The Princess Alexandra Hospital NHS
NHS Trust

Annual Report and Accounts 2017/18

Your future | Our hospital

Contents

The Performance Report 2017/18

Overview

The overview section provides a summary of our hospital, how we have performed over the year and the challenges we have faced.

Statement from the Chairman and the Chief Executive

Princess Alexandra Hospital NHS Trust had a difficult, frenetic and yet very good year in 2017/18.

The highlight of the year was the recognition from the Care Quality Commission (CQC) that the quality of our services had improved to the level that they recommended we exit quality special measures, a recommendation accepted by NHS Improvement. The detailed scorecard can be seen on page 22. It was a fantastic achievement to do this in just 17 months and on our first formal re-inspection, highlighting the hard work and commitment of all of our people to improving the care for all of our patients.

We also launched our 5 year hospital strategy, *Your Future, Our Hospital* in the autumn, underpinned by our 5 strategic objectives and aligned to our 5 Ps of Our Patients, Our People, Our Performance, Our Places and Our Pounds. Local, departmental and specialty specific 5P plans are in development to support our drive to 'good' and 'outstanding' over the next 5 years.

2017/18 was a year of development for our people. Our People are without doubt our greatest asset and our new people strategy underpins the development of and creation of new exciting roles and development opportunities across the whole organisation over the next few years. Despite continuing to run with high vacancy levels for registered nurses, our recruitment continued to improve over the course of the year and we hope and expect that this will continue to improve now that we have exited quality special measures. We also had an exciting year for staff engagement events including a 3 day 'Event in a Tent' on the site, supporting our people with health and wellbeing activities, preparation for the CQC visit and annual awards for our amazing people. 2018/19 promises to be a very exciting time to work at PAH as we build on all our people successes over this year.

2017/18 saw us submit a Strategic Outline Case for the development of a new hospital for Harlow and West Essex. We are continuing to work closely with our health, care and local authority colleagues to develop an Outline Business Case for this, which we expect to be complete during 2018/19 financial year. This is linked in the estates and capital priorities for the Hertfordshire and West Essex Sustainability and Transformation Programme (STP), where we continue to work closely with colleagues to deliver high quality, timely and cost effective care to the whole of Hertfordshire and West Essex. The STP has given a clear clinically led focus on improving standards, financial stability and adapting services to a growing and changing community and we will continue to play an important role in this over future months and years.

Whilst we plan for a new hospital in the future, we need to continue to invest in the current infrastructure and estate to support our people in the provision of high quality care for our patients. In 2017/18, we invested £7.5m of capital monies in our highest risk clinical areas, including:

- New paediatric ED department
- Reshaped, resized and refurbished adult ED department
- Creation of medical and surgical assessment facilities
- Creation of a new ultra clean ward for elective orthopaedic surgery
- Improved outpatient facilities and waiting room facilities
- Addition of a second maternity theatre

We also took the opportunity to refurbish and refresh the main corridors in the hospital as a result of having to undertake some electrical infrastructure work in the ceiling and we replaced the original spiral staircase in the centre of the hospital, with a modern, wider and safer staircase that also brings much needed light in to the lower ground floor. Finally we worked closely with Compass Group to help transform the front of the hospital and the facilities available for our people, patients and visitors. With a £1.2m investment from Compass Group, we now have a fantastic new coffee shop and grocery store at the front of the hospital, and we took the opportunity to work with them to invest the last of our capital monies for the year in a new front door, transforming the organisation as you walk in.

The Trust generally performed well in 2017/18 against the national and local quality and operational performance indicators / access targets over the year. More detail on all of these can be found from page 12 onwards.

The exceptions to our very strong performance are our mortality rate and our performance against the ED four hour waiting time standard. For the latter, we finished the year with a full year performance of 71.05% against the target of 95%. Internal capacity pressures and system wide pressures meant that we were not able to maintain performance consistently during the year. The factors influencing our performance have, in the main, been bed pressures resulting in the lack of capacity impacting on the ability to maintain capacity and flow in the Emergency Department. There have also been fluctuations in major and ambulance attendances, causing challenges with maintaining flow consistently through the hospital. We have worked hard through the year to enhance our physical capacity, improve our processes and management of patients through the hospital, and work with health and care colleagues through our Urgent Care Local Delivery Board to ensure improved and more timely discharge out of hospital. Performance against the 4-hour standard is improving and we expect to see this improve further during 2018/19.

The Trust has experienced a challenging year with its Income and Expenditure (I&E) position. Excluding Sustainability and Transformation Funding (STF) we reported a financial deficit of £31.6m in 2017/18 against a gross control target of £29.1m. These results compare to a £36.7m deficit in 2016/17 therefore we reduced our deficit by £5.1m. Despite this achievement during the winter months elective surgical activity was reduced to support the flow and protect the bed capacity for urgent non-elective admissions. This adversely impacted the Trust's finances by £3.7m. Without this we would have achieved our gross control target and secured the majority of our STF funding entitlement of £7.5m. Our final STF allocation in 2017/18 was £3.2m (compared with £10m in 2016/17) and therefore the adjusted retained deficit in 2017/18 (including £3.2m STF) was £28.4m.

Looking ahead quickly to 2018/19, we have an exciting programme of capital investment to continue to improve the quality of facilities from which we provide care to our patients and an equally exciting Quality improvement programme to support ongoing transformation of the way in which we provide that care. We remain committed to developing and changing the culture to increase the levels of openness and challenge, both of which are fundamental to supporting ongoing service reconfiguration and to getting the organisation to a 'good' CQC rating whilst ensuring good value for money for the taxpayer.

We would like to take this opportunity to thank all the patients, relatives, carers and stakeholders who have contributed to our quality improvement activities during the year. On behalf of the Board, we would also like to thank all of our people, including our volunteers and patient panel members, for their ongoing provision of compassionate and professional care to those needing the Trust's services and who continue to strive for improvements in the care we deliver. 2018/19 promises to be a very exciting year for our hospital, our people and the quality of care that we provide for our patients.

Lance McCarthy
Chief Executive

Alan Burns
Trust Chairman

The Purpose and Activities of the Organisation

The Princess Alexandra Hospital NHS Trust (PAH) is a 497 bedded hospital with a full range of general acute services, including; a 24/7 Accident and Emergency Department (A&E), an Intensive Care Unit (ICU), a Maternity Unit (MU) and a Level II Neonatal Intensive Care Unit (NICU). PAH currently operates over forty different services to meet the needs of its patients.

The Trust serves a core population of around 350,000 and is the natural hospital of choice for people living in West Essex and East Hertfordshire. In addition to the communities of Harlow and Epping, the Trust serves the populations of Bishop's Stortford and Saffron Walden in the North, Loughton and Waltham Abbey in the South, Great Dunmow in the East, and Hoddesdon and Broxbourne in the West. Its extended catchment (radius of 11 to 13 miles) incorporates a population of up to 500,000.

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

The Trust operates over forty different services to meet the needs of its patients (see Service Portfolio below):

Service Portfolio

Directory of our services			
Ambulatory Care	Diabetic Medicine	Gynaecology	Surgical assessment unit
Audiology	Dietetics	High Dependency Unit	Pathology
Breast Screening	Early Pregnancy Unit	Intensive Care unit	Patient Appliances
Breast Surgery	Emergency Department	Interventional Radiology	Physiotherapy & Occupational Therapy
Cardiology	Endoscopy Services	Maternity	Pre Op Assessments
Chemotherapy	Endocrinology	Maxilla- Facial surgery	Radiology
Clinical Decision Unit	ENT	Medical Oncology	Respiratory Medicine
	Frailty service	Neonatal Critical Care	Rheumatology
Clinical Haematology	Gastroenterology	Neurology	Special Care Baby Unit
Clinical Oncology	General Medicine	Obstetrics	Specialist Palliative Care
Colposcopy and hysteroscopy services	General Surgery	Ophthalmology	Speech & Language Therapy
Community	Genito-Urinary	Oral Surgery	Transfusion services

Midwifery	Medicine		
Colorectal services	Geriatric Medicine	Paediatrics	Trauma and Orthopaedics
Day Surgery	Vascular services	Paediatric Diabetic Medicine	Urology
Dermatology	Gynaecology Ambulatory Service	Paediatric Emergency Department	

Strategic Objectives

The Trust's vision is to deliver outstanding healthcare to the local community and the Trust's mission is to put quality first in everything that is done.

Underpinning the Trust's ambition to achieve outstanding healthcare is the Five Ps. The Trust Board set 5 strategic objectives for the 2017/18 year focussed on delivering the Five Ps.

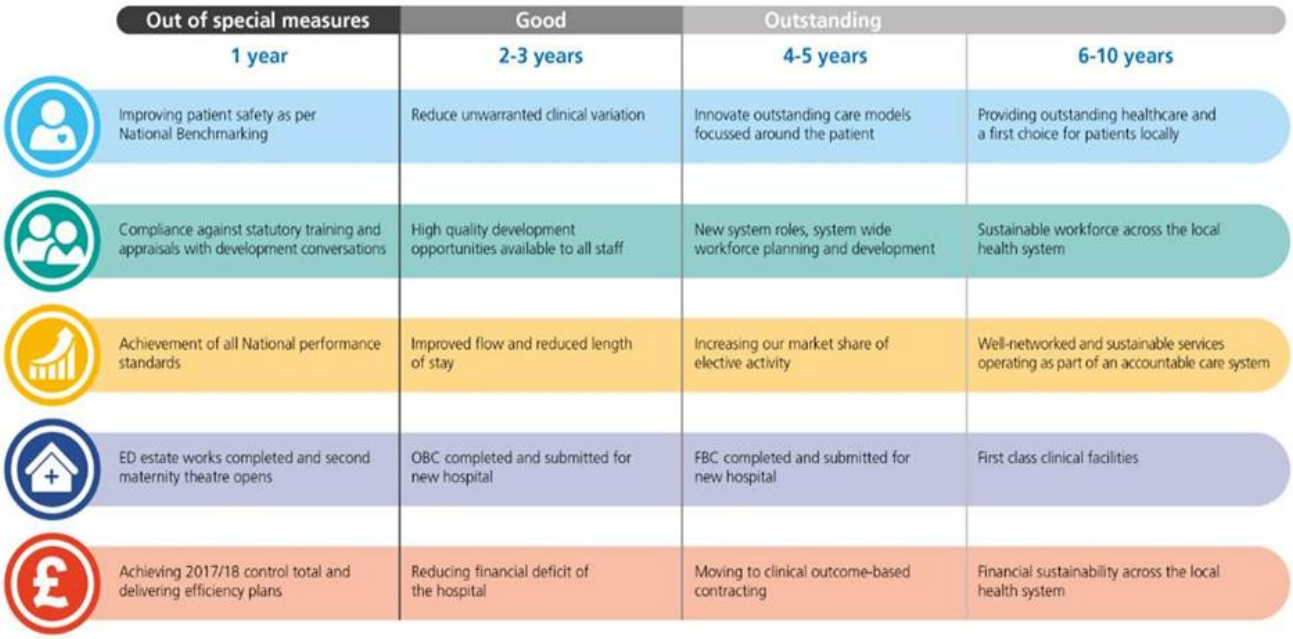
Five Ps	Trust Objectives
	**Our Patients** Continue to improve the quality of care we provide **our patients**, improving our CQC rating.
	**Our People** Support **our people** to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results.
	**Our Places** Maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC for a new build, aligned with the development of our local Integrated Care Alliance.
	**Our Performance** Meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators.
	**Our Pounds** Manage **our pounds** effectively to achieve our agreed financial control total for 2018/19.

The Trust is developing a strategy for the journey to 'outstanding' and delivery of services from a modern, fit for purpose building. The strategy will grow and reflect the outputs from the five year plan to achieve your future, our hospital which was launched in September 2017. To ensure that the focus is not on one area of performance, or multiple things in

isolation, your future, our hospital is categorised into the five P's; patients, people, performance, places and pounds.

During 2017/18, plans within these five areas were developed, built up from individual staff pledges, to specialty and team plans, to healthcare group (divisional) and departmental plans that are informing the Trust strategy as a whole. This inclusive board to ward approach has increased ownership, engagement and accountability in the development of our holistic and sustainable plan for the future.

The roadmap of your future, our hospital and milestones along the 5 year journey to outstanding and beyond are captured below.



The Trust has a clear set of values that are lived by the staff to provide the best possible care for patients and working environment for the staff.

Respectful	We treat others as we would want to be treated ourselves
Caring	We always put patients first
Responsible	We always say what we are going to do
Committed	We strive to be the best

A new hospital is essential for Harlow and a strategic outline case was submitted to the Trust's regulator, NHS Improvement, in July 2017 which explained the need for this.

Over the remainder of 2017/18, work started on an Outline Business Case, which considers in detail the potential location, size and cost of a new hospital and it is expected that this work will be completed by late 2018.

The Trust is part of the Hertfordshire and West Essex STP and during 2017/18 the Trust continued to work closely with its Commissioners and partners to progress key pieces of strategic work intended to help resolve the Trust's sustainability challenges. A number of reviews conducted over the last few years concluded that the Trust would struggle to solve

its financial, demand and service needs on its own and a system wide approach was required.

As set out in the Sustainability Transformation Plan (STP) called “A Healthier Future: Improving health and care in Herts & West Essex”, the focus of our collaborative work is on three key areas:

- Prevention - supporting communities to make the right lifestyle choices and helping people with long term conditions to live as well as possible for as long as possible
- Integrated Primary and Community Care - supporting people to maintain their independence by locating frequently used services close to where people live
- Acute Hospital Service - partnerships between the STP hospitals in order to support improved patient care, clinical and financial sustainability and delivery of services more efficiently

Within the local West Essex system work has continued on developing an Integrated Care Partnership (ICP) bringing together key elements of primary, community, secondary, social and mental health services.

The ICP has identified a number of priorities which will prove effective in managing demand for the hospital but also in developing a more integrated care model. Early transformational changes are being focused on improving respiratory care, Musculoskeletal (MSK) and Urgent Care Services across the system. In addition, we continue to be actively involved in:

- Developing multi-professional neighbourhood teams and build Population Health Management infrastructure
- Managing demand and improve patient access to services moving care closer to home where possible
- Improving service navigation and care transition across settings
- Reducing variation in care delivery and optimise the care management of complex patients with long term conditions
- Strengthening the focus on community activation, well-being and prevention – supporting people to lead healthier lives.

In order to support these ambitious plans there is a need to address key infrastructure requirements. The hospital estate within the West Essex and East Hertfordshire health system has been a source of significant concern for a number of years. This is due to a combination of the condition and capacity of the existing estate, the needs of the local population over the next 20 years, and the plans of health leaders to transform the model of care provided to patients under an ICP. The STP is actively supporting the Trust to find a long term sustainable solution to our estates challenge and supported the submission of our Strategic Outline Case to regulators in 2017/18.

Key risks

The Trust has a Board Assurance Framework (BAF) which provides a mechanism for the Board to monitor risks to delivery of the Trust’s strategic objectives. The 4 highest scoring risks on the BAF throughout 2017/18 were Workforce Capacity, Finance, our Estate and

delivery of the Emergency Department standard. The risks are reviewed monthly and progress is monitored by the relevant Board Committees and Trust Board every other month. A summary of these risks is reflected below:

5P	Highest scoring risks on Board Assurance Framework 2017/18
	**Workforce Capacity:** Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.
	**Estates & Infrastructure:** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.
	**4 hour Emergency Department Constitutional Standard:** Failure to achieve ED standard
	**Finance:** Concerns around failure to meet financial plan including cash shortfall.

Going Concern

Trust management is required to assess (under International Accounting Standard 1 – Presentation of Financial Statements), that as part of the Accounts preparation process, the Trust's ability to continue as a going concern. The HM Treasury Financial Reporting Manual directs that in the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without transfer to another entity.

In approving the Trust's annual Accounts the Board of Directors has carefully considered the principle of 'going concern' and recognises 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, interim financial support has continued to be received as planned in the early part of 2018/19 and the Board of Directors concludes the Trust has a reasonable expectation that the Trust will continue to have access to adequate cash financing to meet its liabilities and continue to provide the planned range of clinical services in the foreseeable future. On that basis and for the reasons outlined below the Board of Directors considers it is appropriate to prepare the 2017/18 Accounts on a going concern basis and the financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern:-

- The Board considers the Trust operates a significant portfolio of clinical services. The Trust has signed a 2018/19 contract with main Commissioners. This contract supports continued provision of services with no plans for disinvestment.

- The Trust has submitted a deficit plan to NHS Improvement (NHSI) totalling £28.5m in 2018/19. This plan is Control Total compliant and is supported by the request to receive interim revenue support loans to the value of the forecast deficit. Subject to delivery of performance the Trust is eligible to receive £8m of Sustainability and Transformation Funding (STF) in 2018/19. If this is secured the planned deficit would be reduced to £20.4m.

- The Trust has included an estimate of £12.4m of capital requirements in its 2018/19 operating plan. The Trust has submitted a Strategic Outline Business Case (SOC) which is considering a number of site redevelopment options. The Trust is awaiting approval to progress to an Outline Business Case (OBC).

