Medical Protection Society and the National Council of Voluntary Organisations.

Dr Emma Whicher

Medical director

In post since 17 December 2018

Emma joined the Trust as our medical director in December 2018 having worked as NHS Improvement's regional medical director for London since 2016. Prior to joining NHS Improvement, Emma was medical director at South West London and St George's Mental Health Trust where she developed its quality improvement series and oversaw a £160m modernisation programme. A consultant psychiatrist specialising in drug and alcohol misuse, Emma continues her clinical practice alongside the Trust's psychiatric liaison team.

Deborah Wheeler

Director of nursing and midwifery

In post since 8 August 2016

Deborah joined the Trust from NHS England where she was deputy chief nurse for the south region. She trained as a nurse at St Bartholomew's Hospital, London and spent her clinical career in orthopaedic nursing, before moving into nursing management. She has been director of nursing at several NHS trusts in London, including the Whittington Hospital NHS Trust. She has been a trustee of the Epilepsy Society, a national charity, since 2012, and chairs a committee overseeing the governance of its care homes. Deborah was awarded a Florence Nightingale Foundation Leadership Scholarship for 2015-16.

David Stacey

Director of finance

In post since 6 February 2017

David was previously deputy director of transformation at Chelsea and Westminster Hospital NHS Foundation Trust which he joined in 2015 and was responsible for delivering the financial benefits of the acquisition of West Middlesex University Hospital. He began his career with KPMG and spent seven years in their healthcare team, working with NHS and international health clients. He joined the NHS in 2013 as director of strategy at West London Mental Health Trust, England's biggest mental health Trust.

Richard Gourlay

Director of strategic development

In post since 9 May 2016

Richard took up his current role in May 2016, having joined the hospital in February 2011 as general manager for clinical support services and specialist medicine. From 2012 he led the hospital's operational reconfiguration for the Barnet, Enfield and Haringey clinical strategy. He has 20 years of acute hospital management experience, working predominantly across north London, managing medical and surgical specialties.

Dr Andy Heeps

Chief operating officer (non-voting member of the Board)

In post since 3 December 2018

Andy is an experienced consultant obstetrician and gynaecologist. Prior to working at the Trust, Andy was divisional director for the specialist medicine division at Barking, Havering and Redbridge University Hospitals Trust. His 15 year career in the NHS has also seen him hold leading roles in clinical and operational areas such as associate medical director for quality improvement, and a brief as acting medical director.

Mark Vaughan

Director of human resources and organisational development (non-voting member of the Board)

In post since 1 June 2018

Mark Vaughan joined the Trust having been a board director for over 16 years in the NHS at three acute and one mental health trust; the Queen Elizabeth Hospital in King's Lynn, West Hertfordshire Hospitals, the Royal National Orthopaedic Hospital, and Barnet, Enfield and Haringey Mental Health Trust. Mark has worked in HR since 1992 and has spent most of his career in the NHS, including three years at Barnet Healthcare in the late 1990s.

During 2018-19 there were a number of changes to the membership of the Board, as follows:

- Sir David Sloman ceased to be the Trust's Accountable Officer on 17 May 2018, with the role being passed to Maria Kane, Chief Executive on 18 May 2018.

- Non-executive directors, Graham Coles and Dalwardin Babu, terms of office came to an end on 31 December 2018.
- Associate non-executive directors, Sarah Rapson and Surendra Deo, were appointed by NHS Improvement as full non-executive directors on 1 January 2019.
- Ken Hutchinson ceased to be interim director of HR from 3 June 2018 following the substantive appointment of Mark Vaughan as director of human resources and organisational development.
- Achim Schwenk ceased to be acting medical director from 16 December 2018 following the substantive appointment of Emma Whicher as medical director.
- Rachel Anticoni left her role as chief operating officer at the Trust on 12 October 2018. This role was subsequently covered on an interim basis by Rab McEwan (from 22 October 2018 until 31 December 2018), and then through the substantive appointment of Andy Heeps.
- Mary Sexton was appointed as interim director of nursing and midwifery from 1 October to 13 December 2018 to provide long term sickness absence cover for Deborah Wheeler.
- Dusty Amroliwala left his role as chair of the trust on 19 February 2019 following the end of his term of office. Peter Carter was appointed as Interim Chair on 20 February 2019.

Board committees 2018-19

To support the work of the Board in carrying out its duties effectively, the Trust has a number of Committees. During the year, the structure, function and membership of the committees were reviewed, which resulted in the formation of the Quality Committee and the Workforce Committee. These replaced the Clinical Quality and Patient Safety Committee and the Patient and Staff Experience Committee. Details of the Trust Board membership, and membership of our six Board level committees, are in table 5.

Board membership of committees (as at 31 March 2019)

Table 5

	Trust Board	Audit committee	Finance, performance and planning committee	Quality committee	Workforce committee	Remuneration committee	Charitable funds committee
Peter Carter	✓ Chair					✓ Chair	
Alan Palmer	✓	✓ Chair	✓			✓	✓
Aine Burns	✓					✓	
Mehboob Khan	✓	✓		✓ Chair		✓	
Sarah Rapson	✓		✓ Chair			✓	✓ Chair
Surendra Deo	✓			✓	✓ Chair	✓	
Maria Kane	✓						
Emma Whicher	✓			✓	✓		
Deborah Wheeler	✓			✓	✓		
David Stacey	✓	Expected but not as a member	✓				✓
Richard Gourlay	✓		✓	✓			
Andy Heeps	✓		✓	✓	✓		
Mark Vaughan	✓		✓		✓		

Audit committee

The audit committee is established to provide the Trust Board with an independent and objective review of its financial systems, financial information, organisational governance and compliance with laws, guidance and regulations governing the NHS. It oversees the work of the trust's internal auditors, external auditors and the local counter fraud service and monitors the integrity of the financial statements of the trust.

Finance, performance and planning committee

The purpose of the finance, performance and planning committee is to obtain assurance on behalf of the Trust Board that the Trust has plans in place to achieve the high levels of financial and operational performance expected.

Quality committee

The purpose of the quality committee (formerly the clinical quality and patient safety committee) is to provide scrutiny and challenge with regard to all aspects of quality and clinical safety, including strategy, delivery, clinical governance and audit, and patient experience in order to provide assurance to the Trust Board.

Workforce committee

The workforce committee (formerly the patient and staff experience committee) is established to maintain a strategic overview of the Trust's workforce, educational and organisational development arrangements with a view to assessing their adequacy to provide a positive working environment for staff, to enable the provision of high quality care and good clinical outcomes for patients.

Remuneration committee

The purpose of the remuneration committee is to determine the remuneration and conditions of service of the Chief Executive and executive directors, ensuring that these properly support the objectives of the Trust, represent value for money and comply with statutory and department of health requirements.

Charitable funds committee

The purpose of the charitable funds committee is to undertake the role as corporate trustee for all funds held in trust and to seek to maximise the benefit to the Trust from charitable funds in support of patient welfare, staff welfare, education and research.

Board members' register of interests

A register of interests for all members of the Board is maintained by the company secretary and made available on the Trust's website. Set out below are the interests of Board members as at 31 March 2019.

Peter Carter, interim trust chair

- Non-Executive Director at East and North Hertfordshire NHS Trust
- Vice president of the Institute of Customer Service
- Honorary Fellow of the Royal College of General Practitioners
- Ad Eundem of the Royal College of Surgeons, Ireland
- Associate at Harvey Nash Ltd
- Visiting professor at the following universities: Anglia Ruskin, Kings College London, Canterbury Christchurch, and Chester
- Member of the court, University of Bedfordshire

Alan Palmer, non-executive director and Vice Chair

- No interests to declare

Aine Burns, University Nominated non-executive director

- Employed as consultant nephrologist and director of medical education at the Royal Free NHS Foundation Trust
- Elected member of the Royal College of Physicians
- B share holder in Urology Limited

Mehboob Khan, non-executive director

- Political adviser at London Councils
- Councillor at the Royal Borough of Greenwich
- Non-executive advisor at Barking, Havering and Redbridge University Hospitals NHS Trust
- Director at VK Consultancy Services, providing coaching services
- Partner employed by Westminster Council and is a Director at VK Consultancy Services

Sarah Rapson, non-executive director

- Employed as director of authorisations at the Financial Conduct Authority

Surendra Deo, non-executive director

- Consultant employer liaison advisor at the General Medical Council
- Chair of Sanatan Cultural Society
- Vice president of Association of Guyanese Nurses and Allied Professionals (AGNAP)

Maria Kane, Chief Executive

- No interests to declare

Emma Whicher, medical director

- Trustee of Hospital Rooms, a charity providing art to mental health hospitals

Deborah Wheeler, director of nursing and midwifery

- Trustee of the Epilepsy Society
- Chair of the services committee of the Epilepsy Society
- Member of the Royal College of Nursing

David Stacey, director of finance

- Occasional consultancy on healthcare topics to KPMG AG Wirtschaftsprüfungsgesellschaft on a freelance basis

Richard Gourlay, director of strategic development

- No interests to declare

Andy Heeps, chief operating officer

- No interests to declare

Mark Vaughan, director of human resources and organisational development

- Partner works as a senior nurse at Imperial College Healthcare NHS Trust

Each director knows of no information which would be relevant to the auditors for the purpose of their audit report and which the auditors are not aware of, and have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

2.1.2 Annual Governance Statement

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 North Middlesex University 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 North Middlesex University Hospital NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As accountable officer, supported by Board members, I have responsibility for the integration of governance systems. I have delegated executive lead to the medical director and the director of strategic development for the implementation of risk management and governance.

The Board recognises that risk management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans.

The Board acknowledges that the provision of appropriate training is central to the achievement of this aim. Staff are appropriately trained and supported in incident reporting, carrying out risk assessments, mitigating risk and maintaining risk registers.

Employees, contractors and agency staff are required to report all incidents and concerns and this is closely monitored. The Trust supports an open culture, meaning that we are open with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory duty of candour.

The Board receives regular updates to ensure compliance in these areas. Guidance on reporting incidents on Datix (an IT system used to record patient safety information), grading of incidents, risk assessment, risk registers, undertaking root cause analysis and statement writing, is available for staff on the Trust's intranet.

The Trust also supports a learning culture, sharing and embedding learning from incidents following an objective investigation or review. In addition, the Trust seeks to identify and share good practice within the organisation. This happens at Board and directorate level through various mechanisms including feedback from non-executive visits and the monthly and annual staff awards event.

National guidelines and standards that relate to good practice are shared and there are processes in place to ensure action plans to implement recommendations are developed and monitored to completion.

The risk and control framework

The key objectives regarding risk and control are to achieve:

- Compliance with external regulatory and other standards for quality, governance and risk including the Care Quality Commission's fundamental standards and regulations
- Delivery of the Trust's strategic aims and objectives
- A culture of effective risk management at all levels of the organisation
- A robust framework to ensure all controls and mitigation of risks are in place and operating and to provide assurance to the Board of directors on all areas of governance

These are:

- Corporate governance
- Quality governance
- Clinical governance
- Financial governance
- Risk management
- Information governance including data security
- Research governance
- Clinical effectiveness and audit
- Operational performance

Executive directors have responsibility for the management of strategic risk and operational risks within their individual portfolios. These include the maintenance of a risk register and the promotion of risk management training to staff within their directorates. A range of risk management training is available to staff based on their role and position within the organisation.