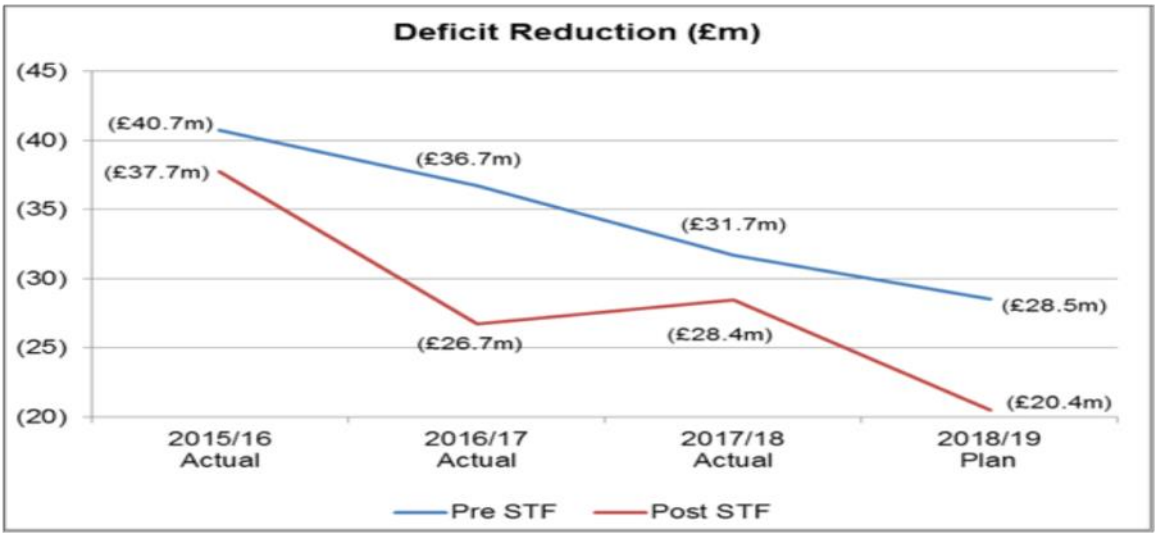
Performance Analysis

Financial performance

Excluding Sustainability and Transformation Funding (STF) the Trust reported a financial deficit of £31.6m in 2017/18 compared to £36.7m in 2016/17 therefore reducing its deficit by £5m.

Deficit Reduction - Pre STF

	Financial Year				Movement between 2016/17 & 2017/18 £m
	2015/16 Actuals £m	2016/17 Actuals £m	2017/18 Actuals £m	2018/19 Plan £m	
Income	193.1	199.9	210.0	219.1	10.1
Expenditure	-233.9	-236.6	-241.7	-247.6	-5.1
Deficit - Pre STF	**-40.7**	**-36.7**	**-31.7**	**-28.5**	**5.0**
Deficit Reduction - Pre STF	**0.0**	**4.0**	**5.0**	**3.1**	



The National decision (December 2018) to suspend inpatient elective activity adversely impacted the Trust's financial results by £3.7m. This subsequently impacted the Trusts ability to qualify for full STF funding in 2017/18 with the Trust recovering £3.2m of STF (£10m 2016/17) compared to total eligibility of £7.5m.

The Adjusted Retained Deficit in 2017/18 (including £3.2m STF) is £28.4m.

The Trusts External Auditors have issued an unqualified opinion on its financial statements in that the Accounts present a true and fair view of the Trust's financial position for the 2017/18 financial year.

Key drivers of the reduction to the deficit included:

- Over-delivery against the £13.6m agency target set by NHSI with an outturn of £13m representing a £2m reduction in agency spend between 2016/17 and 2017/18. This reduction included a £1m medical locum cost reduction and over-achieving the £0.5m target.
- Over-delivery of the Trust's annual CIP target of £8m (£9.2m actuals).
- Continued costs containment and reduction exercises including benefits from the adoption of Modern Equivalent Asset valuation exercise.
- Successful resolution to contractual matters and growth in the income base from Commissioner contracts.

During the year the Trust made significant capital investments in infrastructure, estate, ICT and medical equipment. The Trust's revised Capital plan was to spend £11.4m and the outturn was a spend of £11.1m.

During the year the Trust accessed loans totalling £25.7m, being lower than its Control Target of £29.1m

NHS Trust financial duties

The audited accounts for 2017/18 confirm:

- The Trust's 2017/18 adjusted retained deficit was £28.4m.
- The Trust underspent against its Capital Resource Limit of £11.6m by £0.5m with an outturn of £11.1m. The Trust intends to carry the underspend of £0.3m into 2018/19.
- The Trust underspent against its 2017/19 external financial limit by £0.3m.
- The Trust received net revenue support loans of £25.7m to meet its operating costs.

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

Better Payment Practice Code

The code sets out the following obligations for NHS organisations in respect of the payments it makes to its suppliers - principally:

- Payment terms are to be agreed with suppliers before a contract commences

- Payment terms are not to be varied without prior agreement with a supplier
- By default, bills are to be settled within 30 days unless other terms have been agreed

Performance in 2017/18 against the Better Payment Practice Code (BPPC) is below the 95% target for all NHS organisations.

The Trust has sufficient cash resources to settle invoices and is implementing efficiencies in the procurement to pay process, which together with continued revenue support loans from NHS Improvement in 2018/19 should improve performance against the BPPC target in the coming year. The Trust will also continue to work closely with its lead commissioner to manage the cash position.

Performance is summarised as follows:

	2017/18 Number	2017/18 £000's	2016/17 Number	2016/17 £000's
Non-NHS Payables				
Total Trade Invoices Paid in the Year	51,727	84,375	48,282	85,479
Total Trade Invoices Paid Within Target	20,881	41,425	16,043	38,525
Percentage of Trade Invoices Paid Within Target	40.4%	49.1%	33.2%	45.1%

	2017/18 Number	2017/18 £000's	2016/17 Number	2016/17 £000's
NHS Payables				
Total Trade Invoices Paid in the Year	2,267	20,740	2,130	16,654
Total Trade Invoices Paid Within Target	1,086	10,594	486	5,710
Percentage of Trade Invoices Paid Within Target	47.9%	51.1%	22.8%	34.3%

Financial plan 2018/2019

For 2018/19 we will continue with the deficit reduction programme with plans to deliver a gross deficit position to £28.5m. This is consistent with the 2018/19 Control Target set by NHSI. The Trust's STF eligibility, subject to delivery of performance criteria, is £8.m reducing its net deficit target to £20.5m. The plan has aligned income / activity expectations with Commissioner contracts and expenditure budgets being set to deliver the baseline activity. The key assumptions which underpin the plan are:-

- Delivery of its activity plans and therefore recovery and capture of income.
- Meeting operating performance standards and targets and thereby securing STF
- Managing local and national cost pressures.
- Further reducing agency staff expenditure to at least revised targets levels of £10.3m.
- Delivery of CIP (£10m) and transformation plans and associated efficiency improvements. These programmes being developed by reference to Carter, Model Hospital, GIRFT and other STP benchmarking opportunities.

We have submitted capital requirements totalling £9.6m, which includes the development of Fracture Clinic services as well as ongoing investment in the Trust's overall estate, and on medical equipment and Information Technology assets. In additional we have submitted a

further capital funding request to progress approval of an Outline Business Case (OBC) to consider refurbishment or new build opportunities.

Operational Performance

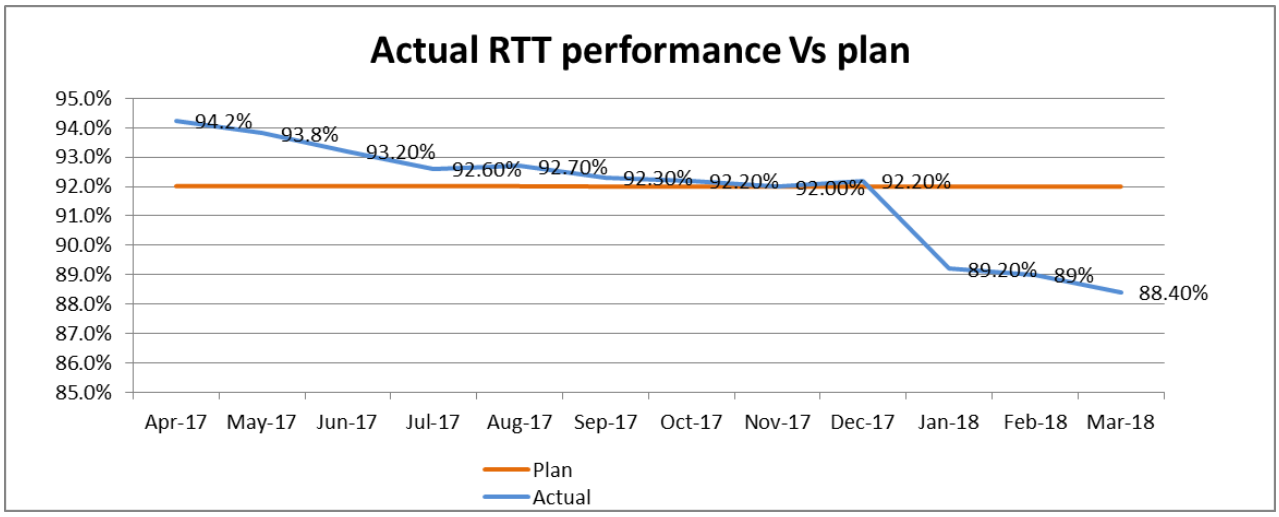
The Trust's operational performance against national and local standards is monitored and reviewed at:

- Regular performance review meetings between members of the executive team and each health care group;
- The Trust's Executive Management Board;
- The Performance and Finance Committee and Trust Board meetings.

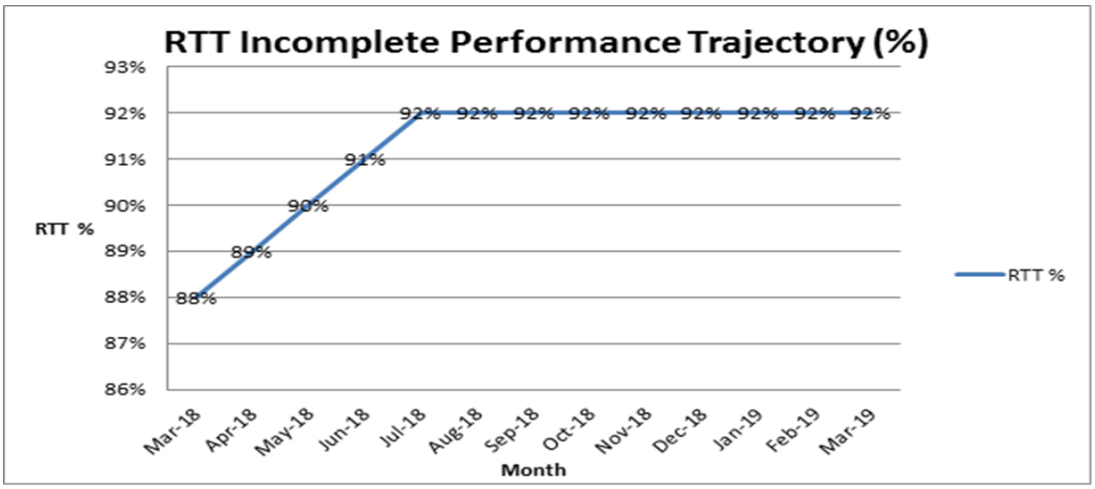
An Integrated Performance Report is presented to the Performance and Finance Committee and Trust Board meetings. Externally, the Trust is held to account for its operational performance by NHS Improvement.

Targets and national standards

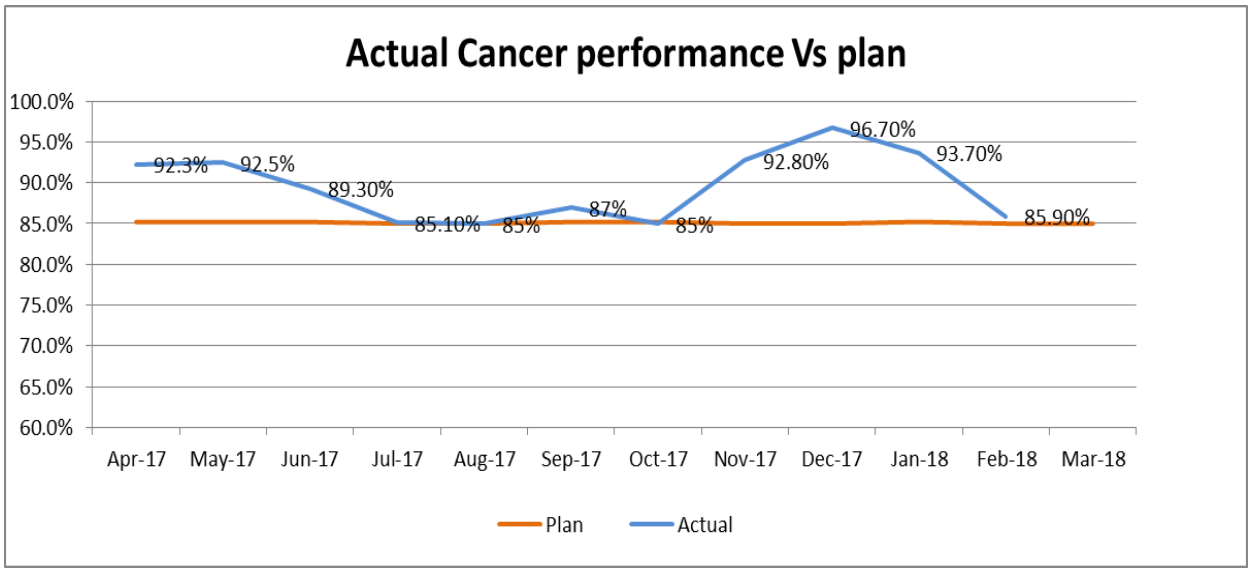
The significant progress made in 2016/17 has been maintained in 2017/18 ensuring the delivery of the Referral to Treatment Standards. The RTT incomplete standard has been consistently delivered throughout the year, with a drop in performance in January 2018 due to the deferral of elective activity as a result of a national directive from the National Emergency Pressures Panel.



A recovery plan commenced on the 26th February 2018 to ensure recovery of the National Standard from July 2018.



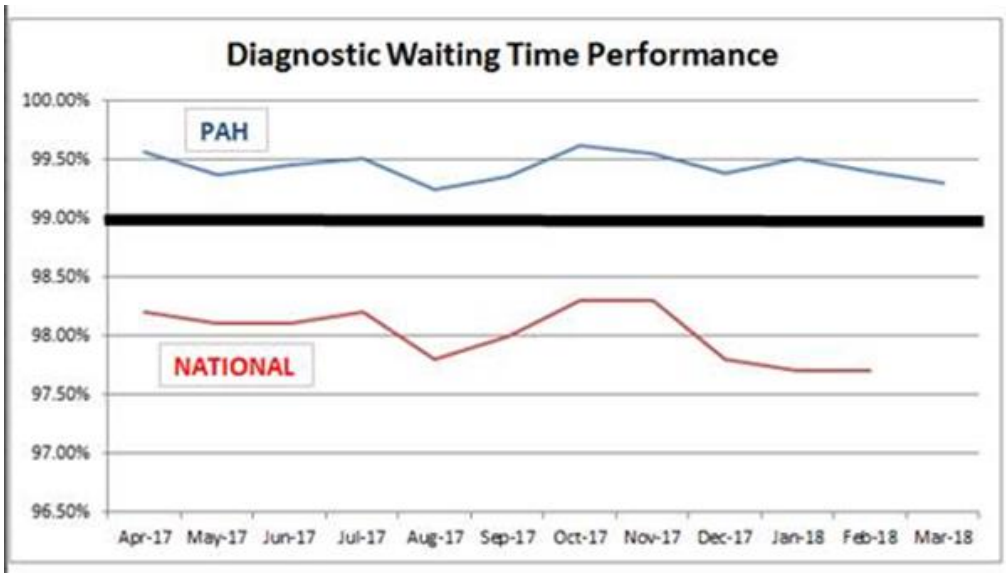
Cancer standards have been consistently delivered throughout 2017/18 since June 2016, with the Trust consistently performing in the top 10 organisations nationally.



The Trust is planning to maintain performance against all national planned care standards in 2018/19.

Diagnostic Performance

The Trust has achieved the 99% Diagnostic Wait standard every month for the last 3 years, which means that over 99% of all our patients waiting for a diagnostic examination have this completed within 6 weeks of the referral being made. This has been achieved consistently despite a 5% growth in demand, year on year. A continuation of this performance is planned for 2018/19.



Urgent Care and ED performance

The Trust has continued to face significant challenges in the delivery of the national 4 hour standard for Emergency Care. The emphasis for 2018/19 is incremental improvement in the standard with sustained improvement in the use of assessment facilities to support emergency flow. We were successful in securing external capital monies to refurbish the Emergency Department, Paediatric Emergency Department and Urgent Care Centre. We were successful in realigning our assessment areas to support flow of emergency flow through the hospital.

A new national Emergency Care Data Set (ECDS) was implemented in December 2017 which enables the capture of more clinically relevant information that can be aggregated at a national level to support existing and new strategic priorities. Real-time A&E reporting was implemented in late January 2018 to support patient flow within the department and large screens have been deployed to ensure visibility in key areas.

The Trust and commissioners will collectively agree through the West Essex Local Delivery Board the extra capacity requirements to support the urgent care system and the process and timescales for reviewing and refreshing our escalation arrangements for managing unplanned changes in demand.

The Trust is taking the following actions to improve ED performance:

- Completing a comprehensive workforce review to ensure that our clinical workforce meets the emergency department activity with safe clinical staff to patient ratios 24/7 with the recruitment of appropriate staff numbers and skill mix to sustain performance.
- Reducing length of stay, with 35% of patients discharged from the wards by midday, and ED patients discharged appropriately (assessment, treatment and discharge criteria and patient pathways are currently being written).

Extensive programmes of work are in place to deliver a trajectory of continuing improvement on the A&E standard. The Trust has been working in close partnership with the Clinical Commissioning Groups (CCGs), and NHS Improvement to review and enhance overall A&E performance. The Trust ran a pilot of the Rapid Assessment and Treatment model (RAT) to support 'early senior review' of patients arriving by ambulance. The model proved to be

highly effective resulting in a significant improvement in ambulance turnaround and handover times.

A process is underway to co-locate all social work and community teams with the hospital discharge team in an effort to improve discharge systems and processes. The Trust is also working with health and social care teams to develop a model of care that will see patients requiring a further period of assessment being assessed at home rather than in hospital. The Trust runs a rolling recruitment programme for nurses and is actively recruiting for all grades of staff to join the current team within Emergency Department and our Emergency Assessment Unit (EAU).

Despite the continued level of pressure on our Emergency Department, we have continued to strive to deliver the best possible experience to patients who attend our hospital as an emergency. With the benefit of strong clinical leadership and thanks to our dedicated teams we are confident that the Trust can transform the delivery of urgent care and ensure sustainable, quality and safe care for all our patients.

Responding in an Emergency

Throughout 2017/18 the Resilience Team have continued to work to ensure that we are in a position to respond to, and recover from a range of emergencies. In the last year we have designed and delivered a range of new training opportunities, including dedicated Emergency Department training, and teaching on our Band 6 and 7 Nursing Development programmes, as well as supporting both operational and emergency responses.

Along with training we are continually working to update our plans, train our staff and to review the effectiveness of the arrangements we have in place through reviews of our response to real and simulated emergencies.

During the previous year largest resilience challenge seen by the Trust was the WannaCry Cyber Attack. Our response to which showed the immense dedication of our staff to ensuring patient safety and quality through the application of resilience and business continuity plans, and a rapid restoration of services.

As an organisation we recognise the importance of multi-agency working, and continue to actively engage in the work of the Local Health Resilience Partnership and the Essex Resilience Forum. As required nationally we undertook the NHS England Emergency Planning, Resilience and Response Core Standards for which we were able to provide full assurance to NHS England.

The coming year we see us continue to provide exciting training and development opportunities, along with undertaking a range of exercises, to enable our staff to have the skills and confidence to respond to the challenges faced by Acute Hospitals.

Clinical Performance

Infection Prevention and Control

The Trust has robust infection prevention and control (IP&C) measures in place that are effective in preventing and controlling healthcare associated infections (HCAIs) including outbreaks of infection. The prevention and control of infection is pivotal to the Trust's overall risk management strategy and fundamental in providing best clinical care. Safety of patients, relatives and visitors is a top priority for the Trust and we are fully committed to this.

This year, PAH has again maintained another year of excellent control of HCAIs and antimicrobial resistance. This is largely attributed to the continuing and sustained commitment by clinical and management staff to patient safety and IP&C and a 'Board to ward' approach. Measures to prevent the transmission of infections are embedded in every day clinical practice and play an essential part in providing a safe environment for our patients

The Trust remains in a favourable positon when compared against other Trusts nationally; we are in the top performing quarter for all four key alert organisms, two of which have set trajectories with financial penalties attached if not met; Meticillin Resistant *Staphylococcus aureus* bacteraemia (MRSA) and *Clostridium difficile* (C *difficile*). For Trust apportioned Meticillin sensitive *Staphylococcus aureus* bacteraemia (MSSA) control we are amongst the best in England.

Alert Organisms

MRSA Bacteraemia

There is a trajectory of zero tolerance of MRSA bacteraemia across the NHS. During 2017-18, there were no Trust-apportioned cases of MRSA in the Trust. There have, in fact, not been any cases of Trust-apportioned cases of MRSA at PAH since 2014 which is testament to the Trust's commitment to IP&C.

Clostridium difficile

The Trust has again had a challenging trajectory of just 10 cases for 2017-18 due to previous good performance. We have managed to achieve this, ending the year on nine Trust-apportioned cases for contractual purposes; this is due to five of the total 14 cases being successfully appealed against (however, there are still three more cases to be taken to the Appeals Panel; this therefore may reduce further).

We have achieved this with a combined effort from all staff through vigilance and commitment to infection control procedures, ward cleaning and antimicrobial stewardship throughout the year. This is despite the challenges of PAH being an old hospital and coming through a difficult winter with many antibiotics being needed to treat infections in our elderly patient population. It should also be noted that PAH had a lower trajectory than our neighbouring Trusts; this reflects our excellent rates in previous years, but means we face a tighter target than other hospitals that have had higher cases.
We also have a robust Root Cause Analysis (RCA) process in place which is significant in contributing to shared learning amongst staff

Meticillin Sensitive Staphylococcus aureus (MSSA)

The Trust remains in an excellent position as one of the top performing NHS organisations in the country in terms of low MSSA blood infections (bacteraemia). This year there have been just four Trust apportioned cases. Asepsis in relation to IV lines has contributed to these low figures.

Escherichia Coli (*E.coli*) and Gram Negative Blood Stream Infections (GNBSI)

In April 2017, a new national target to halve healthcare associated GNBSI by 2021 was introduced. For 2017/18, the focus has been on reducing healthcare associated *E. coli* BSIs because they represent 55% of all Gram-negative BSIs. CCGs are leading on achieving the

Quality Premium from April 2017 for two years, aiming to reduce all E. coli BSIs by 10% in Year one.

Numbers of Trust-apportioned *E.coli* cases are low and the Trust remains in a favourable position when compared with hospitals nationally. The majority of cases are admitted with the infection already present. During 2017/18 we had a total of 175 cases; of these, 155 were found to have an *E. coli* bacteraemia on admission and the remaining 20 cases were considered to have been hospital associated. In comparison with the previous year, our numbers are very similar.

Outbreaks and Incidents

Norovirus

Norovirus outbreaks occurred in the Trust between August 2017 and March 2018. Mostly these were isolated incidences; however in January- March 2018, there were several wards closed at the same time. The Trust has robust systems in place for the management of outbreaks with daily meetings for the duration, led by the IP&C Team and supported by the Chief Nurse or Deputy Chief Nurse.

Other Incidents

IP&C incidences occur sporadically; however, there are robust surveillance measures in place to ensure outbreak and incidents are managed in in a timely and appropriate way, and which minimises the risk of transmission to patients, visitors and staff. There is also excellent engagement from other specialist teams in the Trust when required.

Towards the end of 2016 and in early 2017, an increased number of infections were identified in patients that had undergone hip / knee joint replacements. These cases were fully investigated and measures implemented during 2017 in pre-operative (before), intra-operative (during) and post-operative (after) surgery.

Learning from Incidents

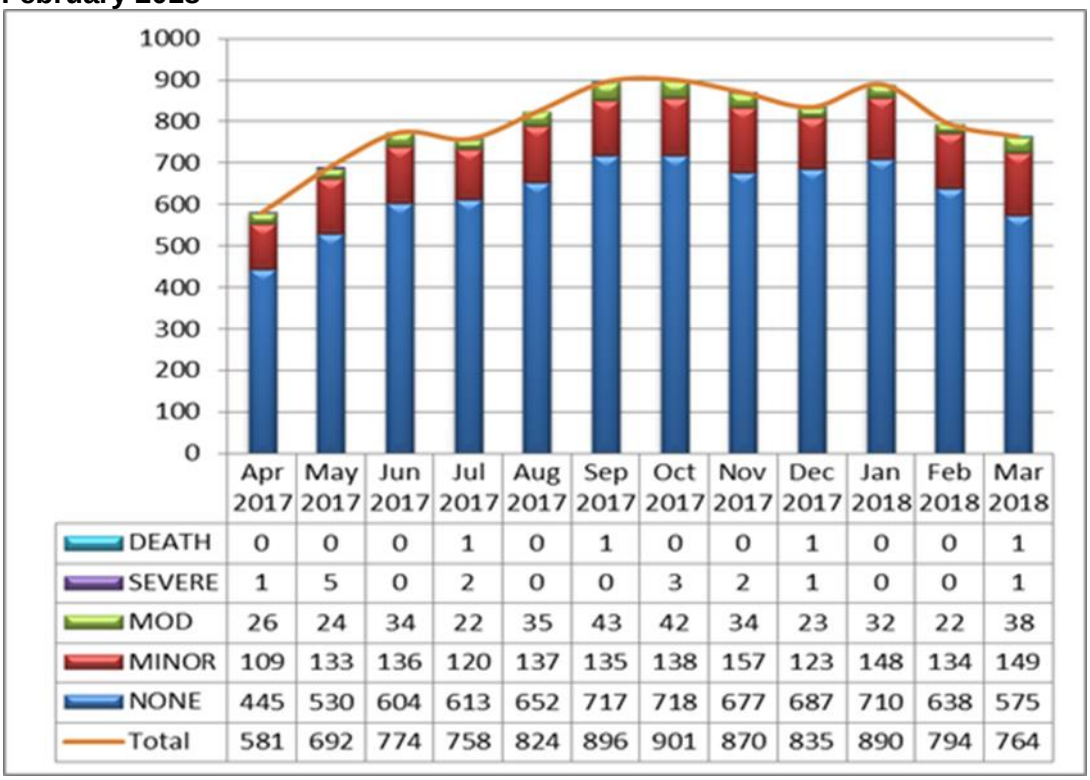
At The Princess Alexandra Hospital NHS Trust, safety is a priority and we continuously work to ensure that incidents are managed effectively and most importantly that we learn and share the improvements from them.

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

A total of 9580 incidents were reported on the Trust’s Datix incident management system, as having occurred in PAH. This a 3.1% increase when compared with 9283 over the same period last year. A high number of incidents raised is a positive step if it is coupled with low levels of patient harm.

The majority of incidents reported were low or no harm incidents (9186) representing 95.9% of the total incidents for this period with the remaining 394 (4.1%) being moderate and severe harm. Of this 375 (3.9%) were Moderate harm. All these incidents are reported to the National Reporting and Learning System (NRLS) now part of NHS England to enable learning and comparison with similar sized organisations to occur. We have increased feedback to staff after an incident occurs to consistently above **80%**

Graph showing severity of incidents reported (numbers) by severity 1st March 2017 to 28th February 2018



	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
DEATH	0	0	0	1	0	1	0	0	1	0	0	1
SEVERE	1	5	0	2	0	0	3	2	1	0	0	1
MOD	26	24	34	22	35	43	42	34	23	32	22	38
MINOR	109	133	136	120	137	135	138	157	123	148	134	149
NONE	445	530	604	613	652	717	718	677	687	710	638	575
Total	581	692	774	758	824	896	901	870	835	890	794	764

Themes of Serious Incidents

There have been 31 serious incidents (SIs) at the Trust in 2017/18. This excludes SIs that have been de-escalated by the CCG as there were no care or service delivery problems or they were found not to meet the SI threshold with the emergence of further information.
Although there is an increasing focus on safety across the organisation, it is important to note that national reporting requirements and SI categories changed in March 2015 and the changes were implemented locally in May 2015. The changes eliminated the use of a pre-determined list of incidents that must be reported. The SI framework encourages the discussion and review of incidents on a case by case basis and a discussion of the level or degree of harm caused.

The Trust ensures open and honest review and discussion of SIs takes place through the Serious Incident Group (SIG). The group is chaired by either the Chief Medical Officer or Chief Nurse and is scheduled every day from Monday to Friday to ensure that there is no delay. All potential serious incidents are presented and discussed to identify whether they meet the national SI framework requirements. The most frequently reported SIs during this reporting period are in the category 'Treatment delay meeting SI criteria'.

Never Events

There were no Never Events in 2017/18.

Sharing the Learning Events

The Trust's central Patient Safety and Quality Team worked with relevant experts to organise and facilitate two sharing the learning events during 2017/2018:

1. **10 October 2017**: **Focus on Consent & Duty of Candour:** Following the revision of the Trusts consent policy, it was decided to use the next STL event to launch the policy and

share learning & cases stories around consent with staff. The central PSQ team, working closely with our Panel solicitors, Kennedys and NHS Resolution, reminded staff of their duties around consent and also watched a patient story around Duty of Candour.

2. **12 January 2018: Focus on Research, Development & Innovation:** The last STL for the year was devoted to celebrating the learning and successes of Research, Development & Innovation at the Trust.

Being Open and Root Cause Analysis (RCA) Investigation Skills Training

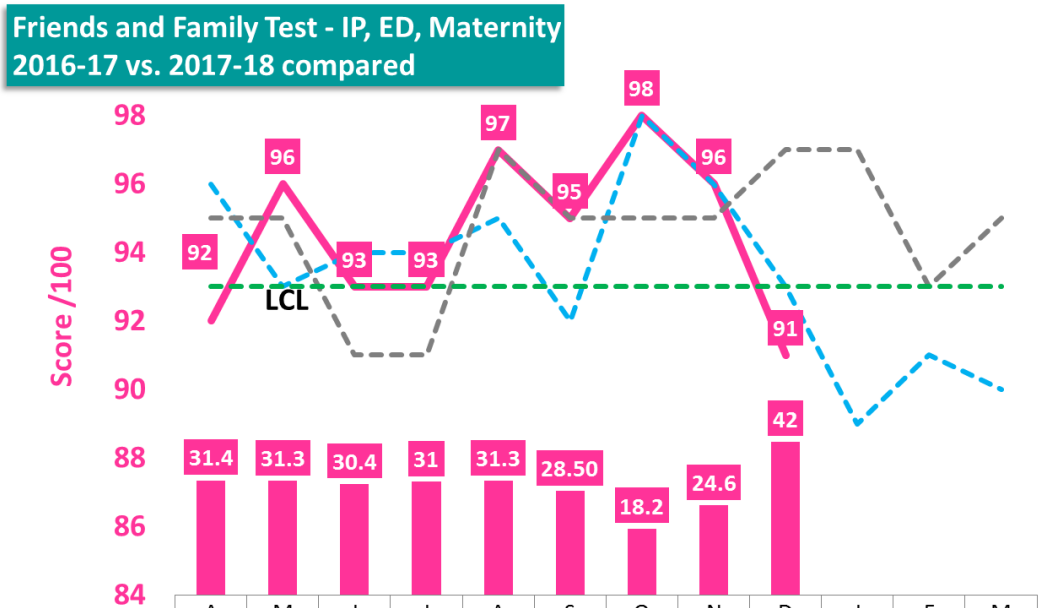
The Trust continues to invest in Root Cause Analysis (RCA) investigation training and ensure that staff are supported in Being Open/ Duty of Candour conversations with patients and families when things go wrong. In year the Trust held two training sessions on Being Open/ Duty of Candour and two sessions on RCA training and 35 staff were trained.

Friends and Family Test

The national average for a composite Friends and Family Test score is 93%. The Trust is just above the national average with a composite average score for the year to date of 94.75% consistent with previous CQC findings of the domain of caring being rated 'good.'

The evidence in the graph below shows that the Trust has been on a positive trajectory for FFT ratings for most of the year, with October being our joint best rated month for 3 years.

The significant change in scoring is found in December 2017 which was the result of 62 patients voting they would be unlikely or extremely unlikely to recommend the Emergency Department were a family member to need similar care or treatment. There is a clear link here with delays in Emergency Department and being seen. Despite evidence available to the public of an Emergency Department under significant pressure – with the longest average waits in the country and the place where patients are least likely to be seen, treated and discharged or admitted within 4 hours, public comment and FFT ratings have remained high. Triangulating this data with evidence from wider experience of care metrics the Patient Advice and Liaison Service have seen an overall increase in volume of activity in PALS over the last 3 years of 28.4% from 4726 to 6600 (2015 to 2017).