Risk identification and assessment is the process that enables the Trust to understand the range of risks faced, the level of ability to control those risks, their likelihood of occurrence and their potential impacts. Risk assessment is

a continuous process with risks assessed at ward, team and departmental level in line with risk assessment guidance. This is carried out proactively as part of the health and safety processes as well as reactively when risks are identified from incidents, complaints, local reviews, patient feedback and so on.

Risks are scored based on the impact or consequence of that risk (score 1-5) multiplied by the likelihood of the risk materialising (score 1-5). The risk scoring matrix evaluates the level of risk as low (1-3), medium (4-6), high (8-12) or significant (15-25). This guides the priorities for action and is used for all risk scoring within the Trust in order to ensure a consistent and standardised approach. This allows the organisation to gain an appreciation of the magnitude of each risk, set targets for improvement based on its risk appetite and track progress against an agreed, timed action plan. The board of directors decides what level of risk is reported to them and has agreed a threshold of a risk score of 15 and above.

Risks are recorded in risk registers and via the Datix system. A risk register is a specific tool for recording and managing risk in a standard format to allow comparison and aggregation. Taking each risk in turn, the risk register records the controls (the things we do to mitigate that risk) already in place, the original risk score and the current risk score based on those controls. Gaps in controls can then be identified and actions agreed to close these gaps.

Targets based on tolerable levels of risk have been agreed and progress towards achieving the tolerable risk score are tracked. Assurances (the evidence that controls are effective) are also recorded. The identification and management of risk as communicated in risk registers aids decision-making and resource prioritisation. It produces proper information by which the Trust can reassure the public, patients and stakeholders that it is effective and efficient and delivering the objectives of the organisation.

The Board Assurance Framework (BAF) is an essential tool which brings together the risks to achieve the Trust's strategic objectives and provides detail and assurance on the systems of control which underpin their delivery. It offers visible assurance on the Board's overall governance responsibilities.

Taking each risk in turn, the BAF records the controls and the assurances already in place. Gaps in controls and assurances can then be identified and actions agreed to close the gaps. By focusing on gaps in controls and assurances, the Board can be confident that all necessary steps are being taken to assure delivery of the Trust's overall objectives and obligations as above and that resources can be allocated in the right place. The BAF is a live document which is reviewed on a monthly basis. Some gaps in controls or assurances will also feature on the significant risk register as they present a current risk which requires mitigation.

In December 2018, the BAF was refreshed and reviewed and now focuses on the risks to achieving the five priorities underpinning the Trust's strategic objectives. The risks contained in the BAF are:

- Failure to safely achieving nationally mandated standards and targets
- Failure to recruit and retain high quality staff
- Failure to invest adequate resources in culture, leadership, staff engagement and experience will lead to low staff morale
- Failure to deliver cost improvement programmes and live within the control total (an annual financial target) to achieve break-even as required by legislation and the 10-year plan
- Failure to ensure effective governance to underpin safety and quality

The Trust has established an Executive Assurance Forum whose objective is to seek assurance that the Trust maintains robust systems of governance, risk management and internal control that enables clinical and managerial leaders to ensure safe, high quality, patient-centred care. Where gaps in controls and assurance are identified, the Forum will;

- Ensure corrective action is taken
- Monitor effectiveness
- Report the matter to the board of directors, as required

The Trust has a number of processes in place to assure the Board and its various committees (specifically the workforce committee) that staffing processes are safe, sustainable and effective. These include the following;

- The Board has agreed a three-year workforce strategy, with responsibility for monitoring its implementation delegated to the workforce committee.
- The Board have also agreed a three year Recruitment Strategy and action plans for addressing engagement / retention, addressing key issues in annual staff surveys, an education and development strategy and a culture and leadership strategy. Responsibility for monitoring each of these has been delegated to the workforce committee.
- The Board receives a monthly safe staffing report which details staffing requirements and fill rates for all Trust wards and clinical areas. The Board also receives workforce details in its monthly integrated performance report – this includes (amongst other things) staff in post and vacancy levels, turnover figures, staff sickness levels and mandatory training compliance. Key workforce indicators are discussed in greater depth at meetings of the workforce committee.
- Identified workforce risks are logged on the Board Assurance Framework and the significant risk register. Both documents are reviewed at meetings of the workforce committee, including an assessment of allocated risk rating and risk mitigation actions.
- Independent audits of workforce processes are submitted to and reviewed by the audit committee.

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

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.

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.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). 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 produces an annual operating plan that is underpinned by detailed plans produced by the divisions. The plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the plan and any mitigation, and is supported by detailed financial forecasting. The annual budget setting process for 2018-19 was approved by the Board before the start of the financial year and was communicated to all managers in the organisation. The director of finance and his team work closely with divisional and corporate managers throughout the

year to ensure that a robust annual budget is prepared and delivered.

Each division is required to deliver cost improvement plans in order to ensure economy, efficiency and effectiveness of the use of resources. The divisions work within agreed objectives and accountabilities which are monitored at monthly performance review meetings. The cost improvement plans are scrutinised and approved by the medical director and director of nursing and midwifery via a series of quality impact assessments to ensure the quality of services are maintained.

The capital programme and the annual operating plan are informed by the Trust's objectives, quality improvement priorities and identified risks.

During 2018-19 the Trust continued to implement a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency. The Trust embarked on a major energy efficiency scheme, with the backing of NHS Improvement, utilising the Mayor of London's Energy Efficiency Fund and other sources of finance. In conjunction with our maintenance partner, Bouygues, under a framework programme run by the Mayor of London, the Trust has identified energy savings which are guaranteed for a period of up to ten years. Other schemes implemented during the year include:

- The continued replacement of light fittings with new energy efficient LED lighting
- Initiating a scheme to collect, sterilise and re-use sharps containers
- Reducing the cost of transporting clinical waste through implementing an on-site facility
- Developing plans to remove all waste from landfill
- Implementing a smart metering system, to better manage electricity consumption from 2019-20

Monthly financial and operational performance reports are presented to the finance, performance and planning committee and the Trust Board. The Trust makes use of both internal and external audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially-related audits, the internal audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk-assessed and action plan priorities are agreed with Trust management and reported to the audit committee. The Trust also reviews information and feedback from regulators and external sources such as the Care Quality Commission, national staff survey and national patient surveys to benchmark performance against other organisations and to improve economy, efficiency and effectiveness.

The deficit affected the Trust's cash reserves during the year it relied on Department of Health and Social Care loans. Due to good cash management the Trust was able to repay £8.1m of historic loans in the year. Taking this repayment into account the Trust's net borrowing for the year was £11.4m. The Trust exhausted its revolving working capital facility in 2016-17 and continued to require interim revenue support loans during the year which were subject to validation by NHS Improvement and the Department of Health. The Trust submits a 13-week rolling cash flow forecast to NHS Improvement each month so any issues are flagged up at an early stage.

With the exception of the break-even duty and Better Payment Practice Code the Trust achieved its other statutory financial targets, namely the 3.5% on average net relevant assets, the capital resource limit and the external financing limit.

As part of their annual audit, the Trust's external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. The conclusions in relation to this work are made available to the Trust and presented to the audit committee.

Fighting fraud

The Trust has in place appropriate anti-fraud and bribery arrangements. A local counter fraud specialist (LCFS) conducts a local risk assessment and devises an anti-fraud and bribery work plan which is approved and monitored by the audit committee. There are inductions and refresher fraud awareness sessions for staff and the Board of directors, with further communications and alerts as needed.

All referrals received by the local counter fraud specialist during 2018-19 have been subject to investigation. Allegations related to failure to work contracted hours, submitting claims for hours not worked, working while on sickness absence, exaggerated sicknesses absence, undertaking private work during Trust time, failure to declare a conviction and the misuse of Trust resources. These cases are being dealt with under the appropriate Trust processes.

Information governance

All new staff are provided with information governance (IG) training at corporate induction. This includes an outline of the relevant legal position, NHS guidance and the Trust's polices relating to the safe and appropriate processing, handling and storage of information. Additionally, in accordance with the requirements of the IG toolkit, all existing staff are required to undergo IG training on an annual basis. This training is available as classroom training, workbook or E-learning.

Information governance and security-related incidents are reported via the Trust's incident reporting system and are managed as part of the Trust's information governance processes. All incidents which have a data protection element are investigated and reviewed by the information governance steering group which has been chaired by the director of finance and senior information risk officer. Where an ongoing information risk is identified, this is recorded on the relevant risk register, along with a note of actions to be taken to minimise the chances of occurrence and impact.

The Trust has a duty to report data breaches likely to result in a high risk of adversely affecting individual's rights and freedoms within 72 hours. Incidents are reported through the NHS digital data security and protection toolkit incident reporting tool. During 2018-19 the Trust reported 16 incidents to NHS Digital, of those four were also reported to the supervisory authority (the Information Commissioner's Office (ICO)). The incidents were investigated and the outcomes of investigations and any remedial actions were provided to the ICO. All incidents were reported within the statutory 72 hours and there were no regulatory actions taken by the ICO.

The Network and Information Systems Regulations (NIS Regulations 2018) came into force on 10 May 2018 and is aimed at boosting the overall level of cyber security and physical resilience of network and information systems. It applies to all providers of essential services including health services. The Trust is designated as an "operator of essential services". The Department of Health and Social Care issued an information notice to the Trust. The information requested sought to ascertain that the Trust had addressed all unsupported systems, had timely plans in place to achieve cyber essential plus accreditation and had adequate business continuity plans in place in the event of disruption of services. The Trust has fully responded to the information requested, provided action plans and assurances that the above requirements are being fully addressed.

Annual quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended) to prepare quality accounts for each financial year.

The content of the quality account has been prepared within the established governance structures and framework and in accordance with the annual reporting manual and other guidance from NHS Improvement. Leadership

comes from the board of directors with clearly devolved responsibility and accountability for individual quality improvement priorities.

Quality improvement priorities informed the Trust's quality strategy and reflect the priorities of the organisation. These measurable goals against which progress can be monitored are overseen by the quality committee.

The medical director is responsible for the preparation of the quality account and for ensuring that this document presents a balanced view of quality within the Trust. The quality account is prepared with contributions from all responsible and accountable leads and drafted by the associate director of quality governance. The quality committee is responsible for reviewing the report prior to submission with the annual report and accounts to the audit committee and then the board of directors.

The quality account is subject to a review by the Trust's external auditors prior to its publication. This review provides assurance that the quality account has been produced based on valid data and is accurate. The external auditors carry out a limited review of the arrangements around the data quality and information included in the quality account and assess whether a balanced view of quality is presented based on other information.

Modern Slavery Act 2015

In accordance with section 54 of the Modern Slavery Act 2015, the Trust is committed to ensuring there is no modern slavery or human trafficking in any part of our business activity and, in so far as is possible, similarly expects the same from our suppliers.

Our overall approach is governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment.

To identify and mitigate the risks of modern slavery and human trafficking in our own business, the Trust has established robust recruitment procedures, details of which are found in its recruitment and selection policy, which supports compliance with national NHS employment checks and Care Quality Commission standards.

The Trust engages the Partners Procurement Service to contract on behalf of the Trust using the NHS conditions of contract. The Partners Procurement Service's senior category managers are Chartered Institute of Purchasing and Supply (CIPS) qualified and uphold the CIPS's code of professional conduct and practice relating to procurement and supply.

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 and executive 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 Board, the audit committee and the quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework and significant risk register (corporate risk register) are reviewed bi-monthly at every public meeting of the Trust Board and by the relevant Board level committees. This provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Board has concluded that the systems of internal control are effective as evidenced

below, but acknowledge that there is scope for improvements in certain areas:

- CQC registration with no conditions
- The Board Assurance Framework and the significant risk register
- Presentation of the annual governance statement to the audit committee
- Reports from the senior leadership group (a meeting involving senior leaders of the Trust), subgroups and directorates
- Clinical audit plan, prioritised on areas of risk and concern
- Internal audit plan, prioritised on areas of risk and concern
- Internal audit periodic reports and follow up of Internal audit recommendations
- Internal audit annual report and head of internal audit opinion
- ISA260 audit highlights memorandum (external audit report)
- Committees effectiveness and structures review (undertaken with support from NHS improvement)
- Drivers of the deficit and baseline review (produced by Deloitte December 2017)
- Self-assessment against the well-led framework supported by NHS improvement (August 2017)

The head of internal audit opinion for 2018-19 concluded that:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

This is due to the fact that the internal auditors issued three 'partial' assurance opinions which require improvement. These are:

- Infection control – the review found that there were deficiencies with the cleaning of some equipment, water dispensers required maintenance and compliance with infection prevention control training was below target.
- Medical appraisals and learning and development – the review found that appraisals were either not being completed in a timely manner or the appraisals had not been completed at all.
- Divisional governance – the review identified a number of issues with governance arrangements in the Trust's divisions.

The three internal audit reports which were rated as 'partial' assurance acknowledge that there are some weaknesses in the system but these do not affect the overall assessment and I do not consider them to be significant internal control issues for the purposes of disclosure in the annual governance statement.

Following all reports Trust management have agreed the actions required to address the issues raised by Internal audit, with the implementation of these actions being monitored by Internal audit and the audit committee.

The Trust continued to face a significant number of challenges in 2018-19, most notably in relation to the 95% A&E standard and the 62 day cancer waiting time standard. Difficulties in discharging patients and the level of activity impeded flow throughout the hospital. In 2018-19, the Trust continued to implement improvements to embed changes to clinical leadership, the on-going implementation of the A&E recovery plan and a refurbishment, which have led to improvements in the care for emergency patients. The Trust has worked closely with partners and are members of a local A&E delivery board, designed to work across the local health economy to effect change.

Conclusion

In summary I am assured that the North Middlesex University Hospital NHS Trust has a sound system of internal control in place, which is designed to manage the key organisational objectives and minimise the Trust's exposure to risk, and that there have been no significant internal control issues. The Board of directors is committed to continuous improvement and enhancement of the system of internal control.

Signed _____

Date: 22 May 2019

Maria Kane

Chief Executive

Our team works 365 days a year to ensure patient care is a high standard.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, 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, recognised gains and losses and cash flows for the year.

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 

Date: 22 May 2019

Maria Kane

Chief Executive

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, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

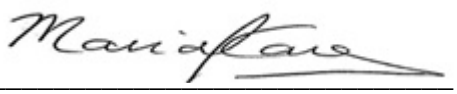
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

22 May 2019 

Date _____

Chief Executive

22 May 2019 

Date _____

Director of Finance

Certificate on summarisation schedules

Trust accounts consolidation (TAC) summarisation schedules for North Middlesex University Hospital NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018-19 have been completed and this certificate accompanies them.

Finance director certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
   - the financial records maintained by the NHS Trust;
   - accounting standards and policies which comply with the Department of Health and Social Care's group accounting manual; and
   - the template accounting policies for NHS trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

David Stacey, Director of finance

22 May 2019

Chief Executive certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the finance director, as the TAC schedules which the Trust is required to submit to NHS improvement.
2. I have reviewed the schedules and agree the statements made by the director of finance above.

Maria Kane, Chief Executive

22 May 2019

Remuneration report

Remuneration policy – directors

The Trust's remuneration committee, which meets twice a year, is responsible for setting remuneration levels and terms and conditions of employment for Trust executive directors and the Trust chief executive. Remuneration decisions are made on the basis of national guidance from NHSI, including guidance issued on award of cost of living increases for 2018/2019. Where necessary, and as determined by national guidance, external authority (including Treasury approval) is secured for remuneration levels that exceed £150,000pa.

The following disclosures have been audited:

- Disclosures on Parliamentary accountability, as detailed in GAM 3.61
- single total figure of remuneration for each director (table 6)
- CETV disclosures for each director (table 7)
- payments to past directors, if relevant
- payments for loss of office, if relevant
- "fair pay" (pay multiples) disclosures
- exit packages, if relevant, and
- analysis of staff numbers and costs.

Salaries and allowances

Table 6

Title	Name	2018-19			2017-18		
		Salary (bands of £5,000)	All pension related benefits[1] (bands of £2,500)	Total[2] (bands of £5,000)	Salary (bands of £5,000)	All pension related benefits[3] (bands of £2,500)	Total[4] (bands of £5,000)
	Non-Executive Directors						
Chairman	Peter Carter (from 20/02/19)	0 – 5	0	0 – 5	0	0	0
Chairman	Dusty Amroliwala (to 19/02/19)	40 – 45	0	40 – 45	45 – 50	0	45 - 50
	Dalwardin Babu (to 31/12/18)	0 – 5	0	0 – 5	5 – 10	0	5 – 10
	Graham Coles (to 31/12/18)	0 – 5	0	0 – 5	5 – 10	0	5 – 10
	Mehboob Khan	5 – 10	0	5 – 10	5 – 10	0	5 – 10
	Alan Palmer	5 – 10	0	5 – 10	5 – 10	0	5 – 10
	Surendra Deo	5 – 10	0	5 – 10	0 – 5	0	0 – 5
	Sarah Rapson	0	0	0	0	0	0
	Aine Burns (from 01/05/18)	0 - 5	0	0 - 5	0	0	0
	Executive Directors						
Chief Executive	Maria Kane	205 - 210	162.5 – 165.0	370 - 375	55 – 60	2.5 – 5.0	60 - 65
Finance director	David Stacey	125 – 130	40.0 – 42.5	165 - 170	110 – 115	32.5 – 35.0	145 - 150
Director of nursing	Deborah Wheeler	125 – 130	135.0 – 137.5	260 - 265	110 – 115	0 – 2.5	110 - 115
Medical director	Emma Whicher (from 17/12/18)	45 – 50	42.5 – 45.0	90 - 95	0	0	0
Acting medical director	Achim Schwenk (to 16/12/18)	100 - 105	0 – 2.5	100 - 105	30 – 35	5.0 – 7.5	35 - 40
Chief operating officer	Andy Heeps (from 03/12/18)	40 - 45	20.0 – 22.5	60 - 65	0	0	0
Chief operating officer	Rachel Anticoni (to 12/10/18)	70 – 75	30.0 – 32.5	100 - 105	110 – 115	35.0 – 37.5	150 - 155
Interim chief operating officer	Rab McEwan (from 22/10/18 to 31/12/18)	15 – 20	0	15 - 20	0	0	0
Director of strategic development	Richard Gourlay	110 – 115	7.5 – 10.0	120 - 125	110 – 115	17.5 -20.0	125 - 130
Director of human resources	Mark Vaughan (from 04/06/18)	110 – 115	87.5.0 – 90.0	195 – 200	0	0	0
Interim director of human resources	Ken Hutchinson (to 03/06/18)	30- 35	0	30 - 35	15 – 20	0	15 - 20

1 The pension related benefits comprise the notional change in the value of the pension over the estimated 20 year period after retirement. This change is calculated by the formula: 20 x the change in pension + change in lump sum. The formula assumes that there is no uplift to the opening pension and lump sum and the resultant increase is net of any employee pension contributions for the period.
2 The TOTAL column reflects both real and notional elements and should not be read as the total salary for the year.
3 The pension related benefits comprise the notional change in the value of the pension over the estimated 20 year period after retirement. This change is calculated by the formula: 20 x the change in pension + change in lump sum. The formula assumes that there is no uplift to the opening pension and lump sum and the resultant increase is net of any employee pension contributions for the period.
4 The TOTAL column reflects both real and notional elements and should not be read as the total salary for the year.

Sir David Sloman was the accountable officer for the Trust until 17/05/18, his remuneration was paid by the Royal Free Hospitals Foundation Trust for which there was no charge to the Trust. Sarah Rapson, a non-executive director elected to not receive remuneration for the role. During 2018-19 one senior manager was seconded to the Trust from another NHS organisation, Mary Sexton, as interim director of nursing. This is not reflected in the table above as her salary was not funded by the Trust.

Pension benefits

Table 7

Name	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at aged 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60, 31 March 2019 (bands of £5,000) £000	Lump sum at aged 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real increase (decrease) in Cash Equivalent Transfer Value £000	Employers contribution to stakeholder pension £000
Executive directors								
Maria Kane	7.5 – 10.0	12.5 – 15.0	40 - 45	95 - 100	842	615	197	0
David Stacey	2.5 – 5.0	0	10 - 15	0	108	67	22	0
Deborah Wheeler	5.0 – 7.5	17.5 – 20.0	55 - 60	175 - 180	1,345	1,093	243	0
Emma Whicher	0 – 2.5	2.5 – 5.0	40 - 45	105 - 110	734	537	51	0
Andy Heeps	0 – 2.5	0 – 2.5	25 - 30	50 - 55	369	273	26	0
Richard Gourlay	0 – 2.5	0	30 - 35	70 - 75	558	481	63	0
Mark Vaughan	2.5 – 5.0	12.5 – 15.0	45 - 50	145 - 150	1,146	930	163	0
Achim Schwenk	0 – 2.5	0 – 2.5	20 - 25	70 – 75	0	0	0	0
Rachel Anticoni	0 – 2.5	0	15 - 20	5 - 10	271	196	30	0

There are no entries in respect of pensions for non-executive members as they do not receive pensionable remuneration. The interim director of human resources and interim chief operating officer were not in the pension scheme.

A cash equivalent transfer value (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 reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The factors used in the table above are 3% for 2018-19 and 1% for 2017-18.

The Government Actuaries Department (GAD) factors for the calculation of cash equivalent transfer values (CETV) assume benefits are in line with CPI rather than RPI, which was used previously.

Fair pay disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The figure for the highest paid director is taken as the total remuneration paid.

The actual remuneration of the highest paid director in the North Middlesex University Hospital NHS Trust in the financial year 2018-19 was £209.1k (2017-18, £114.4k, representing a part year salary). This was 6.0 times (2017-18, 6.2, assuming the annual equivalent salary for the highest paid director) the median remuneration of the workforce, which was £34.8k (2017-18, £33.4k). The median remuneration excludes any bank and agency staff paid by the Trust.

In 2018-19, 0 (2017-18, 72) employees received remuneration in excess of the annualised salary of the highest paid director. The movement between years is due to the fact that the highest paid director pay reflects a full year of office in 2018-19. Individual staff remuneration ranged from £16.7k to £209.1k (2017-18, £16.3k - £233.7k).

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In 2018-19, the majority of staff received an annual increment of 3.4%.