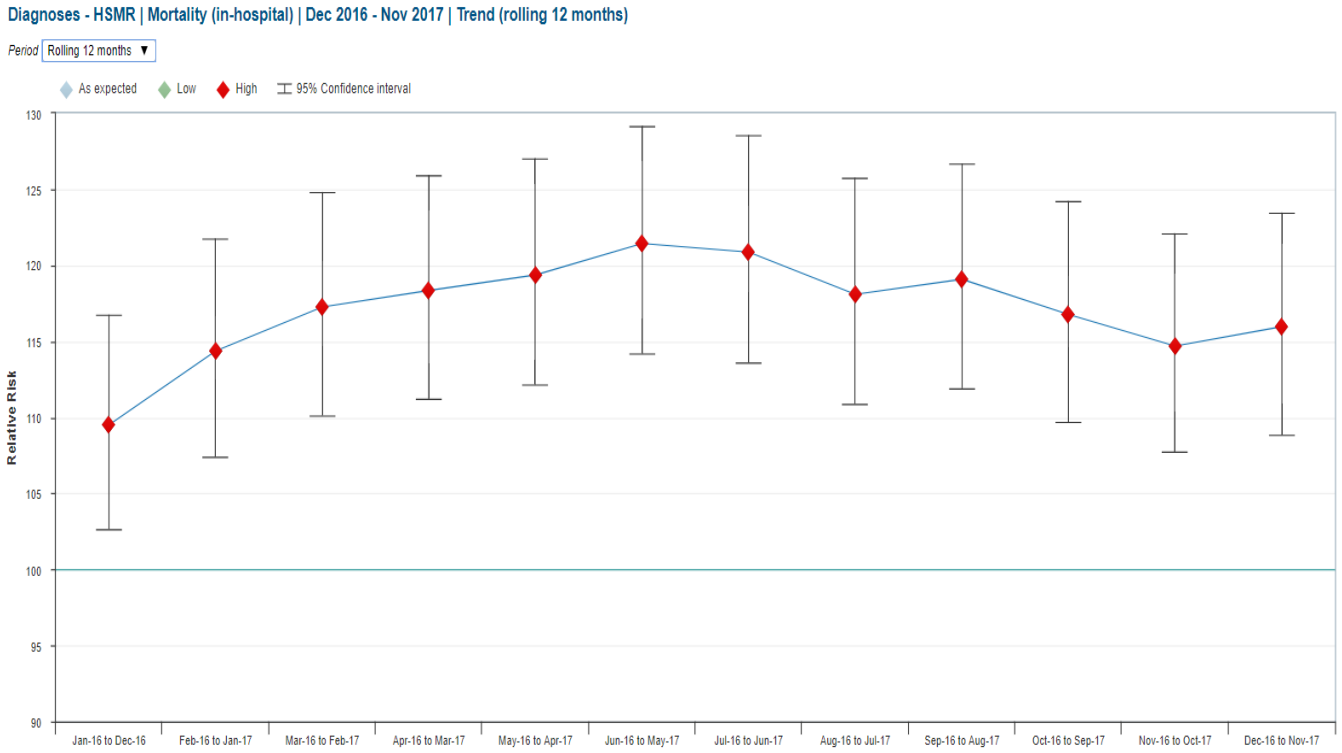
	A	M	J	J	A	S	O	N	D	J	F	M
Sample	31.4	31.3	30.4	31	31.3	28.50	18.2	24.6	42			
2017-18	92	96	93	93	97	95	98	96	91			
2016-17	96	93	94	94	95	92	98	96	93	89	91	90
2015-16	95	95	91	91	97	95	95	95	97	97	93	95
Target	93	93	93	93	93	93	93	93	93	93	93	93

Mortality

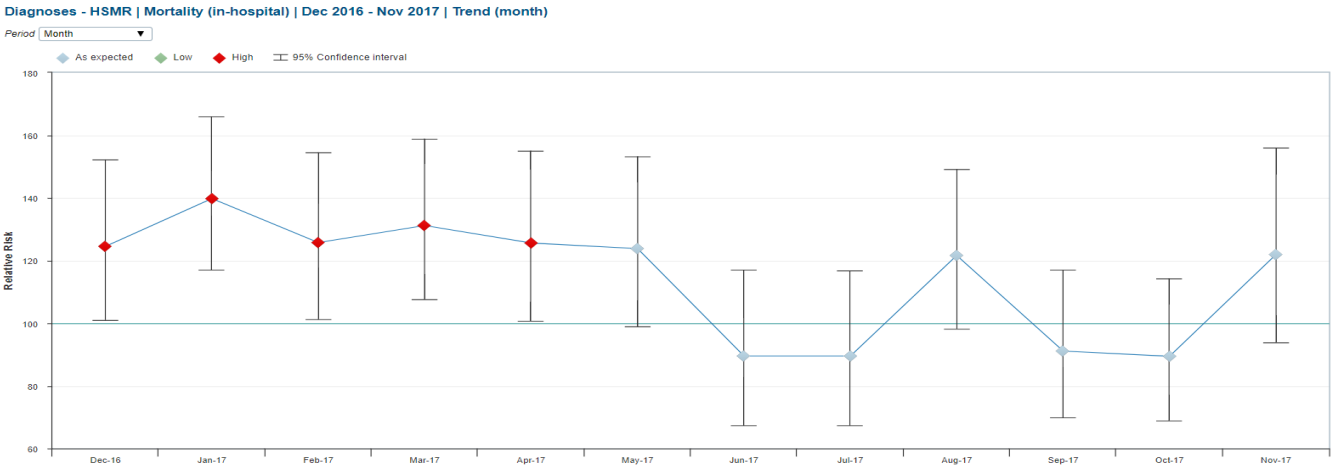
Some of the statistical markers for mortality have been higher than expected for 2017-18.

Hospital Standardised Mortality Ratio (HSMR) and Standardised Mortality Ratios (SMR)

The rolling HSMR and SMR reported for the last 12 months has been higher than expected but here has been an improvement throughout the second half of the year.



The in-month HSMR and SMR show an improving situation:



There have been a number of outlier alerts for several diagnostic codes for this period. These include fractured neck of femur, septicaemia, chronic obstructive airways disease and urinary tract infections. There has been an extensive review and restructure of the governance process and reporting for mortality in line with national requirements.

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI for this period has remained as expected.

Quality Improvement

Each year we assess our performance against previous quality priorities and patient outcomes; taking account of national reports, feedback from regulators and emerging themes from incidents as well as patient and staff feedback.

Our priority in 2017/18 was to initiate action to improve our CQC rating and move out of special measures. In December 2017 the CQC undertook a comprehensive inspection of the Trust in 6 core services; Urgent and Emergency, Medical, Surgery, Critical Care, Children and Young people and End of Life Care. The outcome of the inspection was an overall rating of Requires Improvement and a recommendation that the Trust be removed from special measures.

There are now no services rated as inadequate. End of Life Care and Critical Care were previously rated as inadequate in June 2016 and have now been rated as good. The Trust received a rating of good in 3 of the 5 domains; Effective, Caring and Well Led. The Trust's ratings are reflected below:

Ratings for The Princess Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Requires improvement ↑ Mar 2018	Requires improvement ↑ Mar 2018
Medical care (including older people's care)	Requires improvement →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement →← Mar 2018
Surgery	Requires improvement ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Requires improvement →← Mar 2018	Good ↑ Mar 2018	Requires improvement →← Mar 2018
Critical care	Good ↑↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Requires improvement ↑ Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018
Services for children and young people	Requires improvement ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement →← Mar 2018	Requires improvement →← Mar 2018
End of life care	Good ↑ Mar 2018	Requires improvement →← Mar 2018	Good →← Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018
Maternity and gynaecology	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding 2016
Outpatients and diagnostic imaging	Good Jun 2016	N/A	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016

The Trust has invested in a multi-disciplinary dedicated Quality Improvement Team known as 'Quality First'. The team drives the delivery of improvement and change for the benefit of our patients, staff and wider community.

The key functions identified for Quality First are:

- To support the delivery and realisation of our long term plan (Your future, our hospital and the Five P's).
- To lead quality improvement and organisational development to prepare the Trust for our future health and social care campus.

- To centrally coordinate the delivery of cost improvement plans (CIP) as well as quality improvement initiatives that deliver greater efficiency and productivity as well as reducing unwarranted variation.
- To support the strategic realisation of the Integrated Care Partnership and Sustainability Transformation Plans.

The Trust has identified the following priorities for Quality Improvement in 2018/19:

Priorities for Quality Improvement 2018/2019				
Ref:	**Quality Improvement Area**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
1. Our Patients: Improve Standardised Mortality Rate (HSMR)				
1.1	Reduce mortality and improve the Trusts HSMR	Reduce the number of excess deaths (not due to chance). Reduce HSMR from 116 higher than expected to as expected grade or less	HSMR will be in the as expected range A reduction in the number of mortality outlier alerts from 12 by 50% = 6 Reduced mortality from Acute Kidney Injury by 10% 90% of patients who meet sepsis criteria will be screened for sepsis by 1/10/18 90% of patients identified as having sepsis receive appropriate treatment within 60 minutes of diagnosis by 1/10/18	Sepsis and AKI board to monitor compliance Monthly mortality review Compliance checks reported through Quality dashboards and presented in line with the Governance reporting framework
1.2	Improve our patients experience	Ensure patients receive personalised care and are satisfied with their experience	Improved inpatient survey results, ensuring the we reduce and eliminate questions that were rated in the lowest 20% Want 10 questions to be placed in the top 20%. From this we want the following 3 questions to be rated in top 20%: Question 27: Scored 22 Confidence and trust in nurses Question 39: Scored	Monthly report to Quality and Safety Committee Healthcare group performance review meetings

			23 Care and privacy when discussion my condition Question 54: Scored 43 discharge support from health or social care professional Reduction in complaints received from 229 by 10% = <206 Increase the number of PALs concerns from 2923 successfully resolved and not proceeding to be complaints by 10% = 3215	
2. Our People				
Ref:	**Quality Improvement Area**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
2.1	Recruitment and retention of Registered Nurses	Increase the numbers of registered nurses working across the Trust By reducing the vacancy rate and decreasing the turnover rate of registered nurses	A nursing vacancy rate of equal or less than 20% Staff are retained and working in the Trust for longer periods. Reduce turnover from 17.3 by 2% to 15.3% Develop initiatives to retain staff	Nursing and Midwifery retention group Workforce Committee
2.2	Staff Culture and well being	Our staffs experience will be consistent with the Trusts Strategy, Vision, and four Values of Respectful, Caring, Responsible and Committed	Every member of staff will feel the Trust values are demonstrated and evidence will come from the 2018 National staff survey. The following questions will have an improvement in its scores No.17a scored 94% staff not experiencing discrimination from patient/service users No.17b – scored 91% staff are not experiencing discrimination from manager or	Bi-monthly review at Workforce Committee Health and Safety Committee

		Our staff's health and well-being will be improved	colleagues No.18a scored 71% staff had training and development No.18b scored 80% staff reported training helped me to do my job No.18c – scored 82% training helped me stay up to date professionally No.19 scored 97% staff had mandatory training in last 12 months Improvement in the nursing vacancy rate 50% of staff will feel engaged and take up involvement in local events such as: - Weight loss - Stop Smoking - Local gym membership - Happy to share mental health concerns Reduce sickness absence rate by 0.5% Increase in numbers of staff taking up the flu vaccine from 70% to 75%	
3. Our Performance				
	Quality Improvement Area	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
3.1	Improvement in Emergency Department 4 hour access standards	Improve the numbers of patients that receive timely treatment in the Emergency Department (ED) Reduce the time for patients arriving by ambulance to be handed over from ambulance to Trust staff. Reduce Length of stay for conditions currently outside the benchmark	The department will achieve 90% standard by 30/9/18 Achieve 95% standard by 30/3/19 Reduce the length of time patients spend in the ED (focus on Minor Injuries and paediatric areas) Reduce ambulance delays	Improvement in access standards monitored through IPR ED delivery board Length of time patients spending in the ED monitored through performance reviews Patient experience monitored by patient survey and feedback

		best practice Timely transfer of critical care patients to wards	Reduced length of stay for outlier conditions and variations Improve numbers of discharges earlier in the day Reduce the number of patients delays of more than 4 hours Improve patient experience	Monitor length of stay at performance reviews
3.2	Improve performance against access standards for Referral to treatment (RTT) Cancer performance	Recovery of performance against the RTT incomplete to the national Standard across the Trust and in line with the NHS constitution Maintain performance against all national cancer standards, including recovering the Urology position No patients to be over 104 days on cancer pathways, unless clinically appropriate or the patients choice	Delivery of RTT incomplete standard by the end of June 18 Consistent delivery of the cancer national standards and the internal PAH 7day standard Extend the one stop diagnostic services already available in Breast and Urology to other key specialities Maintain delivery for the rest of 2018/19	Monthly through Patient Target List meetings Access Board Cancer board Performance and Finance Committee Trust Board IPR Trust Board
3.3	CQC preparation to obtain Good at time of next inspection	Ensure PAH is regulation ready Deliver objectives detailed within the Quality Improvement Plan (QIP) Ensure Trust maintains all the improvements implemented during 2017 Use the appreciative enquiry model for teams and staff preparation Staff to be clear about what is takes to achieve both good' and 'outstanding	Implement and deliver CQC preparation plan Deliver all items on QIP as underlying causes and root cause Improve services graded as Requires Improvement and maintain or improve position Focus on Well led to maintain and improve position	Quality Improvement Plan (QIP) milestones and output tracker. Monthly internal review at Quality and Safety Committee System Improvement Board (with local partners) CQC inspection report
4. Our Places				
	Quality Improvement Area	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
4.1	Clinical areas and critical functions to be refurbished	A clear risk assessed and prioritised list of Estates works fully costed.	Plan for implementation approved by the Board of Directors Bring the orthopaedic fracture clinic back on the Harlow site	Compliance with agreed milestones and outputs. Monitored through the Health and safety Committee Quality and Safety

			Refurbishment of our cancer care facilities Create an onsite education facility Refurbished the lifts Complete work to upgrade the electricity systems	Committee Risk committee

People Performance

Without doubt our people are our greatest asset. Our commitment to ensuring the right people with the right skills are in the right place includes a comprehensive provision of relevant training to maintain safety and allow individual career development.

The Trust has implemented an organisational development programme with a focus on growing our own 'Great Leaders'. For 2017/18 the programme introduced an approach to coaching with the development of 'staff coaches' across all levels of staff, as well as formal coaching activities for middle and senior staff. Working with colleagues in the wider health and social care economy, there is also an increased focus on rotating staff and offering secondment opportunities in order to develop a workforce who can move seamlessly to meet the needs of patients.

In 2017/18, the Trust has seen an improvement in overall vacancy rates and voluntary turnover, with improvements made in recruitment and retention processes. These improvements will continue to be a key area of focus during 2018/19. However, the Trust has experienced a significant vacancy rate amongst registered nursing staff. The Trust continues to take a multi-faceted approach to recruitment to this staff cohort. Recruitment open days have been held throughout the year and international recruitment is ongoing and we offer interviews via skype where appropriate to do so. Proactive approaches include direct approaches via nursing data base companies, proactive candidate attraction strategies via social media and consideration of 'refer a friend' initiatives.

The Trust has worked hard to reduce agency spend and delivered against its agency spend target of £13.66m. It is due to our progress in these areas that we have been able to develop a robust set of People KPIs against which our performance will be measured and reported in the year ahead. These new KPIs are summarised below and were agreed with the Workforce Committee in March 2018 in accordance with performance outturn (2017/18) and STP benchmark intelligence.

People KPI	**18/19 Target**
Vacancy Rate	8.0%
Sickness Absence	3.5%
Turnover (voluntary)	12%
Stability	90%
Statutory & Mandatory Training	90%
Appraisal	90%
FFT (care of treatment) Q3	70%
FFT (place to work) Q3	70%
Flu Vaccination	70%
Active Job Plans	100%
Electronic Rosters (clinical staff)	100%

Exception Reports (junior doctors)	3 monthly
Time to hire (Advert to formal offer made)	31 Days

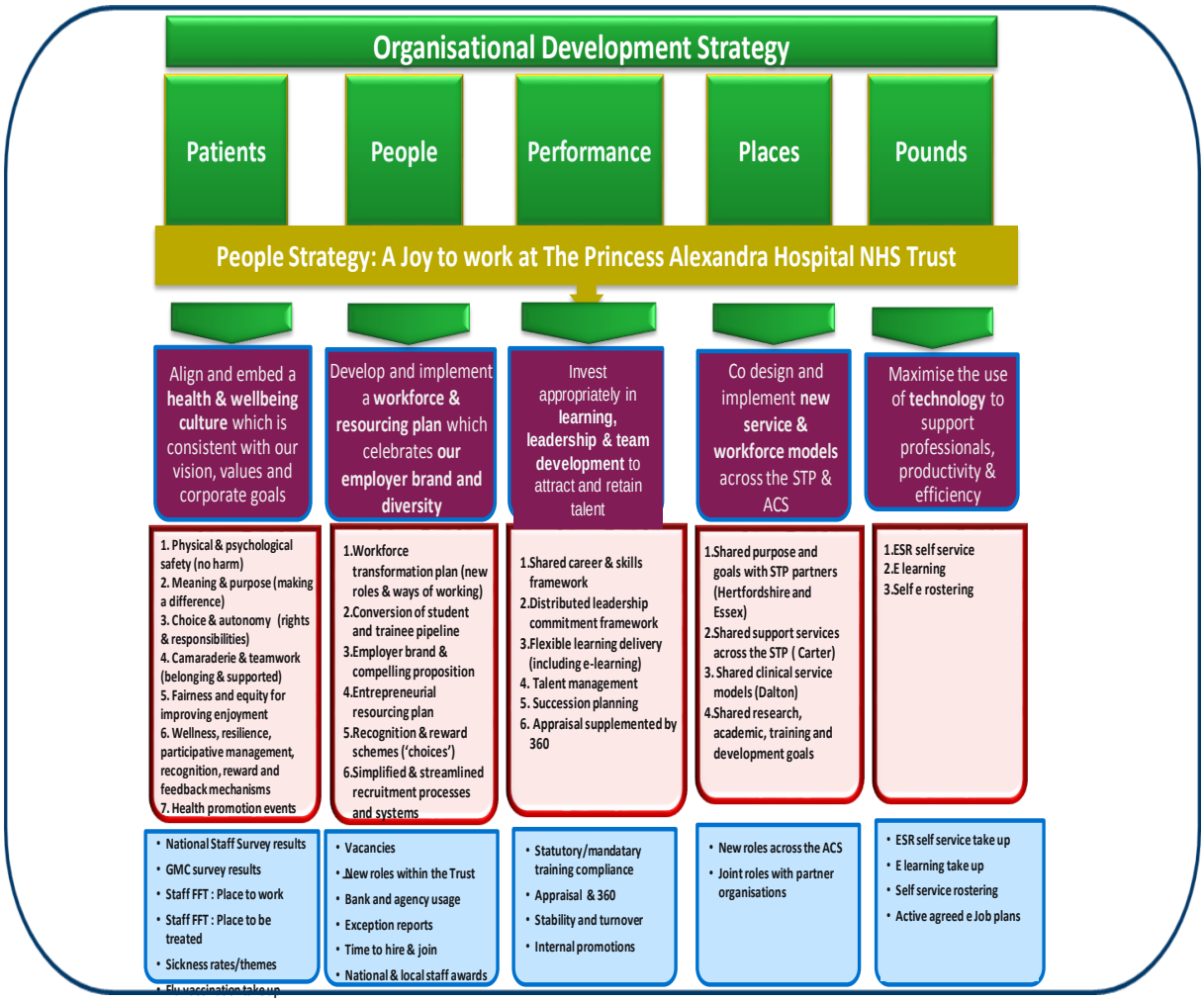
Our People Strategy

Our new People Strategy commences in April 2018 and is aligned to the Organisational Development Strategy.