Staff report

Staff costs

Table 8				
	Permanent £'000	**Other £'000**	**2018-19 total £'000**	**2017-18 total £'000**
Salaries and wages	126,755	0	126,755	120,857
Social security costs	14,932	0	14,932	13,578
Apprenticeship levy	671	0	671	609
Employer's contributions to NHS pensions	15,174	0	15,174	14,398
Termination benefits	0	0	0	32
Temporary staff	0	32,913	32,913	27,302
Total	**157,532**	**32,913**	**190,445**	**176,776**
Costs capitalised as part of assets	415	0	415	352

Average number of employees (wte basis)

Table 9				
	Permanent number	**Other number**	**2018-19 total number**	**2017-18 total number restated**
Medical and dental	511	72	583	541
Administration and estates	598	64	662	611
Healthcare assistants and other support staff	537	92	629	540
Nursing, midwifery and health visiting staff	987	198	1,185	1,118
Nursing, midwifery and health visiting learners	39	0	39	33
Scientific, therapeutic, technical and healthcare science staff	313	23	336	299
Total	**2,985**	**449**	**3,434**	**3,142**
Number of employees (wte) engaged on capital projects	5	1	6	9

As at 31 March 2019 the Trust employed 3,376 members of staff (headcount).

Table 10		
Staff composition	**Male**	**Female**
Directors	4	3
All other staff	828	2,541

Staff sickness absence

The average number of working days lost to staff sickness absence in the year to 31 March 2019 was 8.95 days (2017-18 - 8.20 days)

Disabled staff

The Trust is committed to the employment and subsequent support of staff who declare as disabled. The Trust is an accredited 'Disability Confident' employer and guarantees an interview for any applicant who declares as disabled and who meets the person specification for the post under consideration. Suitable adjustments are made to interview processes to allow for declared disabilities to be accommodated. The Trust has an in-house occupational health department which provides support to disabled staff during the recruitment process and once employed, specifically if a staff member becomes disabled during the course of their employment. The Trust has access to a hearing loop and will make suitable adjustments to premises to accommodate disabled staff. Redeployment to more suitable posts is also offered where a disability prevents an employee undertaking the duties he/she was employed to undertake. Disabled staff have equal access to training, career development and promotion opportunities – access issues are monitored by all protected characteristics and where necessary remedial actions taken.

Trade union (TU) facility time

Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, which took effect from 1 April 2017, trusts are require to publish details of facility time taken by directly-employed recognised trade-union representatives employed by the Trust. The tables below provide details for the trust;

TU representative – the total number of employees who were TU representatives during the relevant period.

Table 11	
Number of employees who were relevant union officials during the relevant period	**FTE employee number**
	16

Percentage of time spent on facility time – the facility time spent by employees who were TU representative officials.

Table 12	
Percentage of time working on facility time	**Number of employees**
0%	1
1-50%	14
51%-99%	0
100%	1

Percentage of pay bill spent on facility time - the percentage of the total pay bill spent on paying employees who were TU representatives for facility time during the relevant period and the percentage based on the total pay bill.

Table 13	
Total cost of facility time	£91.3k
Total pay bill	£190,445k
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.05%

Paid TU activities

Table 14	
Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	97.5%

Expenditure on consultancy

The Trust spent £150k on consultancy in the year to 31 March 2019, (2017-18 - £2,433k), a key aspect of the 2017-18 costs being the Trust's involvement in the financial improvement programme. Consultancy is defined as the provision to management of objective advice and assistance relating to strategy, structure, management or the operation of the Trust in pursuit of its objectives.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

Table 15

Number of existing engagements as of 31 March 2019	Number
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	2
for 4 or more years at the time of reporting	2

For all new off-payroll engagements between 1 April 2018 and 31 March 2019, for more than £245 per day and last longer than six months

Table 16

	Number
Number of new engagements, or those that reached six months in duration between 1 April 2018 and 31 March 2019	0
Of which, the number that have existed:	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	
No. engaged directly (via PSC contracted to the department) and are on the departmental payroll)	
No. of engagements reassessed for consistency / assurance purposes during the year	
No. of engagements that saw a change to IR35 status following the consistency review	

Further to changes in the rules regarding the employment status of workers engaged through personal service companies, the Trust has assessed interim workers. The Trust has ensured that, following assessment of employment status, income tax and national insurance obligations are correctly accounted for.

Table 17

Number of off payroll engagements of Board members and / or senior officers with significant financial responsibility, during the year	1
Number of individuals that have been deemed Board members and / or senior officers with significant financial responsibility during the financial year.	12

An interim HR director was in post from February to June 2018 to cover the vacant post whilst the Trust recruited to the substantive post.

Reporting of compensation schemes – exit packages 2018-19

The Trust offered a mutually agreed resignation scheme (MARS) to staff in the year. Table 18 shows that the application of five members of staff were approved.

Table 18

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	0	1	1
£10,000 - £25,000	0	2	2
£25,001 - £50,000	2	3	5
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total number of exit packages by type	2	6	8
Total cost (£)	59,729	133,947	193,676

Reporting of compensation schemes – exit packages 2017-18

Table 19

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	0	4	4
£10,000 - £25,000	0	1	1
£25,001 - £50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total number of exit packages by type	0	5	5
Total cost (£)	0	32,342	32,342

Other exit packages

Table 20

Other exit packages – disclosures (Excludes compulsory redundancies)	Number of exit package agreements	Total value of agreements £000's	17-18 Number of exit package agreements	17-18 total value of agreements £000's
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	5	101	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice			5	32
Exit payments following Employment Tribunals or court orders	1	33	0	0
Non contractual payments requiring HMT approval	0	0	0	0
Total	6	134	5	32
Non contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Equality, diversity and inclusion

In 2018-19 the Trust has continued to improve its performance on equality, diversity and inclusion. We have a dedicated equality, diversity and inclusion (EDI) lead, reporting to the Board through the director of HR and OD. We are also working in partnership with EDI colleagues from Barnet, Enfield and Haringey (BEH) Mental Health NHS Trust to develop strategic initiatives across both our respective Trusts promoting equality of access and opportunity for our staff and patients. We are an active member of pan-London groups whose aim is to ensure minority staff are treated fairly in terms of standard HR processes. In 2018-19 we successfully established a Women's' Staff Network to support female staff in the workplace, with plans to establish similar groups for other protected characteristic staff to follow.

The Trust is responding to its responsibilities under the Equality Act 2010 and in 2019 published a gender pay gap report and the annual equality information report. Work is underway to develop our equality objectives for 2018-20 in line with the required four-year cycle, however there are specific actions to address the gender pay gap which are listed below:

- Carrying out a spot check of starting salaries by gender. This will enable the Trust to establish if the gender pay gap is introduced at entry level or if this is a disparity that is more institutional.
- Reviewing the range of jobs that fall within the upper and upper middle quartiles by gender and contract type. The divisional structures across the Trust have undergone realignment and in some cases followed a consultation process. As a result, jobs have been uplifted to create new general manager roles, and some roles have been down banded to flatten out the roles and responsibilities between managers. This would have naturally redistributed the definition of upper and upper middle quartiles and it is important this is re-clarified.
- Carrying out a sample of exit interviews to better understand if there are gender differences in the take up and feedback. The process of exit interviews are not consistently managed nor consistently fed back. There needs to be a clear process whereby the purpose and aim of an exit interview is clearly outlined and stock questions can be offered as an example to enable managers to

confidently perform the exit interview. This will ensure a robust data collection process and consistent delivery to allow the analysis of any gender differences.

- Reviewing the processes for supporting women returning to work following maternity or adoption leave. Whilst the maternity and adoption leave policy needs to be reviewed for women, there is work needed with regards to paternity leave and the number of men who are opting to leave full-time employment in a move to stay-at-home. Whilst the numbers of stay at home men in the UK fell in 2018, there is a need to understand what this statistic looks like in the NHS so as not to replicate any oversight in pay and pay progression as has been with women.

We continue to respond to the NHS contractual requirements relating to equality. For example, the NHS Accessible Information Standard has been implemented. In addition, data about our performance against the NHS Workforce Race Equality Standard was submitted to NHS England by the required deadline.

The Board understands its accountability for the Trust's performance on equality and human rights and is committed to improving our performance. In 2018-19 the Board received reports on a range of issues related to the equality agenda. Matters relating to equality, diversity and inclusion are also regular agenda items at the workforce committee and the patient experience group.

Tables 21-26 provide information on the diversity of the Trust's workforce, using headcount figures as at March 2019.

Age profile

Table 21 shows the Trust is a multi-generational workplace with a wide age span.

Table 21: Staff profile by age band – March 2019

	Number	% (to nearest whole number)
16-20	19	<1
21-25	248	7
26-30	454	13
31-35	446	13
36-40	434	13
41-45	465	14
46-50	461	14
51-55	359	11
56-60	282	8
61-65	145	4
66-70	51	2
71 & above	12	<1
Total	**3,376**	**100**

Disability profile

Table 22: Staff profile by disability – March 2019

	Number	% (to nearest whole number)
No disability	2,508	74
Not stated	810	24
Defined disability	58	2
Total	**3,376**	**100**

Ethnicity profile

The Trust has an ethnically diverse workforce with 60% of staff being from black and minority ethnic backgrounds (60% in 2017-18).

Table 23: Staff profile by ethnic group – March 2019		
Ethnic origin	**Number**	**% (to nearest whole number)**
White – British	652	19
White – other	439	13
Mixed ethnic group	106	3
Asian or Asian British	692	20
Black or black British	986	29
Any other ethnic group	228	7
Not stated	273	8
Total	**3,376**	**100**

Gender profile

Table 24 shows the majority of the Trust's workforce is female which reflects the gender balance for the NHS as a whole.

Table 24: Staff profile by gender – March 2019		
Gender	**Number**	**% (to nearest whole number)**
Female	2,544	75
Male	832	25
Total	**3,376**	**100**

Religion or belief profile

Table 25 shows that the Trust is religiously diverse with nearly a quarter of the staff recording a religion other than Christian.

Table 25: Staff profile by religion or belief – March 2019		
	Number	**% (to nearest whole number)**
Buddhism	28	1
Christianity	1,516	45
Hinduism	198	6
Islam	351	10
Jainism	8	<1
Judaism	28	<1
Sikhism	14	<1
Other	199	6
No religion or belief	209	6
Not stated	825	24
Total	**3,376**	**100**

Sexual orientation profile

Table 26 shows that fewer than 3% of staff disclosed that they were lesbian, gay or bisexual. A quarter (25%) of staff did not disclose their sexual orientation.

Table 26: Staff profile by sexual orientation – March 2019		
Sexual orientation	**Number**	**% (to nearest whole number)**
Bisexual	31	1
Gay or Lesbian	32	1
Heterosexual	2,459	73
Other sexual orientation not listed	1	<1
Not stated	852	25
Undecided	1	<1
Total	**3,376**	**100**

Employment consultation, participation and trade-union relationships

We continued to hold regular staff briefing and question and answer sessions in which staff have the opportunity to hear about corporate priorities and to put questions on any topic to members of the executive and other senior leaders. A monthly written team briefing underpins this event and this is shared with all staff through face to face briefings by team managers and is also made available to all staff through the Trust's intranet. Staff regularly contributed to Board presentations about their work, particularly in relation to patient experience.

During 2018-19 we continued our 'Listening into Action' programme. After running a well-supported survey to identify the key issues and challenges facing staff in the workplace a series of workshops were held to identify actions staff themselves could take to address these issues. This has resulted in improvements in clinical administrative support, eradication of many of the blockages staff experience in delivering high quality care and a number of measures designed to support staff health and well-being at work. We also introduced a new Team Brief cascade system, which replaces Executive Question Time and Staff Conversations, and which is designed to improve open discussion and service/team contextualised conversation.