The diagram on the next page summarises the outputs of a workshop held to develop the strategy and clarifies the following five key pillars of the people strategy:

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

The new People Strategy aspires to create a climate of joy to work at The Princess Alexandra Hospital NHS Trust.



Culture, Health and Wellbeing

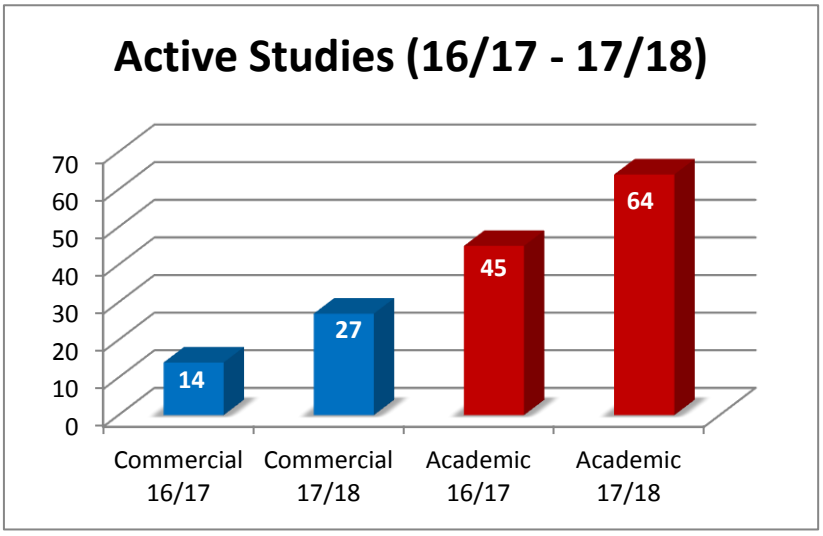
In 2017/18 we continued to embed a culture of health and wellbeing which is consistent with our vision, values and strategic objectives through our employee pathway - from values based recruitment, induction, orientation, appraisal, communications, award and recognition

schemes. We have celebrated the great work that our staff do through annual awards ceremonies, long service awards, employer based awards, “daisy chain” awards for acts of kindness and compassion, “Our Amazing People” programme which highlights the achievements of our staff through various communications channels throughout the hospital.

New staff engagement initiatives which were introduced this year, including Facebook for Staff, direct communications sessions for Bands 6 and above, a new staff council, regular engagement activities involving our CEO from “the big conversation” with all staff, Chief’s briefs” where our CEO visits a specific staff team, the Bands 1-4 forum and band 5 forum, where colleagues can feed back issues and celebrate successes in a supportive environment.

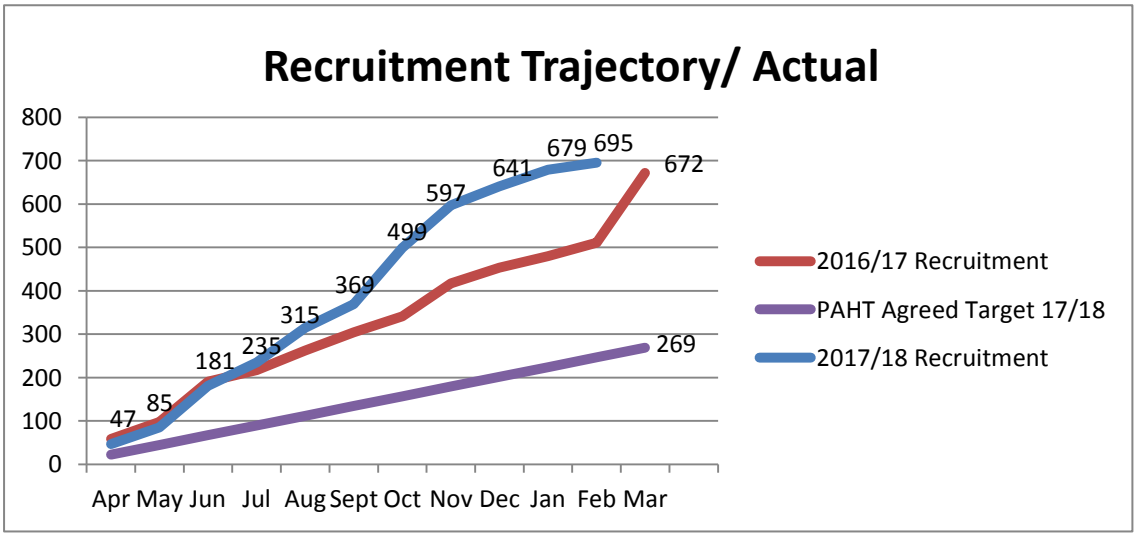
Research, Development & Innovation

Every year we participate in a wide range of research studies. The studies vary in their purpose and may be academic or commercial in nature. A commercial study is one that is developed by the pharmaceutical/device company, whereas an academic study is developed in a university teaching hospital environment. The aim of participating is to support the development or evaluation of treatments and interventions provided to patients.



Recruitment Target

At the beginning of 2017/18, it was agreed with North Thames Clinical Research Network that The Princess Alexandra Hospital NHS Trust would recruit a target of **269** participants into National Institute for Health Research (NIHR) portfolio adopted trials. Nearing the end of the fiscal year, the number of participants recruited into research for this financial year is **695** as of 28th February 2018.



Recruitment per Speciality

Recruitment	Speciality	Directorate	Commercial/Non Commercial
Portfolio Activity			
327	Cancer	C,C & CSS	Non – Commercial
1	Emergency	Medical	Non – Commercial
1	Diabetes	Medical	Non-Commercial
11	Dermatology	Medical	Non – Commercial
48	Survey	Medical	Non – Commercial
25	Maternity	F & W,S	Non – Commercial
2	Ophthalmology	Medical	Non – Commercial
70	Respiratory	Medical	Non – Commercial
20	Rheumatology	Medical	Non – Commercial
7	Surgical	Surgery	Non – Commercial
6	Cancer	C,C & CSS	Commercial
10	Cardiology	C,C & SS	Commercial
8	Ophthalmology	Medical	Commercial
3	Rheumatology	Medical	Commercial
135	Emergency	Medical	Commercial

Good News Stories

- Penthrox Pass Study - To date, the Trust has recruited 98 patients out of the overall national study target of 282 patients - 35% of the total needed. We are the top recruiter to the patient-arm of the study.
- Trial Data Manager appointed in November 2017.
- Research and development funding of £20k awarded to projects covering:-
  - End of Life
  - Frailty
  - Delirium
  - Patient Panel
  - Breast
  - Diabetes
- The Research illustration for PAH has now been completed, and will be shown in designated areas across the Trust and various social media.
- The Trust has a Patient Research Ambassador – Phillip Wingfield, who is currently on the STAMPEDE study. Philip will be assisting with a number of projects within the department, including the International Clinical Trials Day scheduled for May 2018
- Our first interventional study in the Respiratory specialty is now open, the CLEAR study.
- The department received Research Capability Funding in June 2017 to the sum of £20,000 which is awarded for recruiting in excess of 500 participants from 1st October 2015 to 30th September 2016. There is an expectation that the Trust will receive this funding again for this previous year's award period.

Estate Improvements:

Whilst work on developing plans for our new hospital is well underway we still have to ensure we improve the existing buildings on the main hospital site. When the Trust

developed its capital programme for 2017/18 it recognised the need for considerable improvements to address our patient and visitor experience, service capacity and organisational resilience across a range of diverse projects which included:

Emergency Department – The Princess Alexandra Hospital NHS Trust secured additional capital funding from two successful bids to NHS England to support patient flow and safety in our main emergency department. As a result of this funding award we were able to carry out clinically-led extensive modifications to our Emergency Department which included alterations to the main reception for patients, a discharge lounge and were specifically targeted to improve the flow of patients through the emergency department and to reduce waiting times.

Paediatric Emergency Department - We were also able to commission and build a new paediatric emergency department as well as a paediatric ambulatory care unit since the completion of these project's there has been a demonstrable improvement in patient experience and a reduction in patient waiting times.

Outpatients Department Waiting Area, Main Corridors, Lift Lobby and Stairwell – This project was approved to positively impact on our patient experience. The Stairwell designed when the hospital opened was a spiral design which was now not fit for purpose and required to be removed and replaced, the outpatients department was reconfigured to increase waiting capacity and the wellbeing of our patients and visitors whilst within the

hospital environ. In addition the changes impacted positively on the patient flows, wayfinding, and in the case of the staircase refurbishment, improvements to safety and security.

Maternity Theatres Refurbishment – The Trusts annual birth numbers have grown dramatically since the build of the present theatre in the 1960s, and further growth and complexity of cases is anticipated as Harlow continues to expand. This project will ensure the Trust's maternity department can operate effectively and in the event of a complex birth, the ability to operate in environments that conform to the highest healthcare standards.

Main Hospital Entrance – Patients will enjoy transformed access to services at Harlow's Princess Alexandra Hospital following a major upgrade. The installation of a new door was essential to enhance the patient experience on entering the building, to meet disability discrimination legislation and to improve the general environment of the 1960s built infirmary.

Backlog Maintenance Schemes – Additionally, the Trust has made significant strides in engineering compliance by addressing a number of high risk backlog maintenance schemes, including; electrical remedial works, replacement generators, within our plantrooms, we have replaced valve systems, plate heat exchangers, motorised pump, heating and ventilation and building management system controls.

Sustainability:

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and longer term even in the context of the rising cost of natural resources. Demonstrating that we consider the social and environmental impacts of our activities ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, staff, visitors and local communities by working hard to minimise the 'footprint' of our local and global environmental impacts. As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline), equivalent to a 28% reduction from a 2013 baseline by 2020.

An organisation's carbon emissions fall into two distinct groups:

- 'internal' carbon emissions over which we have direct control. For the Trust this includes those emitted from on-site utilities consumption, travel for work, on-site waste management and specific clinical or research processes.
- 'external' carbon emissions that are embedded within the broad expanse of supply and disposal chains which provide goods and services to the Trust. This includes those associated with the extraction of natural resources, the manufacture of goods, their distribution and subsequent off-site waste management contracts.

However, it is important to recognise where we have direct control over our environmental impacts and where we can only seek to apply influence indirectly. Over the past ten years the Trust has used specific policies and programmes of work to improve consumption efficiency and reduce waste. This has saved the Trust significant amounts of money whilst managing its carbon footprint, saving natural resources and reducing pollution. Weighing against this progress, in terms of achieving absolute reductions, has been the ongoing expansion of the campus and its services and an increasing demand for healthcare provision.

From this position, the Trust is working to contribute to the NHS, public health and social care system carbon reduction target under two distinct headings:

- Internal and directly controllable emissions: covering those of material significance emitted from on-site utilities consumption, travel for work, on-site waste management and specific clinical or research processes. The Trust is currently on a trajectory to reduce these directly controllable emissions by 20% by 2020 (from a 2013/14 baseline). This contribution should reach 25-30% by 2025.
- External supply chain emissions: covering those associated with the extraction of natural resources, manufacture, distribution and off-site disposal of all the goods and products the Trust uses and consumes in everything it does.

We will attempt to exert influence through procurement processes and contractual relations in order to contribute to the national target. However, we cannot genuinely measure this contribution and so are unable to set a meaningful target. Accurate carbon disclosure in the supply chain and any claims of savings are beyond the Trust's capacity to verify. One of the difficulties that organisations have in delivering carbon reduction is that, in itself, it often means little to people in a practical day-to-day way. The Trust has recognised this and now seeks to promote sustainability through what has been called the 'circular' economy, as opposed to what has become the more typical 'linear' economy of take-make-use-throwaway. This circular approach endeavours to look at all goods, services and healthcare practices in terms of lifecycle assessment. This means that for everything we do, or purchase, we really make sure that all the costs (many of which are hidden) are included in decision-making. These will include the costs associated with utility consumption, carbon emissions, biodiversity, pollution, transport and how to re-use or recycle items at the end of their immediate use to us. Once included, it is an easier job to account for and reduce them: saving money, creating sustainable value and cutting carbon emissions.

Policies

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The Trust's Board adopted the Princess Alexandra Hospital SDMP in early 2018. This is currently in the process of being comprehensively redrafted and will be put forward for approval in the summer of 2018. This document is supported and augmented by a range of more subject specific policies and procedures. These include an extensive Travel Plan that appropriately embraces the wider Princess Alexandra Hospital. This is also presently subject to a comprehensive review, with adoption again scheduled for the coming summer. Other key documents include our Environmentally Sustainable Design and Construction Protocol, the Waste Management Policy and Waste Disposal Procedures, and several policies relating to aspects of energy and water management.

Sustainable Procurement

It is estimated that over 60% of the Trust's carbon footprint is 'embedded' within the goods and products it uses and consumes. These comprise the carbon emissions from the extraction of materials and subsequent manufacture and distribution of all the items that The

Princess Alexandra Hospital purchases to provide safe, kind and excellent healthcare. Although we cannot directly control the individual supply chain elements, we can influence them through our purchasing decisions. Practically measuring and thereby setting targets for the impact of this influence is currently beyond the Trust's reach, but, on a case by case basis, some sustainable inroads can be made into supply chains. This is done by requesting disclosure of lifecycle assessment (LCA) evidence from suppliers of all the materially significant energy, water, waste and transport aspects of the individual products being purchased. This LCA evidence should relate to:

- extraction, manufacture and distribution prior to receipt,
- all the in-use elements of energy and water consumption, and,
- any implications for The Princess Alexandra Hospital regarding transportation and waste disposal (of both packaging and the items themselves). An LCA is a detailed piece of work that is only worth pursuing when some, or all, of these elements have been recognised as material to more sustainable decision-making.

From some trial work begun last year, we are now more formally using this approach in drawing up tender specifications which we know will have material implications for furthering sustainability. These have included: the transport service – showing a clear preference for low emission vehicles; the boiler house plant upgrade project – prioritising very high efficiency burners, and; disposable bed-bay curtains – specifically including supplier recycling options within the specification and assessment process.

Partnerships and collaboration

Partnerships, networks of change and less formal collaborative working arrangements are fundamental aspects of the route to sustainability for any organisation and the communities it serves. This point is very clearly made in the Trust's SDMP. Actions for a more sustainable world make little impact in isolation.

Sustainability is for everyone. Some responses are very technical whilst others are just about 'doing the right thing' as we go about our lives. Everything from upgrading our gas boilers to simply putting what we see as rubbish into the correct bin so that it can be properly recycled. No one wants to waste resources, experience pollution, see our natural environment decline or face the dangerous impacts of climate change. The Trust recognises that the responsibility to prevent this happening is not something that one department, one team of 'green champions' or one hospital can shoulder on its own. Reaching out and searching for support that works in both directions across all our healthcare colleagues, patients and visitors, and our partners in the public, private, voluntary and community sectors is essential to an environmentally sustainable future.

Behaviour Change

Few people want to see resources wasted or cause avoidable damage to our natural environment. The pressures of a busy hospital often mean, however, that the impacts of our day-to-day actions on these issues can easily be overlooked. Maintaining a constant background of communications around saving energy and water, minimising waste and more active travel is therefore very important.

Looking forward

2018/19 will be another busy year in meeting our patient, staff, visitor and local community responsibilities to minimise the 'footprint' of our local and global environmental impacts. High on the priority list will be the adoption and implementation of the new Trust wide Travel Plan and the introduction of a combined heating and power plant. Alongside this the new SDMP will refresh and update our delivery approach to take us into the 2020s.

We will be pushing the ‘Think Green’ Impact to secure total coverage of Estates and Facilities whilst continuing to attract the outstanding contribution from volunteer teams across all health groups. This will be backed up by endeavouring to ensure that new staff quickly become familiar with their individual responsibilities for sustainable energy and water use, and waste segregation, through the new starter induction process.