We continue to enjoy healthy and constructive partnership arrangements with our staff-side organisations. There are well-established mechanisms in place to formally consult with trade-union organisations through our Joint Staff Committee (JSC) and Local Negotiating Committee (LNC) for medical staff. We also have agreed procedures for consulting with staff on organisational changes affecting staff working arrangements and conditions. These procedures allow staff and their representatives to actively participate and shape proposals to change and improve their working environments with formal means of redress if staff are not happy with any changes being proposed.

Pay policy

As an NHS body we honour and fully implement nationally-determined agreements on staff pay and terms and conditions of employment, including cost-of-living pay increases and incremental progression. We submit our views on national pay arrangements and actively participate in national discussions on the future of pay, pensions and terms and conditions of employment in the NHS.

Conclusion

To the best of my knowledge and belief, the 2018-19 accountability report is fair, true and accurate.

Signed 

Date: 22 May 2019

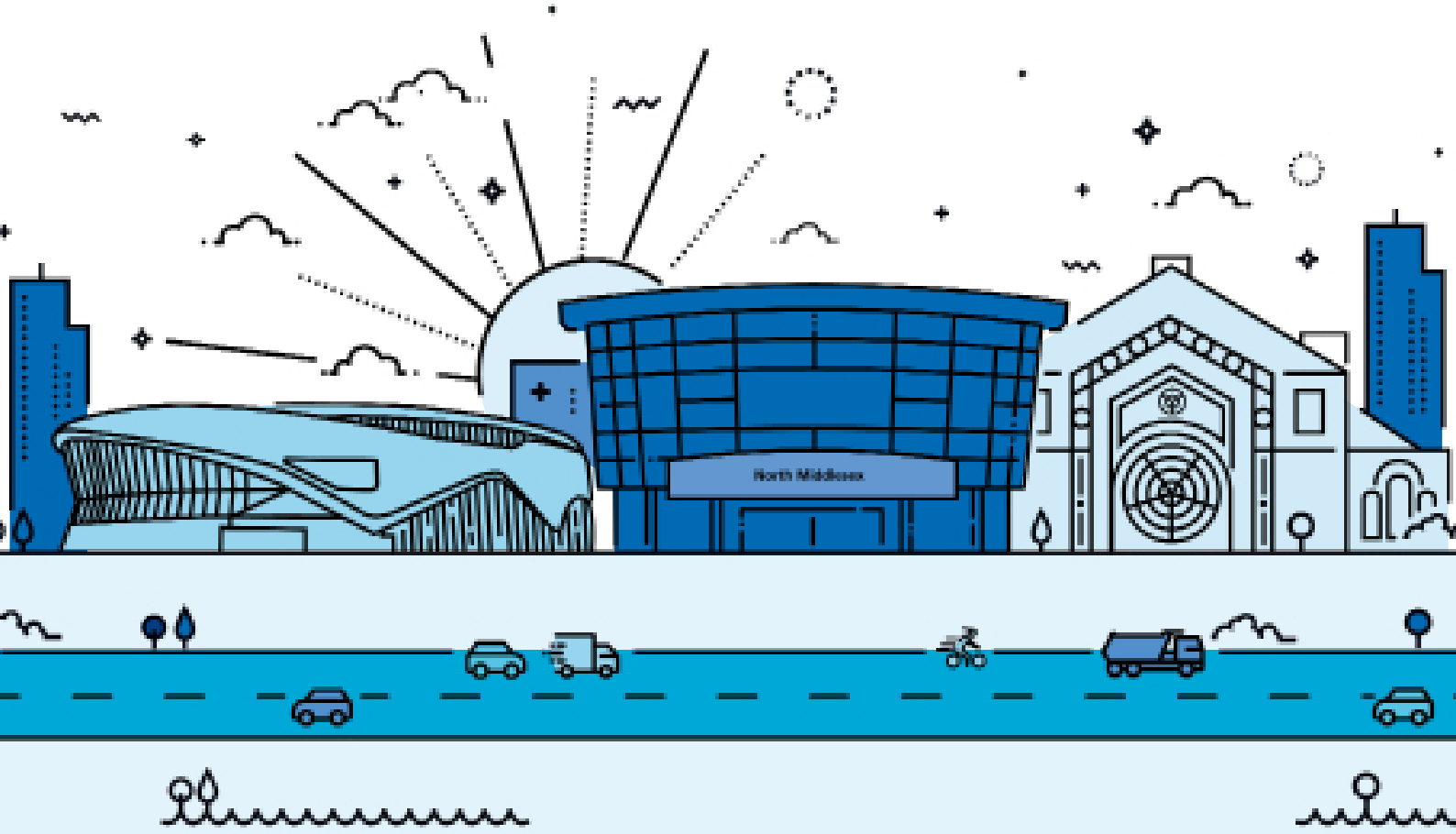
Maria Kane

Chief Executive

North Middlesex University Hospital NHS Trust

Our annual accounts

for year ended 31 March 2019



Annual accounts for year ended 31 March 2019

Statement of comprehensive income for year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	*3*	285,555	260,755
Other operating income	*4*	35,168	17,023
Operating expenses	*5.1*	(316,931)	(289,049)
Operating surplus/(deficit) from continuing operations		**3,792**	**(11,271)**
Finance income	*10*	151	50
Finance expenses	*11.1*	(7,671)	(6,977)
PDC dividends payable		-	(554)
Net finance costs		**(7,520)**	**(7,481)**
Other gains / (losses)		(46)	(16)
Retained deficit for the year		**(3,774)**	**(18,768)**
Other comprehensive income			
Impairments	*6*	(854)	-
Revaluations		691	3,720
Total comprehensive expense for the year		**(3,937)**	**(15,048)**
Adjusted financial performance (control total basis):			
Retained deficit for the year		(3,774)	(18,768)
Remove Impairments charged to operating expenses		601	(9,271)
Remove I&E impact of capital grants and donations		(11)	83
CQUIN risk reserve adjustment (2017/18 only)		-	(1,001)
Adjusted retained deficit		**(3,184)**	**(28,957)**

The Trust's financial performance is based on the retained deficit after technical adjustments relating to historic accounting policy changes. Additional costs of accounting for PFI schemes on the balance sheet under IFRIC12 as well as impairment costs are excluded. The impact of the removal of the donated asset reserve is reversed.

The notes on pages 7 to 40 form part of this account.

Statement of financial position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	*13.1*	5,609	5,806
Property, plant and equipment	*14.1*	190,946	191,345
Total non-current assets		**196,555**	**197,151**
Current assets			
Inventories	*15*	3,153	3,316
Trade and other receivables	*16.1*	26,086	19,537
Cash and cash equivalents	*17.1*	27,609	17,603
Total current assets		**56,848**	**40,456**
Current liabilities			
Trade and other payables	*18.1*	(39,261)	(31,507)
Borrowings	*20*	(6,864)	(6,555)
Provisions	*22.1*	(325)	(320)
Other liabilities	*19*	(4,689)	(4,826)
Total current liabilities		**(51,139)**	**(43,208)**
Total assets less current liabilities		**202,264**	**194,399**
Non-current liabilities			
Borrowings	*20*	(171,569)	(165,498)
Provisions	*22.1*	(634)	(604)
Total non-current liabilities		**(172,203)**	**(166,102)**
Total assets employed		**30,061**	**28,297**
Financed by			
Public dividend capital		135,418	129,717
Revaluation reserve		17,379	17,931
Income and expenditure reserve		(122,736)	(119,351)
Total taxpayers' equity		**30,061**	**28,297**

The notes on pages 7 to 40 form part of these accounts.

The financial statements on pages 2 to 40 were approved by the Board on 22 May 2019 and signed on its behalf by

Chief Executive:  Date: **22 May 2019**

Statement of changes in equity for year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**129,717**	**17,931**	**(119,351)**	**28,297**
Deficit for the year	-	-	(3,774)	**(3,774)**
Other transfers between reserves	-	(389)	389	**-**
Impairments	-	(854)	-	**(854)**
Revaluations	-	691	-	**691**
Public dividend capital received	5,701	-	-	**5,701**
Taxpayers' equity at 31 March 2019	**135,418**	**17,379**	**(122,736)**	**30,061**
Taxpayers' equity at 1 April 2017 - brought forward	**129,625**	**14,441**	**(100,813)**	**43,253**
Deficit for the year	-	-	(18,768)	**(18,768)**
Other transfers between reserves	-	(230)	230	**-**
Revaluations	-	3,720	-	**3,720**
Public dividend capital received	92	-	-	**92**
Taxpayers' equity at 31 March 2018	**129,717**	**17,931**	**(119,351)**	**28,297**

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
for year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/ (deficit)		3,792	(11,271)
Non-cash income and expense:			
Depreciation and amortisation	*5.1*	12,522	11,987
Net impairments	*6*	601	(9,271)
Income recognised in respect of capital donations		(104)	(7)
(Increase) in receivables and other assets		(6,237)	(477)
(Increase) / decrease in inventories		163	(11)
Increase in payables and other liabilties		4,607	2,156
Increase in provisions		34	128
Net cash generated from / (used in) operating activities		**15,378**	**(6,766)**
Cash flows from investing activities			
Interest received		175	67
Purchase of intangible assets		(366)	(553)
Purchase of property, plant, equipment and investment property		(9,031)	(4,466)
Sales of property, plant, equipment and investment property		20	-
Net cash (used in) investing activities		**(9,202)**	**(4,952)**
Cash flows from financing activities			
Public dividend capital received		5,701	92
Movement on loans from the Department of Health and Social Care		11,440	26,650
Capital element of finance lease rental payments		(657)	(682)
Capital element of PFI, LIFT and other service concession payments		(4,549)	(4,601)
Interest paid on DOH loans		(1,892)	(1,104)
Interest paid on finance lease liabilities		(89)	(97)
Interest paid on PFI, LIFT and other service concession obligations		(5,741)	(5,557)
PDC dividend paid		(383)	(40)
Net cash generated from financing activities Increase in cash and cash equivalents		**3,830**	**14,661**
		10,006	**2,943**
Cash and cash equivalents at 1 April - brought forward		**17,603**	**14,660**
Cash and cash equivalents at 31 March	*17.1*	**27,609**	**17,603**

Notes to the accounts

1. Accounting policies and other information

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 2018-19 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.

1.1.1 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.

1.2 Going concern

These accounts have been prepared on the going concern basis.

International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The Trust Board has considered the advice in the Department of Health and Social Care Group Accounting Manual that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. Department of Health bodies should therefore prepare their financial statements on a going concern basis unless informed by the Department of Health and Social Care of the intention for dissolution without transfer of service or function to another entity.

The Trust has incurred a deficit of £3.2m (excluding impairments) in 2018/19. This position includes provider sustainability funding (PSF) of £14.4m, without which the deficit would have been £17.6m, £1.35m favourable to the control total.

The 2019/20 Board-approved plan is to break even. The plan includes £14.2m of central funding which is payable to the Trust on achieving its financial plan on a quarterly basis, this funding is therefore contingent on future events.It is anticipated that it may be some time before the Trust can achieve financial balance on a sustainable basis given constraints in the wider health economy. The Board has prepared its financial plans and cash flow forecasts on the assumption that support funding will continue to be received through the Department of Health Social Care and NHS Improvement if required, this support funding has not yet been requested nor confirmed. On the basis that the Trust achieves the 2019/20 financial plan, it is not anticipated that any further borrowing will be required in the financial year and £12m of existing loan can be repaid whilst maintaining the cash balance within the limits set out by the Department of Health Social Care through to June 2020. This is in comparison to 2018/19 where the Trust had net borrowing of £11.4m. The Trust has a commitment to repay principal on existing loans of £2.0m in the next 18 months, and the Trust will generate sufficient cash from continuing activities so that no loan repayments will need to be rescheduled in this time.

The £12m capital plan for 2019/20 includes £1.4m of external funding, the remaining expenditure being managed through internally-generated resources.

The Trust Board has carefully considered the principle of going concern and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

Nevertheless, the going concern basis remains appropriate. This is because the Trust Board has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health and Social Care to continue to deliver the full range of mandatory services for the foreseeable future.

1.3 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.

1.4 Property, plant and equipment

1.4.1 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

1.4.2 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.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. 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.

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.

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 income.

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.

1.4.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:
- management is committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

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. 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.

1.4.4 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.

1.4.5 Private finance initative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM , are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

The implicit interest rate at the inception of the finance lease applied in calculating the annual finance cost is 3.31%. The Operator's model assumes RPI inflation at 2.5% per annum (where the actual rate is not yet known) to the completion of the concession in 2041. This has been represented as contingent rental interest from financial year 2011-12 onwards. The sum total of the annual finance cost and the contingent rentals is comparable with the Operator's overall borrowing interest rate. The Trust has therefore concluded that the annual finance cost of 3.31% is an appropriate interest rate.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.5 Intangible assets

1.5.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

1.5.2 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 under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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.

1.6 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.7 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.

1.8 Financial assets and financial liabilities

1.8.1 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 Office of National Statistics.

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, ie, when receipt or delivery of the goods or services is made.

1.8.2 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 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, 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).

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.

1.8.3 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.

1.9 Leases

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.

The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

1.10 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation 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 the discount rates published and mandated by HM Treasury.

1.11 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 22.2 but is not recognised in the Trust's accounts.

1.12 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.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22.3 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22.3, 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.

1.14 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.

At any time, 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, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.15 Value added tax

Most of the activities of the Trust are outside the scope of VAT and,so 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.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.17 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, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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.

1.18 Critical accounting judgements and key sources of estimation uncertainty

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 that are considered to be 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 the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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

The Trust has a PFI contract for a number of buildings and management has judged that following the principles of IFRIC 12 the assets are recognised as items of property, plant and equipment together with a liability to pay for them.

The Trust took the decision not to consolidate the charitable funds on the grounds of material. The Charitable Funds generated a total revenue of 101k for the year ended 31 March 2019.

Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In order to calculate the carrying value of the Trust's provisions there are a number of areas which require to be estimated:

(i) In the cases of pension and other benefits payable in the future, an estimate is made of the length of time that payment will be required to be made, using actuarial mortality tables and the discount rate used to estimate the present value of the estimate future payments. This has been reviewed in year and adjusted accordingly.

(ii) The Trust has estimated the level of recovery of its non NHS receivable and made allowances of £2,039,000 (£1,997,000 as at 31 March 2018) for the expected level of impairment to those receivables. The provision is based both on the age of the debt and knowledge of the recoverability of specific debts.Actual experience may differ from these estimates. A provision of 21.89% (22.84% in 2017/18) is made in respect of Road Traffic Act Debtors.

(iii) The Trust has used component lives based on historic and new data provided by the external Valuers to depreciate buildings on a component basis.

(iv) The Trust's estimation of its non-current asset values and useful economic life involves estimation and judgement. During 2018/19, a valuation of all the Trust's land and buildings was carried out by an external professional valuer as at 31 March 2019. Specialised buildings are valued based on a depreciated Modern Equivalent Asset (MEA) basis with non-specialised buildings valued based on Existing Use (EUV). The valuation provided has been used for closing net replacement costs. The valuation is based on current location and footprint. This reflects the Trust's favourable location based near the border of Enfield and Haringey - the two key purchasers and with minimal unutilised space. Remaining useful economic lives are included at note 14.5.

(v) The Trust has estimated the provisions for pensions relating to former staff using estimates provided by the NHS Pensions Agency provided at the time of the member's early retirement. These are updated if the member dies or if it becomes apparent that the provision is not sufficient to meet the liability. Forecast future pension payments are discounted by a real discount rate of 0.29% (0.1% in 2017/18).

1.19 Early adoption of standards, amendments, and interpretation

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.20 Charitable funds

The Trust has not consolidated the Charitable Funds within the Trust's own accounts. The Charitable Funds transactions, assets and liabilities are immaterial in the context of the accounts of the Trust. The charity is called the North Middlesex Hospital General Charitable Fund, registered with the Charity Commission (no.1054451). North Middlesex University Hospital NHS Trust is the corporate trustee of the charity.

1.21 Revenue

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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 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.

1.22 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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.

Employer's pension cost 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.

1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The following is a list of recently issued IFRS Standards and amendments that have not been adopted within the FReM, and are therefore not applicable to the Truts's Accounts in 2018-19:

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 April 2020, but not yet adopted by the FReM, early adoption is therefore not permitted.
- IFRS 4 Insurance Contracts– Application required for accounting periods beginning on or after 1 April 2021, but not yet adopted by the FReM, early adoption is therefore not permitted.
- IFRic 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 April 2021, but not yet adopted by the FReM, early adoption is therefore not permitted.

2. Operating segments

North Middlesex University Hospital NHS Trust operates within one segment of healthcare provision.

3. Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

3.1 Income from patient care activities (by nature)

	2018/19	2017/18
	£000	£000
Acute services		
Elective income	32,179	28,552
Non elective income	93,306	87,580
First outpatient income	19,080	20,414
Follow up outpatient income	27,732	20,904
A & E income	22,024	22,300
High cost drugs income from commissioners (excluding pass-through costs)	18,119	18,258
Other NHS clinical income	64,923	57,162
Community services		
Community services income from CCGs and NHS England	1,099	1,047
Income from other sources (e.g. local authorities)	2,860	2,774
All services		
Private patient income	106	133
Agenda for Change pay award central funding	2,453	-
Other clinical income	1,674	1,631
Total income from activities	**285,555**	**260,755**

3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	48,767	44,077
Clinical commissioning groups	229,074	211,998
Department of Health and Social Care	2,453	-
Other NHS providers	673	142
Local authorities	2,808	2,774
Non-NHS: private patients	106	133
Non-NHS: overseas patients (chargeable to patient)	609	551
Injury cost recovery scheme	1,065	1,080
Total income from activities	**285,555**	**260,755**
Of which:		
Related to continuing operations	285,555	260,755
Related to discontinued operations	-	-

3.3 Overseas visitors disclosure

	2018/19	2017/18
	£000	£000
Income recognised this year	609	551
Cash payments received in-year	196	398
Amounts added to provision for impairment of receivables	149	141
Amounts written off in-year	96	123

4. Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	554	539
Education and training (excluding notional apprenticeship levy income)	12,507	11,487
Non-patient care services to other bodies	3,623	2,703
Provider sustainability / sustainability and transformation fund income (PSF / STF)	14,435	-
Income in respect of employee benefits accounted on a gross basis	45	44
Other contract income	3,723	1,972
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	177	271
Receipt of capital grants and donations	104	7
Total other operating income	**35,168**	**17,023**
Of which:		
Related to continuing operations	35,168	17,023
Related to discontinued operations	-	-

4.1 Revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	3,494
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

4.2 Transaction price allocated to remaining performance obligations

The Trust's review determined that there is no revenue from existing contracts that requires to be allocated to remaining performance obligations.

5.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	456	967
Purchase of healthcare from non-NHS and non-DHSC bodies	2,077	1,107
Staff and executive directors costs	189,836	176,424
Remuneration of non-executive directors	81	85
Supplies and services - clinical (excluding drugs costs)	29,709	28,558
Supplies and services - general	9,602	9,144
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	23,634	23,198
Inventories written down	2	26
Consultancy costs	150	2,433
Establishment	2,522	2,004
Premises	12,236	11,906
Transport (including patient travel)	2,119	1,980
Depreciation on property, plant and equipment	10,999	10,404
Amortisation on intangible assets	1,523	1,583
Net impairments	601	(9,271)
Movement in credit loss allowance: contract receivables / contract assets	62	
Movement in credit loss allowance: all other receivables and investments	99	216
Increase/(decrease) in other provisions	190	296
Change in provisions discount rate(s)	(3)	9
Audit fees payable to the external auditor		
audit services- statutory audit	54	71
other auditor remuneration (external auditor only)	11	12
Internal audit costs	127	127
Clinical negligence	17,277	15,295
Legal fees	220	243
Insurance	152	145
Education and training	1,605	1,156
Rentals under operating leases	516	350
Redundancy	161	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	7,475	6,952
Car parking & security	859	757
Hospitality	40	36
Losses, ex gratia & special payments	44	5
Other services, eg external payroll	2,257	2,449
Other	238	382
Total	**316,931**	**289,049**
Of which:		
Related to continuing operations	316,931	289,049
Related to discontinued operations	-	-

5.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. All assurance services	11	12
Total	**11**	**12**

5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

6. Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	113	(10,460)
Other	488	1,189
Total net impairments charged to operating surplus / deficit	**601**	**(9,271)**
Impairments charged to the revaluation reserve	854	-
Total net impairments	**1,455**	**(9,271)**

7. Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	126,755	120,857
Social security costs	14,932	13,578
Apprenticeship levy	671	609
Employer's contributions to NHS pensions	15,174	14,398
Termination benefits	-	32
Temporary staff (including agency)	32,913	27,302
Total gross staff costs	**190,445**	**176,776**
Recoveries in respect of seconded staff	-	-
Total staff costs	**190,445**	**176,776**
Of which		
Costs capitalised as part of assets	415	352

7.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £0k (£98k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

9. Operating leases

9.1 North Middlesex University Hospital NHS Trust as a lessee

	31 March 2019 £000	31 March 2018 £000
Operating lease expense		
Minimum lease payments	516	350
Total	**516**	**350**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	579	455
- later than one year and not later than five years;	1,519	1,435
- later than five years.	124	-
Total	**2,222**	**1,890**
Future minimum sublease payments to be received	-	-

10. Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	151	50
Total finance income	**151**	**50**

11.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,827	1,294
Finance leases	90	96
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	3,557	3,704
Contingent finance costs on PFI and LIFT scheme obligations	2,196	1,880
Total interest expense	**7,670**	**6,975**
Unwinding of discount on provisions	1	2
Total finance costs	**7,671**	**6,977**

11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	1
Amounts included within interest payable arising from claims under this legislation	-	1

12. Other gains / (losses)

	2018/19	2017/18
	£000	£000
Losses on disposal of assets	(46)	(16)
Total other losses	**(46)**	**(16)**

13.1 Intangible assets - 2018/19

	IT - Purchased	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018	**12,195**	**-**	**12,195**
Additions	496	830	**1,326**
Disposals / derecognition	(10)	-	**(10)**
Valuation / gross cost at 31 March 2019	**12,681**	**830**	**13,511**
Amortisation at 1 April 2018	**6,389**	**-**	**6,389**
Provided during the year	1,523	-	**1,523**
Disposals / derecognition	(10)	-	**(10)**
Amortisation at 31 March 2019	**7,902**	**-**	**7,902**
Net book value at 31 March 2019	**4,779**	**830**	**5,609**
Net book value at 1 April 2018	**5,806**	**-**	**5,806**

13.2 Intangible assets - 2017/18

	IT - Purchased	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017	**11,754**	**-**	**11,754**
Additions	447	6	**453**
Reclassifications	6	(6)	**-**
Disposals / derecognition	(12)	-	**(12)**
Valuation / gross cost at 31 March 2018	**12,195**	**-**	**12,195**
Amortisation at 1 April 2017	**4,806**	**-**	**4,806**
Provided during the year	1,583	-	**1,583**
Amortisation at 31 March 2018	**6,389**	**-**	**6,389**
Net book value at 31 March 2018	**5,806**	**-**	**5,806**
Net book value at 1 April 2017	**6,948**	**-**	**6,948**

The Trust capitalises the cost of procured software and software licences, plus the cost of implementing new systems. These assets are held at amortised cost price. There has been no indexation or revaluation applied to the current intangible assets.