Lance McCarthy

Chief Executive

The Accountability Report 2017/18

Corporate Governance Report

Our Board

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

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

The Trust Board formally operates in accordance with its Governance Manual comprising the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Members of the Trust Board

Name	Position	Voting	From	To
Executive Directors:				
Phil Morley	Chief Executive Officer	Y	07.07.14	14.04.17
Lance McCarthy	Chief Executive Officer	Y	03.05.17	Current
Trevor Smith	(Acting Chief Executive Officer) Chief Financial Officer	(Y) Y	(22.02.17) 15.07.13	(31.05.17) Current
Dr Andy Morris	Chief Medical Officer	Y	01.03.15	Current
Stephanie Lawton	Chief Operating Officer	Y	02.03.16	Current
Nancy Fontaine	Chief Nurse	Y	01.11.12	Current
Marc Davis	Director of Pathways & Partnerships	N	01.10.12	Current
Liz Booth	Director of HR	N	15.09.15	17.11.17
James Mc Leish	Director of Quality Improvement	N	01.04.16	Current
Simon Covill	(Acting Chief Financial Officer)	(Y)	(22.02.17)	(31.05.17)
Raj Bhamber	Interim Director of People	N	20.11.17	Current
Non-Executive Directors:				
Alan Burns	Chairman	Y	01.12.16	30.11.18
Andrew Holden	NED (Chair of PAF)	Y	01.01.15	31.03.19
Pam Court	NED (Chair of CFC)	Y	28.09.15	27.09.19
James Anderson	NED (Chair of WFC)	Y	28.09.15	31.03.18
Stephen Bright	NED (Chair of Audit Committee)	Y	03.10.16	02.10.18
John Hogan	NED (Chair of QSC)	Y	01.08.17	31.07.19
Helen Glenister	Associate NED	N	01.08.17	31.07.19
Steve Clarke	Associate NED	N	01.08.17	31.07.19

Attendance at Board Meetings

Number of Board members present at Board meetings in 2017/18:

	27.04.17	25.05.17	30.05.17	29.06.16	27.07.16	08.17	28.09.17	26.10.17	30.11.17	18.12.17	15.01.18	25.01.18	22.02.18	29.03.18
	Private	**Public & Private**	**Extra-Ordinary Trust Board**	**Private**	**Public & Private**	**No meeting held**	**Public & Private**	**Private**	**Public & Private**	**Private**	**Extra-ordinary Trust Board**	**Public & Private**	**Private**	**Public & Private**
Public		13/14*	8/14*		13/13		13/16		15/16		15/16	15/16		15/16
Private	12/13	13/14*		13/13	12/13		13/16	15/16	15/16	16/16		15/16	15/16	15/16

Note:

Phil Morley retired: 14.04.17

Lance McCarthy appointed: 03.05.17

John Hogan, Helen Glenister and Steve Clarke appointed: 01.08.17

Liz Booth departed: 17.11.17

Raj Bhamber appointed: 20.11.17

* New CEO in post but on annual leave so meeting attended by both previously acting CEO and CFO.

Committees

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

Audit Committee

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

Charitable Funds Committee

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

Performance and Finance Committee

The purpose of the Performance and Finance Committee is:

- Considering, challenging and recommending the Trust's Annual Business plan to the Board and undertaking bi-annual reviews of performance against the Annual Plan.
- Scrutinising operational and financial performance and monitoring achievement of national and local targets and recommending any re-basing or re-forecasting of operational and financial performance trajectories to the Board;
- Assuring the Board of Directors that the Trust has rigorous processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable – recommending any re-basing or re-forecasting of financial assumptions or plans to the Board;
- Monitoring progress on the Cost Improvement Programme and investigating reasons for variance from plan;
- Monitoring the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities;
- Reviewing and monitoring the management of finance, performance and contracting risks.

Quality and Safety Committee

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

Workforce Committee

The purpose of the Workforce Committee is:

- Maintain oversight of the development and design of the Workforce and ensure it is aligned with the strategic context within which the Trust is required to operate.
- Assure the Board on all aspects of Workforce and Organisational Development and provide leadership and oversight for the Trust on workforce issues that support delivery of the Trust's annual objectives.
- Assure the Board that the Trust has staff with the skills, competencies and information to meet both the current and future needs of the Trust and ensure delivery of efficient services to patients
- Assure the Board on all aspects of recruitment, retention, staff experience and engagement

- Assure the Board that the Trust's structures and systems support the delivery of inter-professional training and development.

Remuneration and Nominations Committee

The Remuneration & Nominations Committee determines the remuneration and terms of service of the Trust's directors and senior managers; it also considers the overall skill mix and balance of the Board of Directors.

Statement of Board Members' Interests

Name	Title	Interests/Memberships Declared
Alan Burns	Chairman	• Independent Chair of Suffolk and North East Essex STP Board • Chair of Kettering General Hospital NHS Trust.
James Anderson (until 29.03.18)	Non-Executive Director	• Principal at IQVIA
Pam Court	Non-Executive Director	• Chief Executive Officer of Saint Francis Hospice
Stephen Bright	Non-Executive Director	• Chairman Vistem Sarl • Director SDF Consulting Limited • Vale of Aylesbury Housing Association – Non Executive and Chair of Audit committee from June 2017
Andrew Holden	Non-Executive Director	• Board Director, Liaison Financial Services
John Hogan	Non- Executive Director	• Self-employed at private medical practice. • Consultant cardiologist at Barts Health NHS Trust
Helen Glenister	Associate Non-Executive Director	• Chair of Accelerate CIC Limited • Trustee and Vice Chair of Isabel Hospice
Steve Clarke	Associate Non-Executive Director	• Director of Finance at Health Education England • Trustee and honorary treasurer of Dementia UK
Lance McCarthy (from 03.05.17)	Chief Executive Officer	• Director, Anglia Ruskin Health Partnership
Phil Morley (until 14.04.17)	Chief Executive Officer	• Director, Anglia Ruskin Health Partnership • Trustee, Aspire Academy
Liz Booth (until	Director of HR	• No Interests Declared

17.11.17)		
Raj Bhamber	Director of People	• Trustee of Scott's Project Trust • Director of Bhamber Estates Ltd • Consultant of Bhamber Consultancy Ltd
Marc Davis	Director of Pathways & Partnerships	• Seres GIFTS Limited (Spouse's Company) • Governor - Sir Charles Kao UTC • Own GP Surgery • Own Dental Surgery • Own Optician Surgery
Nancy Fontaine	Chief Nurse	• Professor of Nursing at Anglia Ruskin University and University of Essex • Chair of Adult Safeguarding Performance and Audit Committee for Essex
Stephanie Lawton	Chief Operating Officer	• No Interests Declared
James McLeish	Director of Quality Improvement	• Spouse is a Paramedic for East of England Ambulance Service
Andy Morris	Chief Medical Officer	• Consultant Anaesthetist • Independent work with EoE Clinical Senate
Trevor Smith	Chief Financial Officer Acting CEO until 31.05.17	• Spouse is a Director of Salonica Consulting Limited
Simon Covill	Acting Chief Financial Officer until 31.05.17	• No Interests Declared

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

Statement of Director's responsibilities

The full statement of Director's responsibilities is included in the Financial Statements.

The Statement of Accounting Officer's responsibilities

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

Lance McCarthy
Chief Executive

Date:

Annual Governance Statement 2017/18

My Annual Governance Statement (AGS) has been written describing the governance arrangements in place at the Trust during 2017/18. During the year, we continued to review and strengthen our governance arrangements and took into account the findings of the last CQC inspection together with continuing feedback and support from NHS Improvement.

At the same time, we have taken a full and active role within the Hertfordshire and West Essex Sustainability and Transformation Programme (STP) and the West Essex Accountable Care Provider (ACP) system. Delivering high quality, timely and cost effective care to our local community are core components of our strategic objectives, and the STP and ACP both give clear clinically led focus on improving standards, financial stability and adapting services to a growing and changing community across West Essex and Hertfordshire.

Excluding Sustainability and Transformation Funding (STF) the Trust reported a financial deficit of £31.6m in 2017/18 compared to £36.7m in 2016/17 therefore reducing its deficit by £5.1m. The National decision (December 2018) to suspend inpatient elective activity adversely impacted the Trust's financial results by £3.7m. This subsequently impacted the Trusts ability to qualify for full STF funding in 2017/18 with the Trust recovering £3.2m of STF (£10m 2016/17) compared to total eligibility of £7.5m. The Adjusted Retained Deficit in 2017/18 (including £3.2m STF) is £28.4m.

The Trust delivered its agency target for the year, its planned medical locum cost reduction and its cost improvement target for the year.

The Trust's External Auditors have issued an unqualified opinion on its financial statements in that the Accounts present a true and fair view of the Trust's financial position for the 2017/18 financial year.

Following a formal re-inspection in December 2017, the CQC Report, published on 19 March 2018, confirmed the Trust's services to be safer, more effective, more responsive and better led than they were at their last inspection in June 2016. The CQC rated the Trust as 'Requires Improvement' and recommended that it be removed from quality special measures, a recommendation that NHS Improvement accepted. I am deeply grateful to all of our people for their hard work and commitment to improving the quality of care that Princess Alexandra provides and we will continue to focus on improving engagement and communication with our patients, our people and our partners, listening to their concerns and ideas as we further improve care for the local population in 2018/19.

1. 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.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Princess Alexandra Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Princess Alexandra Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts

3. The governance framework of the organisation

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

The Trust Board is responsible for making sure we provide safe, effective and compassionate care to our patients at the same time as supporting their families, relatives and carers. It does this by making the key decisions that affect our hospital and setting the values, aims and strategic direction for the Trust. It also reviews performance against our objectives, as well as against national standards and targets. It has overall responsibility for the effective control of the Trust and is accountable, through its Chairman, to NHS Improvement and the Secretary of State for Health and Social Care. Arrangements are in place to ensure that statutory functions are legally compliant.

Trust Board – Membership and Committees:
The Trust Board consists of:

- a Chairman
- five other voting Non-Executive Directors and two non-voting Associate Non-Executive Directors
- five voting Executive Directors (Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Operating Officer and Chief Nurse) and three further Executive Directors without voting rights; namely the Director of HR (followed by the Interim Director of People from 20 November 2017), the Director of Pathways and Partnerships and the Director of Quality Improvement.

Each of our non-executive directors is appointed to bring their personal qualities and experience to the Board.

In August 2017 the Trust appointed one Non-Executive Director as Chairman of the Quality and Safety Committee and two non-voting Associate Non-Executive Directors.

In January 2017 the Chief Executive Officer announced his retirement and the Chief Financial Officer was appointed as Acting Chief Executive with effect from 22 February 2017 until the current Chief Executive was appointed in May 2017. The Deputy Chief Financial Officer took up the role of Acting Chief Financial Officer during this period.

The Director of HR left the Trust in November 2017 and the Interim Director of People took up post on 20 November 2017.

Attendance at Board and Committee meetings throughout 2017/18 has been monitored and is recorded in the Annual Report.

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

- Audit Committee
- Quality & Safety Committee
- Performance and Finance Committee
- Workforce Committee
- Remuneration & Nominations Committee
- Charitable Funds Committee.

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

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

Board Development**:** During 2017/18 the Board held the following development sessions:

Date	Seminar session
April 2017	ICT
June 2017	Quality Improvement/UCLP
October 2017	CQC
February 2018	Recruitment and Retention

In addition to the above sessions the Trust Board has dedicated time to discussing the progression of the Trust's Strategic Outline Case for a new hospital, urgent care and Mortality rates.

4. Capacity to handle risk

As Chief Executive Officer, I am accountable for the overall risk management activity within the Trust. Committed leadership in the area of risk management is essential to maintaining sound systems of internal control required to manage risks associated with the achievement of the corporate goals of the Trust. The Trust's Risk Management Strategy details my overall accountability to the Trust Board for risk management. I am responsible for ensuring that the Trust is in a position to provide overall assurance that the organisation has in place the necessary controls to manage its risk exposure. In discharging these responsibilities I was assisted by the following Directors during 2017/18:

- The Director of Finance has delegated responsibility for co-ordinating the management of financial and business related risk and assisted me in ensuring that the Trust's resources were managed efficiently, economically and effectively. The Director of Finance also has delegated responsibility that Information Governance arrangements at the Trust are suitable and is the Trust's Senior Information Risk Owner (SIRO).

- The Chief Nurse has delegated authority and responsibility for the professional leadership of the Nursing and Allied Health Professions. The role also has delegated responsibility for overall Quality Improvement, to include being accountable to the CEO as the Director of Infection Prevention and Control. The role has delegated responsibility for reporting to the Trust Board on the achievement of quality and patient experience standards and complaints and claims management and is the Trust's Safeguarding Lead.

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

- The Chief Operating Officer (COO) has delegated authority for managing the Trust's performance delivery both against national operating standards and key performance indicators together with local contractual standards set by the Clinical Commissioning Groups (CCGs).

- The Director of People, OD and Communications has delegated responsibility for overseeing all HR functions across the Trust including recruitment, staff training and managing absence as well as developing the Workforce and People Strategy.

- The Director of Quality Improvement has delegated responsibility for managing the Estates Strategy and the comprehensive Capital Programme for the Trust.

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

All of our people receive risk management and related training at induction and further updates as required. The training covers topics such as risk assessments, Health & Safety at work, moving and handling, fire safety, incident reporting, information governance as well as infection prevention and control. In addition to providing staff with skills and knowledge to carry out their work safely, staff are actively encouraged to report incidents and escalate any identified risks in a timely manner. In addition, thematic learning from incidents is shared through newsletters, internal safety alerts, simulation sessions and/or case scenarios through the Trust's Sharing the Learning sessions. We also support a programme of Counter fraud training and awareness provided by the Local Counter Fraud Specialist team.

5. The Risk and Control Framework

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

Within the Trust, there are systems and processes in place for identifying, managing and monitoring risks. These include:

- a Risk Management Strategy (for the effective management of clinical and non-clinical risk)
- a Committee structure with clear reporting mechanisms to the Board
- a Risk Management Group
- A Significant Risk Register and Board Assurance Framework
- Monitoring systems for incidents and complaints.

Risk is managed at different levels of the organisation. Each Health Care Group and Corporate Department has a risk register that is regularly reviewed, ensuring that risk scores are accurate and that risks are appropriately mitigated, managed and escalated. Each risk on the register has a risk owner accountable for that risk. The Health Care Group leads regularly meet with the Trust's

Compliance Manager for risk discussion, review and moderation and any significant risks are escalated to management for discussion and review.

Proactive risk assessment is carried out using the 5 x 5 matrix method of multiplying the consequence/severity of an event and likelihood/probability of that event materialising. This produces risk scores that guide the treatment and escalation of risk within the organisation. Identified risks are documented on risk registers which are then regularly reviewed with controls and actions monitored.

The Risk Management Group meets on a monthly basis. The Group's objectives are:

- To champion and promote the identification, proactive management of risks and sound risk management practices across the Trust, facilitating and embedding a strong risk management process and culture
- To ensure the identification of the burden of risks across the Trust by providing a critical review of risks on all risk registers.
- To offer constructive challenge, serving as risk moderators in the Trusts risk escalation process and ensuring that significant risks are appropriately escalated.
- To support the delivery of the Trust's objectives by obtaining assurance on the effectiveness of controls and actions identified to minimise risks.
- To improve the standard of decision making on risk management

During 2017/18 we improved the use of technology to support the risk management process; this included the use of the Allocate system to improve processes for reporting and monitoring risk across Health Care Groups and Corporate Departments.

6. Quality Governance Arrangements

The Trust has four Health Care Groups, each of which has a Patient Safety and Quality group where themes and trends from reviews of incidents and complaints and learning are reported.

At our Quality & Safety Committee, each Health Care Group presents an overview of its performance on a rolling programme, in line with the CQC key lines of enquiry. A monthly update from each of the Health Care Groups in relation to areas of specific focus or concern has also been introduced during 2017/18.

Throughout 2017/18, the Quality & Safety Committee continued to receive updates on progress against the Quality Improvement Plan developed to address concerns raised by CQC during their visit in June 2016. Regular 'Sharing the Learning' reports providing an overview of themes, trends and learning arising from incidents, serious incidents and on-going quality improvement initiatives for topics such as falls, dementia and pressure ulcers are also received.

Mortality is monitored by the Quality and Safety Committee as well as the Board. The rolling 12 month HSMR for December 2016 to November 2017 was 114.7 and statistically "higher than expected". However, the in-month HSMR for the same period has been "as expected" for the last 7 months of this period. This is also reflected in a downward curve in the crude mortality for the last 9 months. There have been 12 different diagnostic outlier alerts in this period, for all of which have there has been a deep dive. Fractured neck of femur has alerted throughout the whole period. Over this period the Trust has strengthened its internal oversight, scrutiny and governance arrangements relating to patient deaths. A three year look back has been completed and this showed no relation to nursing numbers or patient acuity.

The Quality and Safety Committee and Board received monthly reports on Nurse and Midwifery Staffing levels in line with guidance received from NHS England and the Care Quality Commission on the delivery of the 'Hard Truths' commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels. Staffing has continued to be a challenge throughout 2017/18 and has been escalated to the Board as an ongoing area of risk. The risk is reflected on the Trust's Board Assurance Framework and is one of the Trust's highest scoring risks (20).

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

There have been no ‘never events’ in 2017/18.

7. Board Assurance Framework

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

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

The 4 highest scoring risks on the BAF throughout 2017/18 were Workforce Capacity, Finance, our Estate and delivery of the ED standard. Further detail on these risks / issues is outlined in section 18.

8. Well-Led Framework

The Board conducted a self-assessment against the CQC’s well-led framework on the 29 June 2017. Priority strategic actions were identified and included the development and implementation of:

- An integrated corporate strategy
- An organisational development strategy to include leadership
- A plan to enhance risk, issues & performance
- A review of data quality and how data is utilised as ‘intelligence’ across the organisation.