All intangible assets are amortised. The useful lives are estimated by Trust management or based on contract terms. Useful lives are regularly assessed to ensure reasonableness. The current software has total useful lives of between 3 and 8 years with remaining lives between 0 and 8 years.

14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April	**20,402**	**194,476**	**663**	**33,571**	**119**	**9,338**	**3,555**	**262,124**
Additions	-	5,422	1,750	3,585	-	498	185	**11,440**
Impairments	-	(854)	-	-	-	-	-	**(854)**
Revaluations	-	691	-	-	-	-	-	**691**
Reclassifications	-	562	(562)	-	-	1	(1)	**-**
Disposals / derecognition	-	-	-	(2,728)	-	(22)	(16)	**(2,766)**
Valuation/gross cost at 31 March 2019	**20,402**	**200,297**	**1,851**	**34,428**	**119**	**9,815**	**3,723**	**270,635**
Accumulated depreciation at 1 April 2018	**-**	**39,897**	**-**	**22,031**	**79**	**6,522**	**2,250**	**70,779**
Provided during the year	-	7,284	-	2,551	12	874	278	**10,999**
Impairments	-	1,779	-	-	-	-	-	**1,779**
Reversals of impairments	-	(1,178)	-	-	-	-	-	**(1,178)**
Disposals / derecognition	-	-	-	(2,654)	-	(21)	(15)	**(2,690)**
Accumulated depreciation at 31 March 2019	**-**	**47,782**	**-**	**21,928**	**91**	**7,375**	**2,513**	**79,689**
Net book value at 31 March 2019	**20,402**	**152,515**	**1,851**	**12,500**	**28**	**2,440**	**1,210**	**190,946**
Net book value at 1 April 2018	**20,402**	**154,579**	**663**	**11,540**	**40**	**2,816**	**1,305**	**191,345**

14.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017	**20,402**	**177,902**	**1,221**	**32,526**	**119**	**9,093**	**3,508**	**244,771**
Additions	-	742	2,482	1,369	-	245	93	**4,931**
Impairments	-	(1,388)	-	-	-	-	-	**(1,388)**
Reversals of impairments	-	10,460	-	-	-	-	-	**10,460**
Revaluations	-	3,720	-	-	-	-	-	**3,720**
Reclassifications	-	3,040	(3,040)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(324)	-	-	(46)	**(370)**
Valuation/gross cost at 31 March 2018	**20,402**	**194,476**	**663**	**33,571**	**119**	**9,338**	**3,555**	**262,124**
Accumulated depreciation at 1 April 2017	**-**	**33,607**	**-**	**19,766**	**67**	**5,480**	**2,008**	**60,928**
Provided during the year	-	6,489	-	2,573	12	1,042	288	**10,404**
Reversals of impairments	-	(199)	-	-	-	-	-	**(199)**
Disposals / derecognition	-	-	-	(308)	-	-	(46)	**(354)**
Accumulated depreciation at 31 March 2018	**-**	**39,897**	**-**	**22,031**	**79**	**6,522**	**2,250**	**70,779**
Net book value at 31 March 2018	**20,402**	**154,579**	**663**	**11,540**	**40**	**2,816**	**1,305**	**191,345**
Net book value at 1 April 2017	**20,402**	**144,295**	**1,221**	**12,760**	**52**	**3,613**	**1,500**	**183,843**

During the year a revaluation of the whole Trust estate as at 31 March 2019 was carried out by Gary Howes MRICS, Chris Soar MRICS and Jaspreet Rahi MSc of Montagu Evans LLP. Following the valuation exercise, there was a reduction in the building value of £764k. This included a reduction of £488k for a new extensio, valued on a modern equivalent asset basis for the first time. This reduction has been treated as an impairment with a charge to operating expenditure. The remaining £276k net reduction has been split between a further £113k impairment with a charge to operating expenditure with the balance of £153k offset against the Revaluation Reserve. The land value was unchanged.

For the substantial majority of buildings, valuations were carried out at Depreciated Replacement cost on a Modern Equivalent Asset basis in line with the GAM for specialised buildings. This represents fair value under IFRS assuming that the buildings continue to be used for the provision of NHS services. A number of non-specialised areas were valued at market value for existing use. This included parts of buildings used for administration with a value of £145k.

14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	20,402	69,077	1,851	12,245	28	2,105	1,168	**106,876**
Finance leased	-	-	-	-	-	322	-	**322**
On-SoFP PFI contracts and other service concession arrangements	-	83,195	-	-	-	-	-	**83,195**
Owned - donated	-	243	-	255	-	13	42	**553**
NBV total at 31 March 2019	**20,402**	**152,515**	**1,851**	**12,500**	**28**	**2,440**	**1,210**	**190,946**

14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	20,402	72,361	663	11,278	40	2,320	1,302	**108,366**
Finance leased	-	-	-	-	-	482	-	**482**
On-SoFP PFI contracts and other service concession arrangements	-	81,967	-	-	-	-	-	**81,967**
Owned - donated	-	251	-	262	-	14	3	**530**
NBV total at 31 March 2018	**20,402**	**154,579**	**663**	**11,540**	**40**	**2,816**	**1,305**	**191,345**

During 2017/18 a valuation of the Trust's education buildings as at 31 March 2018 was carried out by Gary Howes MRICS and Jaspreet Rahi MSc of Montagu Evans LLP. This followed major refurbishment work. As a result of the valuation exercise there was a reduction in the building value of £1.189m which was treated as an impairment with a charge to operating expenses.

At the end of 2017/18 the building values were indexed based on the BCIS Tender Price Index of Public Sector Building Non Housing. This resulted in an increase in value of £14.18m. Of this total £10.46m was treated as a reverse impairment with a credit to operating expenses to the extent that impairment costs had been recognised for the individual buildings. The balance of £3.72m was taken to the revaluation reserve.

14.5 During 2018/19 donations of PPE with a value of £104k (2017/18 £7k) were received from the North Middlesex Hospital General Charitable Fund.

14.6 Range of lives of property, plant and equipment - 2018/19

Economic lives of non-current assets	Min Life Years	Max Life Years
Buildings excl dwellings	5	60
Plant & machinery	5	15
Transport equipment	5	7
Information technology	5	8
Furniture and fittings	5	10

15. Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,686	1,419
Consumables	1,392	1,810
Energy	75	87
Total inventories	**3,153**	**3,316**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £36,444k (2017/18: £35,604k). Write-down of inventories recognised as expenses for the year were £2k (2017/18: £26k).

16.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	23,485	-
Trade receivables*	-	17,261
Accrued income*	-	212
Allowance for impaired contract receivables / assets*	(1,594)	-
Allowance for other impaired receivables	(445)	(1,997)
Prepayments (non-PFI)	1,686	1,714
Interest receivable	55	79
PDC dividend receivable	336	-
VAT receivable	1,479	1,301
Other receivables	1,084	967
Total current trade and other receivables	**26,086**	**19,537**

The great majority of trade is with CCGs. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

16.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**1,997**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,651	(1,651)
New allowances arising	106	100
Reversals of allowances	(44)	(1)
Utilisation of allowances (write offs)	(119)	-
Allowances as at 31 Mar 2019	**1,594**	**445**

16.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017	**1,905**
Increase in provision	274
Amounts utilised	(124)
Unused amounts reversed	(58)
Allowances as at 31 Mar 2018	**1,997**

17.1 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.

	2018/19	2017/18
	£000	£000
At 1 April 2018	**17,603**	**14,660**
Net change in year	10,006	2,943
At 31 March 2019	**27,609**	**17,603**
Broken down into:		
Cash at commercial banks and in hand	2	1
Cash with the Government Banking Service	27,607	17,602
Total cash and cash equivalents as in SoFP	**27,609**	**17,603**
Total cash and cash equivalents as in SoCF	**27,609**	**17,603**

17.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019 £000	31 March 2018 £000
Bank balances	24	14
Total third party assets	**24**	**14**

18.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	19,072	14,967
Capital payables	5,654	2,389
Accruals	6,968	6,979
Social security costs	2,128	1,887
Other taxes payable	2,028	1,739
PDC dividend payable	-	47
Accrued interest on loans*		210
Other payables	3,411	3,289
Total current trade and other payables	**39,261**	**31,507**
Of which payables from NHS and DHSC group bodies:		
Current	8,091	4,415
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

18.2 Early retirements in NHS payables above

There were no early retirements due to ill health in 2018/19. (2017/18 nil)

19. Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	4,689	4,826
Total other current liabilities	**4,689**	**4,826**

20. Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Scoial Care	1,495	1,350
Obligations under finance leases	682	656
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	4,687	4,549
Total current borrowings	**6,864**	**6,555**
Non-current		
Loans from the Department of Health and Scoial Care	68,157	56,717
Obligations under finance leases	1,072	1,754
Obligations under PFI, LIFT or other service concession contracts	102,340	107,027
Total non-current borrowings	**171,569**	**165,498**

The Trust currently has 13 loans with the Department of Health and Social Care the details are as follows :

The first capital loan was taken out in September 2010. £440k is payable every 6 months until September 2025. Interest of 2.74% is payable on the outstanding balance.

The second capital loan was taken out in December 2012. £95k is payable every 6 months until September 2022, Interest of 1.04% is payable on the outstanding balance.

The third capital loan was taken out in December 2014. £140k is payable every 6 months until December 2024, Interest of 1.9% is payable on the outstanding balance.

The fourth loan is a revolving working capital facility which is repayable by February 2021 or earlier if the Trust has surplus cash. Interest of 3.5% is payable on the outstanding balance.

During 2017/18 the Trust took out 6 individual interim revenue support loans totalling £28m. These are repayable within 3 years of the loan date or earlier if the Trust has surplus cash. Interest of 3.5% is payable on the outstanding balance.

During 2018/19 the Trust took out 5 individual interim revenue support loans totalling £20.89m. These are repayable within 3 years of the loan date or earlier if the Trust has surplus cash. Interest of 1.5% is payable on the outstanding balance. Early repayments were made of 2 of the loans taken out in 2017/18 with a value of £8.1m.