All of these have been progressed throughout the year.

9. Care Quality Commission

The trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Through 2017/18 the Trust has been in quality special measures, following an inspection by the CQC in June 2016. Following a formal re-inspection in December 2017, the CQC Report, published on 19 March 2018, confirmed the Trust’s services to be safer, more effective, more responsive and better led. The CQC rated the Trust as ‘Requires Improvement’ and recommended that it be removed from quality special measures, a recommendation that NHS Improvement accepted. I am deeply grateful to all of our people for their hard work and commitment to improving the quality of care that Princess Alexandra provides and we will continue to focus on improving engagement and communication with our patients, our people and our partners, listening to their concerns and ideas as we further improve care for the local population in 2018/19.

10. NHS Pension Scheme

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

11. Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Board received the Annual Equality & Diversity Report in January 2018.

12. Carbon reduction

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. The Trust's corporate objectives (5P's) are aligned with the Annual Operating Plan. Performance against the objectives and targets is monitored through a number of channels:

- Approval of the annual Operating Plan by the Board of Directors
- Monthly reporting to the Board's Performance and Finance Committee (PAF), Quality and Safety Committee (QSC), Workforce Committee and Board on key performance indicators covering finance, performance, patient safety and quality, workforce indicators and information management and technology.
- Monthly presentations from Health Care Groups to Performance Review meetings
- Periodic performance management of Health Care Groups by the Executive Management Team
- The Trust's internal auditors have undertaken the following finance related audits in 2017/18: Cost Improvement Programme, Key Finance Systems (both rated as reasonable assurance) and Income Activity (limited assurance).
- External auditors are required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources (known as value for money conclusion) and report their findings to both the Audit Committee and Board
- The Trust follows the Standards for Providers as set out by the NHS Counter Fraud Authority (NHS CFA). Staff are trained in fraud awareness and are actively encouraged to report any concerns about potential fraud or corruption. All concerns are investigated by the local counter fraud specialist and the outcomes of all investigations are reported to the Audit Committee.

14. Information Governance/Data Security Risks

The Trust reported six Level 2 Information Governance (IG) data security breaches to the Information Commissioner's Office (ICO) during 2017/18. The fifth breach was reported jointly with a Level 2 Cyber Security data breach. The first breach related to sensitive information having been sent to the correct recipient, but via an insecure email transfer route. The second breach related to two patient's health records dropped from a trolley, left temporarily unattended and found by an external business partner. A third breach related to sensitive information having been sent to the incorrect recipient via secure email transfer route and a fourth breach related to a medical record transferred by incorrect process. The fifth breach related to the accidental deletion of one of the Trust's live servers containing patient observation information during routine maintenance. None of these met the ICO's criteria for formal enforcement action and local actions have been undertaken within the Trust to address the issues raised from these and to reduce the likelihood of similar breaches occurring in the future. The sixth incident is still under investigation by the ICO.

15. Quality Account

The directors of the Trust are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Our annual quality account reports on progress with delivery of the strategy and confirms the priorities for the following year. The data included within the quality accounts is subject to audit, by both a structured

annual programme from the internal auditors, and specific item review by the external auditors. The external auditors perform limited scope testing on two of the indicators shown in the quality accounts. The external auditor also undertakes a review of the consistency of the information contained within the quality accounts.

16. Elective waiting time data

Patients who have been referred to the Trust on a Cancer Waiting Time or RTT pathway are managed daily by the clinical and operational teams, in line with the hospital's Access Policy. These pathways are reviewed at bi-weekly PTL review meetings, chaired by the Deputy Chief Operating Officer (COO) for Planned Care where pathway trigger points are reviewed and remedial actions taken, if required. The PTL review meetings report to the weekly Access Board meetings which are chaired by the Deputy COO or COO.

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

17. Review of effectiveness

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

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

The Trust's Internal Auditors provide an opinion on the overall arrangements for gaining assurance as part of the risk-based Annual Internal Audit Plan. During the year, the following internal audit reports received limited assurance ratings:

- ICT Review of Cyber Security
- Clinical Audit
- HR Recruitment
- Income Activity
- Compliance with ED Standards

Action plans are in place to address Internal Audit's recommendations for each of the audits. The Internal Auditor's provide a progress report to the Audit Committee. The Executive Team as well as the Audit Committee continues to focus on the implementation of recommendations to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed. During the year Internal Audit attended meetings of the Trust's Executive Management Board and Executive Management Team to provide updates on progress with the Internal Audit and Counter fraud Plans.

The Head of Internal Audit Opinion for 2017/18 is that:
Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk**.** The basis for forming this opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

18. Significant issues

The following is a summary of significant issues which were and will continue to be the focus of the Trust Board's attention and direct the Trust's management efforts during 2017/18 and 2018/19 (and beyond); these issues are also reflected on the Board Assurance Framework:

18.1 Registered Nurse Vacancy rate

In 2017/18, the Trust has seen an improvement in overall vacancy rates and voluntary turnover, with improvements made in recruitment and retention processes. These improvements will continue to be a key area of focus during 2018/19. However, the Trust has experienced a significant vacancy rate amongst registered nursing staff with a vacancy rate as high as 24% for this group at some points in the year. The Trust continues to take a multi-faceted approach to recruitment to this staff cohort. Recruitment open days have been held throughout the year and international recruitment is ongoing. Proactive approaches include direct approaches via nursing data base companies, proactive candidate attraction strategies via social media and consideration of 'refer a friend' initiatives.

18.2 Operational Performance – A&E Standard

The Trust has struggled to deliver against this standard throughout the year. Year to date the Trust achieved 71.05% against the standard. A key factor driving this underperformance has been the significant workforce challenges the Trust has faced this year together with physical space and size of the ED department to see and treat patients. Steps have been taken to address the space constraints by completely refurbishing the department providing increased resuscitation space and provision of additional clinical space within the department. Members of the Trust's Quality 1st team have provided additional leadership support to the teams working within the department. The ED team meet on a weekly basis with the Executive team to review actions being taken to improve discharges, reduce specialty wait times and embed the use of real time data. Recovery plans remain in place to address performance issues both internally and across the health and social care system.

18.3 Financial Sustainability and Strategic Options

The Trust's deficit plan for 2017/18 was £29.1m. This plan was consistent with the notified gross Control Total set by NHSI. The plan provided eligibility to receive £7.5m of STF if we delivered a combination of performance and financial targets.

In January 2018, along with all NHS acute providers, we received a national directive to temporarily suspend inpatient elective activity in order to support emergency activity. This action significantly impacted on our activity numbers and associated income streams. Excluding the impact of this, we continued to forecast delivery of our Control Target for 2017/18.

Our 2017/18 plan built on the improvements in management of our cost base and expenditure controls that were recognised in 2016/17. The plan was underpinned by an £8m cost improvement programme and included an agency target of £13.6m (compared to £15m of agency spend in 2016/17). Both targets were delivered. Our plan assumed that the deficit would be supported by a combination of revenue support and working capital loans, as agreed with NHSI. The plan also established a fully funded £11.4m capital investment programme targeting Estates (including a significant ED refurbishment and maternity theatres), ICT and Medical Equipment.

At a strategic level we continue to work actively with our commissioners, regulators, and independent advisers and STP. We submitted a Strategic Outline Business Case (SOC) for a new hospital to NHS Improvement in July 2017, which includes an option to develop an integrated healthcare campus. Approval to proceed with an OBC is expected to establish recommendations going forward and to quantify the financial implications for the Trust and a wider integrated health and social care system.

Whilst transformational plans to readdress financial and clinical sustainability are progressing, at the current time, our plans do not achieve our statutory financial duty of cumulative break-even over a three year period. In line with their duties as Auditors, the Trust's External Auditors have reported this position to the Secretary of State for Health and Social Care. Our external auditors qualified their 2017/18 value for money conclusion; the purpose of this is to bring the Trust's financial standing to the attention of the public and to seek the Trust's response to:

- its failure to meet its statutory financial duties;
- the seriousness of its current financial position; and
- the actions being taken to improve its financial position and meet its statutory financial duties on a sustainable basis.

Moving forward into 2018/19 we are working towards a gross deficit plan of £28.5m, consistent with the 2018/19 Control Target set by NHSI. We have submitted capital requirements totalling £9.6m, which includes the development of Fracture Clinic services as well as ongoing investment in the Trust's overall estate, and on medical equipment and Information Technology assets. In additional we have submitted further capital funding request to progress an Outline Business Case (OBC).

18.4 Estate

The quality and safety of the estate remain significant challenges for us at a time of financial constraint. It has been well communicated that the current hospital estate has reached its limit in terms of capacity and development. A significant portion of the hospital site is 50 years old and falls short of modern day legislation with areas of key infrastructure in need of replacement. Our ability to keep up with the changing clinical landscape, technological advances and delivery of new models of care is limited by our current estate.

These key risks and concerns drive our longer term estate strategy which considers the advantages of building a new hospital to address these challenges and enable the Trust to be successful in delivering integrated care as part of an Integrated Care Partnership / Alliance (ICP / ICA). However we still needs to deliver high quality, efficient services from the current estate for at least the next 5-10 years.

These critical infrastructure risks, highlighted on the Board Assurance Framework have been reviewed by the Trust Board and a decision was made to realign the capital resources available in 2017/18 to address, where possible some of these key risks or constraints.

The result of those decisions has seen a number of these key risks being mitigated whilst providing much improved facilities for our patients and staff; some of which are highlighted below:

- Refurbishment and replacement of our Emergency Assessment Unit (EAU) building a new Paediatric Emergency Department combined with a new discharge lounge and Clinical Decision Unit.
- Complete refurbishment of the Emergency Department providing increased resuscitation space and provision of additional clinical space within the department.
- Creation of medical and surgical assessment facilities.
- Complete refurbishment of a ward area to create a clean elective Orthopaedic Surgical Unit.
- A new maternity theatre and upgrade of the existing one.
- Upgrade to public areas and outpatients reception area.
- Rewiring and electrical infrastructure repairs to the main building and sub stations.

Whilst the improvements in year have been very welcome they do not resolve the longer term need to replace the ageing estate.

19. Conclusion

As Accountable Officer, I receive information and assurance from a wide range of sources about the Trusts internal control systems and structures in place to ensure the effective operation of the Trust. These facilitate the identification of strengths and areas in need of attention enabling appropriate action plans to be established and acted on. Although some significant issues have been identified, my review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and statutory duties. I and the Trust Board remain committed to achieving continuous improvement and enhancement of the systems of internal control.

Lance McCarthy
Chief Executive
(May 2018)

Remuneration and Staff Report

Background

This report includes details regarding "senior managers" remuneration in accordance with paragraphs 3.33 to 3.57 of the DHSC (Department of Health and Social Care) Group Accounting Manual 2017/18. The Remuneration Report set out below is subject to audit by our external auditors.

The Trust has established a Remuneration and Nominations Committee to advise and assist the Board in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Executive Directors and Very Senior Managers. The Remuneration Committee is chaired by the Trust Chairman and meets at least annually. Membership of the committee consists of Trust Chairman and all Non-Executive Directors with the Director of People and others in attendance. The Chief Executive and Directors remuneration is determined on the basis of reports to the Remuneration and Nominations Committee taking account of any independent evaluation of the post, national guidance on pay rates and market rates. Pay rates for the Chair and Non-Executive Directors of the Trust are determined in accordance with national guidance.

The Trust does not operate any system of performance related pay and no proportion of remuneration is dependent on performance conditions. The performance of Non-Executive Directors is appraised by the Chair. The performance of the Chief Executive is appraised by the Chair. The performance of Trust Executive Directors is appraised by the Chief Executive. Annual pay increases are implemented in accordance with national pay awards for all other NHS staff.

Staff report

Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

- The banded remuneration of the highest paid director in The Princess Alexandra Hospital NHS Trust in the financial year 2017/18 was £250k to £255k (2016/17, £270k to £275k). This was 12.7 times (2016/17, 13.3 times) the median remuneration of the workforce, which was £21k (2016/17, £20k).
- In 2017/18, no employees received remuneration in excess of the highest paid director (this was the same in 2016/17). Remuneration ranged from the bands £0k-£5k to £250k-£255k (2016/17 £0k-£5k to £290k to £295k).

- Total remuneration includes salary, benefits-in-kind, golden hellos and compensation for loss of office. It does not include employer pension contributions, termination payments and the cash equivalent transfer value of pensions.

Consultancy and Professional Services Spend

2017/18 total expenditure on consultancy and professional services was £2,158k (2016/17 £2,139k).

Employee Benefits and Staff Numbers (subject to audit)

Employee Benefits

Gross Expenditure	Permanently employed	Other	2017/18 Total	2016/17 Total
	£000's	£000's	£000's	£000's
Salaries and wages	109,311	297	**109,608**	103,773
Social security costs	10,907		**10,907**	10,035
Apprenticeship levy	490		**490**	0
Employer's contributions to NHS pensions	12,856		**12,856**	12,082
Termination benefits	0		**0**	13
Temporary staff	0	26,024	**26,024**	25,360
Total employee benefits	**133,564**	**26,321**	**159,885**	**151,263**
Less: Employee costs capitalised	766	705	**1,471**	1,286
Gross Employee Benefits excluding capitalised costs	**132,798**	**25,616**	**158,414**	149,977

There were no termination benefits in 2017/18. In 2016/17 the Termination Benefits total of £13k represents the year termination costs of £146k offset and reduced by the removal of a provision for £133k made in 2015/16 that was not used.

Average Staff Numbers

Average Staff Numbers	Permanent Number	Other Number	2017/18 Total	2016/17 Total
	Number	Number	Number	Number
Medical and Dental	483	38	**521**	480
Administration and Estates	576	7	**583**	588
Healthcare Assistants and Other Support Staff	255	2	**257**	255

Nursing, Midwifery and Health Visiting Staff	855	71	**926**	885
Nursing, Midwifery and Health Visiting Learners	423	0	**423**	420
Scientific, Therapeutic and Technical Staff	245	21	**266**	239
Healthcare Science Staff	158	0	**158**	151
Other	123	3	**126**	118
Total	**3,118**	**142**	**3,260**	**3,136**
Staff Engaged on Capital Projects (included in above)	15	20	35	22

Staff sickness absence and ill health retirements

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

	2017/18	**2016/17**
	Number	**Number**
Total days lost	23,688	20,676
Total staff years	2,904	2,725
Average working days lost	8.2	7.6
	2017/18	**2016/17**
	Number	**Number**
Number of persons retired early due to ill health grounds	1	3
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	0	0

Reporting of compensation schemes - exit packages 2017/18 (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	0	0	0
£10,000 - £25,000	0	4	4
£25,001 - £50,000	0	1	1
£50,001 - £100,000	0	1	1
£100,001- £150,000	0	0	0

£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total	**0**	**6**	**6**
Total resource cost (£)	0	£166,000	**£166,000**

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

Reporting of compensation schemes - exit packages 2016/17 (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	0	0	0
£10,000 - £25,000	0	0	0
£25,001 - £50,000	1	0	1
£50,001 - £100,000	0	0	0
£100,001- £150,000	1	1	2
£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total	**2**	**1**	**3**
Total resource cost (£)	£146,000	£118,000	**£264,000**

The other departure disclosed above is in respect of a director, and is further disclosed within the Executive Directors Table of Salaries on pages 58 and 59. The total cost of exit packages disclosed above in Table 1 differs from the redundancy charge in the Accounts because £118,240 was charged to pay cost, and redundancy provision movements have been excluded from Table 1.

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

Exit packages-Other Departures analysis	2017/18		2016/17	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000's	Number	£000's
Contractual payments in lieu of notice	5	104	1	118

Exit payments following Employment Tribunals or court orders	1	62	0	0
Total	**6**	**166**	**1**	**118**

Off payroll arrangements

No individual holding a Board position was paid directly through an associated limited company.

During 2017/18 there were no Executive posts covered by off-payroll arrangements.