20.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**58,067**	**2,410**	**111,576**	**172,053**
Cash movements:				
Financing cash flows - payments and receipts of principal	11,440	(657)	(4,549)	**6,234**
Financing cash flows - payments of interest	(1,892)	(89)	(3,557)	**(5,538)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	210	-	-	**210**
Application of effective interest rate	1,827	90	3,557	**5,474**
Carrying value at 31 March 2019	**69,652**	**1,754**	**107,027**	**178,433**

21. North Middlesex University Hospital NHS Trust as a lessee

Obligations under finance leases where North Middlesex University Hospital NHS Trust is the lessee.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**2,054**	**2,644**
of which liabilities are due:		
- not later than one year;	769	733
- later than one year and not later than five years;	1,285	1,911
Finance charges allocated to future periods	(300)	(234)
Net lease liabilities	**1,754**	**2,410**
of which payable:		
- not later than one year;	682	656
- later than one year and not later than five years;	1,072	1,754

22.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**709**	**31**	**112**	**72**	**924**
Change in the discount rate	(3)	-	-	-	**(3)**
Arising during the year	175	1	59	35	**270**
Utilised during the year	(98)	(6)	(14)	(35)	**(153)**
Reversed unused	(1)	-	(70)	(9)	**(80)**
Unwinding of discount	1	-	-	-	**1**
At 31 March 2019	**783**	**26**	**87**	**63**	**959**
Expected timing of cash flows:					
- not later than one year;	165	10	87	63	**325**
- later than one year and not later than five years;	418	16	-	-	**434**
- later than five years.	200	-	-	-	**200**
Total	**783**	**26**	**87**	**63**	**959**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

Pensions cost relate to the funding of pensions for staff made redundant or taking voluntary early retirement. The full projected cost is charged in the year the employee leaves the Trust based on actuarial estimations. The primary uncertainty is the actual length of life. Legal claims are employment tribunal cases. The probability of the claim succeeding and potential cost are estimated by the Trust's legal advisors. The NHSLA have assessed the personal injury cases, included in Other, and provided similar estimations for both potential cost and probability that the cost will materialise.

22.2 Clinical negligence liabilities

At 31 March 2019, £270,944k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of North Middlesex University Hospital NHS Trust (31 March 2018: £222,701k).

22.3 Contingencies

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(322)	(402)
Employment tribunal and other employee related litigation	(86)	(195)
Gross value of contingent liabilities	**(408)**	**(597)**
Amounts recoverable against liabilities	297	369
Net value of contingent liabilities	**(111)**	**(228)**
Net value of contingent assets	**-**	**-**

The contingencies represent the balance of potential costs not accrued for the personal injury and employment tribunal cases included within provisions. These values have not been recognised as a cost or

23. Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	1,151	97
Intangible assets	825	-
Total	**1,976**	**97**

Capital commitments for PPE include a partially completed order for engineering works for a new IT hub room and an order placed in March 2019 for a CT scanner. Commitments for intangibles includes two partially complete software orders as part of the Trusts global digital exemplar (GDE) faster followers programme.

24 On-SoFP PFI and LIFT - additional information

During 2010/11 the Trust took possession of a new PFI hospital. Under IFRIC 12 this is accounted for as an asset of the Trust with a corresponding liability on the balance sheet.

The contract with the PFI provider, ByNorth, runs until May 2041. At the end of this period ownership of the PFI assets will transfer to the Trust without charge. Monthly Unitary Payments are made covering the repayment of finance, including interest, building maintenance costs of the new buildings and replacement of components of these buildings. Maintenance of the Trust's existing buildings are also covered by the unitary payments.

The construction scheme was in two phases with phase two completed in July 2011 when an additional asset and liability was recognised.

The Unitary Payment increases each year in line with inflation as measured by the Retail Price Index (RPI). The increased cost will be split between operating costs and contingent rental. Contingent rentals, related to the impact of inflation on the lease liability, are included within finance costs.

In March 2017 the Trust agreed to a refinancing of ByNorth's PFI borrowing, which involves a change from a sixmonth loan facility to a monthly one. This takes effect from 2017/18 and runs for 5 years. In accordance with the terms of the PFI contract, the benefits are shared between ByNorth and the Trust. The net savings to the Trust will be a total of £346k over the five years by reducing the annual expense each year.

24.1 Imputed finance lease obligations

North Middlesex University Hospital NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019	31 March 2018
	£000	£000
Gross PFI, LIFT or other service concession liabilities	194,127	199,713
Of which liabilities are due		
- not later than one year;	10,533	10,291
- later than one year and not later than five years;	40,378	39,956
- later than five years.	143,216	149,466
Finance charges allocated to future periods	(87,100)	(88,137)
Net PFI, LIFT or other service concession arrangement obligation	107,027	111,576
- not later than one year;	4,687	4,549
- later than one year and not later than five years;	18,809	18,696
- later than five years.	83,531	88,331

24.2 Total on-SoFP PFI

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019	31 March 2018
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	407,827	414,247
Of which liabilities are due:		
- not later than one year;	18,303	17,789
- later than one year and not later than five years;	73,383	71,252
- later than five years.	316,141	325,206

24.3 Analysis of amounts payable to service concession

This note provides an analysis of the unitary payments made to the service concession operator:

	31 March 2019	31 March 2018
	£000	£000
Unitary payment payable to service concession operator	17,777	17,137
Consisting of:		
- Interest charge	3,557	3,704
- Repayment of finance lease liability	4,549	4,601
- Service element and other charges to operating expenditure	6,372	6,111
- Revenue lifecycle maintenance	1,103	841
- Contingent rent	2,196	1,880
Total amount paid to service concession operator	17,777	17,1

25. Financial instruments

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 its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those 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 the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out 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 borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority / NHS Improvement. The borrowings are for 1 – 15 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The PFI contract, which runs for a further 24 years, includes an implicit interest rate of 3.31%. The Trust therefore has low exposure to interest rate fluctuations. The total finance charges for the PFI contract includes contingent rent, which results from cumulative indexation of the finance lease payments by RPI inflation. The impact of inflation is expected to be mitigated by increasing cash generated from activities.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. Repayment of DHSC capital loans, detailed in note 20, is funded from the depreciation of the assets funded by the loans. The PFI borrowing described in note 24 is repayable monthly over the 31 year term. This is funded from a combination of depreciation and operating income. The Trust put in place a Revolving Working Capital facility of £20.652m for which no repayments need be made before 2021 unless the Trust has sufficient cash to do so. In addition the Trust has taken out £40.8m of interim revenue support loans for which no repayment is required for 2 years unless sufficient cash is available. The Trust is not expected to need further Department of Health borrowing in 2019/20. However NHSI has indicated that further revenue support will be made available to Trusts in deficit if required. Assuming continuing support, the Trust does not face significant liquidity risk.

26. Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Total book value
	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9	
Trade and other receivables excluding non financial assets	22,585
Cash and cash equivalents at bank and in hand	27,609
Total at 31 March 2019	**50,194**

	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**
Trade and other receivables excluding non financial assets	23,332
Cash and cash equivalents at bank and in hand	17,603
Total at 31 March 2018	**40,935**

26.1 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Total book value
	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Loans from the Department of Health and Social Care	69,652
Obligations under finance leases	1,754
Obligations under PFI, LIFT and other service concession contracts	107,027
Trade and other payables excluding non financial liabilities	32,897
Total at 31 March 2019	**211,330**

	Total book value
Carrying values of financial liabilities as at 31 March 2018 under IAS 39	**£000**
Loans from the Department of Health and Social Care	58,067
Obligations under finance leases	2,410
Obligations under PFI, LIFT and other service concession contracts	111,576
Trade and other payables excluding non financial liabilities	27,880
Total at 31 March 2018	**199,933**

26.2 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	39,761	34,436
In more than one year but not more than two years	6,403	6,719
In more than two years but not more than five years	79,455	67,107
In more than five years	85,711	91,671
Total	**211,330**	**199,933**

27. Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	3	1
Fruitless payments	2	29	1	4
Bad debts and claims abandoned	28	96	23	123
Stores losses and damage to property	6	10	8	30
Total losses	**36**	**135**	**35**	**158**
Special payments				
Compensation under court order or legally binding arbitration award	2	1	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	15	76	23	28
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**17**	**77**	**23**	**28**
Total losses and special payments	**53**	**212**	**58**	**186**
Compensation payments received		-		-

28.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £210k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,443k.

28.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

29. Related party transactions

During the year none of the Department of Health ministers, Trust Board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with North Middlesex University Hospital NHS Trust.

The Department of Health is regarded as a related party. During the year North Middlesex University Hospital NHS 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. The Trust has listed below, in order of significance, organisations which had transactions in excess of £1m with the Trust during 2018/19.

- Enfield CCG
- Haringey CCG
- NHS England
- Health Education England
- East and North Hertfordshire CCG
- Waltham Forest CCG
- Barnet CCG
- Department of Health
- City and Hackney CCG
- West Essex CCG
- Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- The Whittington Health NHS Trust
- NHS Resolution
- NHS Blood and Transplant

The Trust has significant balances with the following Government departments:

- HMRC
- NHS Pension Scheme
- London Borough of Enfield

30. Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Nu	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	36,991	188,527	38,914	177,108
Total non-NHS trade invoices paid within target	27,532	159,585	25,213	136,761
Percentage of non-NHS trade invoices paid within target	74.4%	84.6%	64.8%	77.2%
NHS Payables				
Total NHS trade invoices paid in the year	1,457	26,755	1,522	26,406
Total NHS trade invoices paid within target	590	23,049	504	18,750
Percentage of NHS trade invoices paid within target	40.5%	86.1%	33.1%	71.0%

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.

31. External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19	2017/18
	£000	£000
Cash flow financing	1,929	18,516
Finance leases taken out in year	0	0
External financing requirement	**1,929**	**18,516**
External financing limit (EFL)	20,211	26,224
Under / (over) spend against EFL	**18,282**	**7,708**

32. Capital resource limit

	2018/19	2017/18
	£000	£000
Gross capital expenditure	12,766	5,384
Less: Disposals	(76)	(28)
Less: Donated and granted capital additions	(104)	(7)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**12,586**	**5,349**
Capital Resource Limit	12,616	5,424
Under / (over) spend against CRL	**30**	**75**

33. Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£								
Breakeven duty in-year financial performance		6,044	3	669	1,9	10,662	415	(8,284)	(10,464)	(27,956)	(3,184)
Breakeven duty cumulative position	(4,897)	1,147	4			17,554	17,969	9,685	(779)	(28,735)	(31,919)
Operating income		168,126	1							277,778	
Cumulative breakeven position as a percentage of operating income		0.7%	2.4%	2.7%	3.7%	8.1%	7.4%	3.9%	(0.3%)	(10.3%)	(10.0%)

34. Events after the end of the reporting period

There are no material post balance sheet events that require disclosure.

Independent auditor's report to the Directors of North Middlesex University Hospital NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of North Middlesex University Hospital NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates the Trust incurred a deficit of £3.2 million in 2018/19. The Trust's financial plan for 2019/20 is to break-even, but this assumes receipt of £14.2m of funding which is payable to the Trust on achieving its financial plan and so is contingent on future events. It is therefore anticipated that it may be some time before the Trust can achieve financial balance on a sustainable basis. The Board has prepared its financial plans and cash flow forecasts on the assumption that support funding will continue to be received through the Department of Health and Social Care (DHSC) and NHS Improvement (NHSI) if required. On the basis that the Trust achieves its 2019/20 financial plan, it does not anticipate that any further borrowing will be required in the financial year. DHSC and NHSI have not, as at the date of our report, confirmed that support funding will be provided if it is required by the Trust.

These events or conditions, along with the other matters as set forth in note 1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information 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, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; 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; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 23 May 2019 we referred a matter to the Secretary of State:

- under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2019
- under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the Trust setting a deficit budget for the year ending 31 March 2020 and the resultant ongoing breach of the Trust's breakeven duty for the three-year period ending 31 March 2020.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for 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 dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - 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 to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) 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 and to report where we have not been able to satisfy ourselves that it has done so. 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 have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of North Middlesex University Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the 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 Trust's Directors 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 Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Grady

Paul Grady
Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor
London

23 May 2019