The Trust had no off-payroll engagements as of 31 March 2018, and there were no new engagements during the period 1 April 2017 to 31 March 2018.

i. Table of salaries – Non-Executive Directors (subject to audit)

		2017/18				2016/17			
Name	**Title**	**Period**	**Salary (bands of £5,000)** **£000's**	**Expense payments (taxable to nearest £100)** **£'s**	**Total (bands of £5,000)** **£000's**	**Period**	**Salary (bands of £5,000)** **£000's**	**Expense payments (taxable to nearest £100)** **£'s**	**Total (bands of £5,000)** **£000's**
Alan Burns	Chairman	All Year	35 - 40	2,600	35 - 40	01/12/16-31/03/17	10-15	0	10-15
Andrew Holden[1]	Non-Executive Director	All Year	5 - 10	0	5 - 10	01/04/16-16/10/16 01/12/16-31/03/17	5-10	100	5-10
James Anderson	Non-Executive Director	All Year	5 - 10	100	5 - 10	All Year	5-10	100	5-10
Pam Court	Non-Executive Director	All Year	5 - 10	0	5 - 10	All Year	5-10	0	5-10
Stephen Bright	Non-Executive Director	All Year	5 - 10	0	5 - 10	03/10/16-31/03/17	0-5	100	0-5
Dr John Hogan,	Non-Executive Director	01.08.17 - 31.03.18	0 - 5	0	0 - 5	-	-	-	-
Dr Helen Glenister,	Associate Non-Executive Director	01.08.17 - 31.03.18	0 - 5	100	0 - 5	-	-	-	-
Steve Clarke,	Associate Non-Executive Director	01.08.17 - 31.03.18	0 - 5	100	0 - 5	-	-	-	-
Douglas Smallwood	Chairman	-	-	-	-	01/04/16-03/10/16	10-15	0	10-15
Neil Goulden	Non-Executive Director	-	-	-	-	01/04/16-18/05/16	0-5	0	0-5
Mike Roberts	Non-Executive Director	-	-	-	-	01/04/16-31/01/17	5-10	0	5-10

1 Andrew Holden held the Acting Chair role from 17/10/16 to 30/11/16, for which his remuneration was £1.8k. There was a gap from 5/10/16 to 17/10/16 for which the Acting Chair role was vacant.

ii. Table of salaries – Executive Directors (subject to audit)

None of the directors received remuneration other than their salary and pension related benefits tabled below									
		2017/18				2016/17			
Name	**Title**	**Period**	**Salary (bands of £5,000) £000's**	**All pension-related benefits (bands of £2,500) £000's**	**TOTAL (bands of £5,000) £000's**	**Period**	**Salary (bands of £5,000) £000's**	**All pension-related benefits (bands of £2,500) £000's**	**TOTAL (bands of £5,000) £000's**
Lance McCarthy	Chief Executive	03.05.17 - 31.03.18	160 - 165	115 - 117.5	275 - 280	-	-	-	-
Phil Morley[2]	Chief Executive	01.04.17 - 14.04.17	5 - 10	0	5 - 10	All Year	290-295	-	290-295
Nancy Fontaine[1]	Chief Nurse	All Year	130 - 135	30 - 32.5	160 - 165	All Year	125-130	30-32.5	160-165
Andrew Morris[3]	Chief Medical Officer	All Year	250 - 255	45 – 47.5	295 - 300	All Year	270- 275	72.5-75	340-345
Trevor Smith[1]	Chief Financial Officer	All Year	145 - 150	97.5 - 100	245 - 250	All Year	135-140	30-32.5	165-170
Stephanie Lawton[1]	Chief Operating Officer	All Year	130 - 135	30 - 32.5	160 - 165	All Year	105-110	32.5-35	140-145
James McLeish	Director of Quality Improvement	All Year	100 - 105	15 - 17.5	115 - 120	All Year	100-105	102.5-105	205-210
Marc Davis	Director of Pathways and Partnerships	All Year	100 - 105	25 - 27.5	125 - 130	All Year	100-105	22.5-25	120-125

Simon Covill[1]	Acting Chief Financial Officer	01.04.17 - 31.05.17	20 - 25	5 – 5.5	25 - 30	22/02/17-31/03/17	10-15	2.5-5	10-15
Elizabeth Booth	Director of Human Resources	01.04.17 - 11.12.17	65 - 70	35 – 37.5	100 - 105	All Year	90 -95	22.5-25	115-120
Raj Bhamber	Director of People	20.11.17 - 31.03.18	40 - 45	0	40 - 45	-	-	-	-

1. These directors held the following acting up roles, for which none of them received acting up allowances during 2016/17:
   Trevor Smith was Acting Chief Executive from 22/02/17 to 4/06/17, and Deputy Chief Executive from 01/04/16 to 21/02/17.
   Stephanie Lawton was Acting Deputy Chief Executive from 22/02/17 to 03/05/17.
   Simon Covill was Acting Chief Financial Officer from 22/02/17 to 3/5/17. Prior to this, he was the Deputy Chief Financial Officer.

2. Phil Morley was on leave from 22/2/17 until his employment ceased on 14th April 2017. £118k of his salary within the total £290k-295k salary banding disclosed is payment in lieu of notice including holiday pay entitlement. This is disclosed in Exit Packages 2016/17 Table 2 Non-Compulsory Departures page 45. He had opted out of the NHS Pension Scheme.

3. £156k of the salary within the total £250k-£255k salary banding disclosed for Andrew Morris, Chief Medical Officer, is for their clinical role (2016/17 £100k of the total £270-£275k salary of Andrew Morris was for their clinical role).

Salary pension entitlement of Senior Managers (subject to audit)

Executive Directors	Title	Real increase / (decrease) in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017 £000's	Real increase in Cash Equivalent Transfer Value £000's	Cash Equivalent Transfer Value at 31 March 2018 £000's	Employer's contribution to stakeholder pension £000's
Lance McCarthy[1]	Chief Executive Officer	5 - 7.5	10 - 12.5	45 - 50	120 - 125	599	130	729	0
Nancy Fontaine[1]	Chief Nurse	0 - 2.5	(2.5) - 0	45 - 50	115 - 120	768	71	839	0
Andrew Morris[1]	Chief Medical Officer	2.5 - 5	(2.5) - 0	90 - 95	245 - 250	1,613	92	1,705	0
Trevor Smith[1]	Chief Financial Officer	5 - 7.5	7.5 - 10	60 - 65	155 - 160	901	138	1,039	0
Stephanie Lawton[1]	Chief Operating Officer	0 - 2.5	(2.5) - 0	40 - 45	105 - 110	569	61	630	0
James McLeish	Director of Quality Improvement	0 - 2.5	2.5 - 5	20 - 25	65 - 70	412	49	461	0
Marc Davis[1]	Director of Pathway and Partnership	0 - 2.5	0 - 2.5	20 - 25	55 - 60	375	44	419	0
Simon Covill[1]	Acting Chief Financial Officer	0 - 2.5	0 - 2.5	35 - 40	95 - 100	555	40	595	0
Elizabeth Booth[2,3]	Director of Human	2.5 - 5	0	5 - 10	0	33	38	71	0

	Resources								
Raj Bhamber	Director of People (interim)	0 – 2.5	0 – 2.5	20 - 25	70 - 75	477	18	495	0

1 Real increase to Lump Sum may be low, negative or zero as employee now a member of 2015 Scheme which does not provide a mandatory Lump Sum
2 No mandatory Lump Sum as member of the 2008/2015 Section of the Scheme
3 Part year calculation not done as no other NHS Pension Scheme membership this year other than that attributable to PAH employment

There are no entries in respect of pensions for Non-Executive members as they do not receive pensionable remuneration.

CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Staff Survey and Staff Friends and Family Test Results

The annual NHS Staff Survey and the quarterly Staff Family and Friend Test are crucial barometers of how our staff views their workplace. The feedback is useful in helping us highlight improvements that will make the hospital a better place to both work and be treated.

The results reflect the good progress we have made over the past twelve months to improve the quality of care we provide. However, as we already know, there is more we need to do to improve the satisfaction of people working here and I am committed to doing exactly that.

We are now in the top 20% best performing Trusts in the country for:

- The quality of staff appraisals
- Support given to staff by immediate managers
- Staff feeling confident and secure should you need to report unsafe clinical practice
- Effective team working
- Using the feedback we receive from patients and service users effectively

What staff told us has improved:

- Most staff received an appraisal in the last 12 months (*up from 14 in 20 staff, to 17 in 20*)
- Many staff agree that the Trust offer opportunities for flexible hours
- Communications between senior managers and staff
- Quality of patient care by reporting errors, near misses and accidents
- Care of patients being the Trust's top priority
- The Trust promoting your health and well-being

What we need to improve:

- Continue to be in the top 20% for appraisals, management support, safe clinical practices, team working and acting on patient feedback
- Continue to embed our improvements as detailed above
- Many staff said they felt under pressure at work
- Some staff feel our non-mandatory training could be improved
- Staff would like more opportunities for career progression
- Many staff work additional hours
- Some staff experience violence, harassment and abuse from staff, patients and visitors which is unacceptable

We are committed to making further improvements across all these areas with the overarching aim of improving staff satisfaction. This is particularly important as we continue to deliver our quality improvement plan, which focuses on enabling outstanding care for *all* of our patients, *all* of the time.

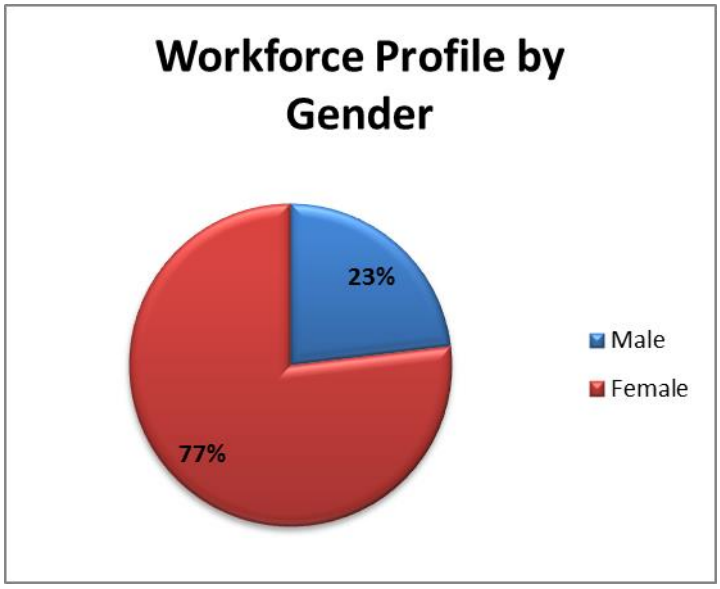
Our staff breakdown

2017/18 Staff Composition	Male	Female
Executive Directors	5	3
Other Employees	774	2583
Total	**779**	**2586**

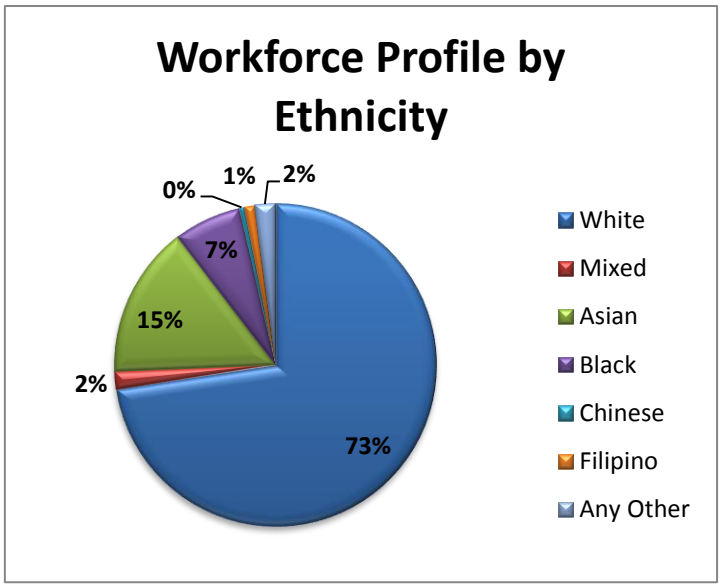
Turnover rate

Turnover Rate	2016/17	2017/18
Overall Staff Turnover	22.30%	19.57%
Voluntary Turnover	15.45%	13.2%

Our workforce – gender profile



Our workforce – ethnic profile



Equality and diversity

Significant achievements during 2017/18

Equality and Inclusion Steering Group

The Trust established an equality and inclusion steering group in April 2017 which works to an agreed terms of reference and has contributed to a number of successes this year:

- New Trust policy on equality and inclusion
- Production of a new equality and inclusion statement

- Co-ordination of the refreshed EDS2
- Co-ordination of a Black History Month celebration
- Contribution to the WRES action plan

Accessible Information Standard (AIS)

This information standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

Support for vulnerable groups is a key part of our Patient Experience Strategy; as part of work on the Accessible Information Standard led through Patient Experience, we will soon be able to provide Braille, Easy Read and Large Print letters through an entirely automated process.

The outcome is the result of changes in our Patient Administration System (COSMIC) Synertec (our contracted external postal print and mailing service) following 18 months of development work with Outpatient Services, IT, Information Governance, Informatics, the Patient Panel, Health Access Champions and Learning Disabilities leads and will help achieve compliance with the Accessible Information Standard in a more consistent way.

These changes will allow the Trust to identify, record, flag and meet the need for accessible information; the remaining element will be to share this data with system partners such as GPs, community, mental health and social care colleagues.

Policy in Relation to Disabled Employees

Physical and cognitive disability and mental health

We successfully bid for a Point of Care Foundation Patient project which supports better care at the end of life, using lean improvement methods such as observational analysis and shadowing exercises.

The project is based on our awareness that dementia patients have not always had equal access to effective palliative and end of life care, recognising that:

- patients with dementia at the end of life are often difficult to identify
- there is often inadequate assessment and management of their symptoms
- as a result pain and symptom control can be challenging
- and, people with dementia at the end of life often receive aggressive and burdensome interventions, or none at all

We also have an active and highly effective Learning Disability Specialist Nursing Team who support the development and implementation of individualised care planning. This means we are able to make reasonable adjustments such as:

- Giving more time to patients with a Learning Disability by booking the first and last slots in the clinic and booking double slots where needed
- Creating a serene and quiet environment around the patient where noise and large numbers of people create distress by offering a quiet room for patients with LD
- Monitoring the number of people at the hospital on a day to day basis who are known to have a learning disability
- Providing patient information and letters in easy read format so that a patient with a learning disability can understand the information they are being given independently without compromising privacy and confidentiality

- The Learning Disabilities Steering Board also supports these measures by scrutinising the ability of the organisation to deliver these reasonable adjustments and then challenging them to do more.

We are also working with Support for Sight (a charity working to improve access for people with visual impairments) to run training inside the Eye Unit and for a wider group of staff to better support people with a visual impairment. Essex Cares Limited (ECL) is another organisation that we are commissioning to improve access by running audits, reviewing information, the environment and all sensory awareness training to ensure the service is fit for purpose for people with dual disability (deaf-blind) and hearing impairments.

The Trust is proud of a long history of patient engagement and in the last four years has delivered a conference every year on a variety of subjects. The Patient Panel was formed in 2014 following the Francis report and has held annual conferences on a range of subjects, including infection control and end of life care. All conferences were attended by the Trust's Chief Executive Officer or Chair as well as the Chief Executive from West Essex Clinical Commissioning Group. We also worked with students from Harlow College on a conference related to discharge from hospital, which we called "I'm a patient, get me out of here!"

Most recently the Trust held an event for the voluntary sector aimed at improving representation for all groups across our community. Follow up work to this event has already begun to show improvements in effective partnerships for the delivery of events and recruitment of volunteers.

Mental Health continues to receive increasing national coverage and we are committed to looking after the mental health of our staff and patients. We are committed to providing mental health first aid training to our Board during 2018/19. We will be using the same provider that we use for our support with smoking cessation, for this training.

The Staff Health and Wellbeing department are planning a range of health and wellbeing interventions for staff during the coming year. We will base these on feedback from staff as well as acknowledging national awareness campaigns, including Mental Health Awareness Week and other events, utilising available tools and resources from NHS Employers.

1.8% of our workforce has declared some form of disability. The Trust is also adopting UNISON's Disability Leave model agreement which will ensure all staff that declare a disability will receive appropriate support in the workplace. We have also updated related People policies to reflect this, for example our Attendance Management Policy.

Our commitment for 2018/19

We acknowledge that inclusive leadership is a good area to focus on for 2018/19 and beyond and we will strive to perform to the best of our ability against the EDS2 in this regard.

All other EDS2 goals will be monitored to ensure we maintain our performance in these areas and we will continue to seek stakeholder input and feedback as to our progress.

2018/19 will see improvements in our workforce processes as we strive to recruit and retain the best possible talent to deliver safe, effective patient care.

We will continue to learn from what our patients tell us and also what our staff tell us through the various surveys that we run. All feedback is useful and where we can we will respond to those who submit views and comments with what action we have been able to take.

The equality and inclusion group will continue to be an integral vehicle on our journey to improve even further and will report into our Workforce Committee, as a committee of the Board, to ensure visibility and scrutiny of all interventions.

We are proud of the achievements we have made this year and are looking forward to building on these in 2018/19. The work of the Equality and Inclusion Steering Group has provided a solid foundation on which to build and with an increased focus on inclusive leadership we are confident

that the Trust will continue to be able to demonstrate its commitment to learning and therefore be an employer of choice.

Lance McCarthy
Chief Executive

The Princess Alexandra Hospital
NHS Trust

The Princess Alexandra Hospital NHS Trust

Annual Accounts for year ended
31 March 2018

Your future | Our hospital

respectful | caring | responsible | committed

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.

- 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.

Chief Executive _____  _____ **Date** ____**10 July 2018**_____

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.

By order of the Board

Chief Executive  **Date** **10 July 2018**

Chief Financial Officer  **Date** **10 July 2018**

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

Opinion

We have audited the financial statements of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 39.1. 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 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:
- give a true and fair view of the financial position of The Princess Alexandra Hospital NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

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 below. 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 the Comptroller and Auditor General's (C&AG) AGN01 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.

Use of our report

This report is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust 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 Directors, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust has not met its financial targets, has reported a significant deficit in year and is budgeting for a further deficit in the next financial year. The Trust is reliant on continued revenue support loans from the Department of Health and Social Care to continue operating. As stated in note 1.1.2, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST (continued)

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this 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.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:
- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects

In respect of the following we have matters to report by exception:

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act

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

On 18 April 2018, we referred a matter to the Secretary of State under section 30 (2)(a) of the Local Audit and Accountability Act 2014 In reporting a deficit for the financial year ended 31 March 2018 and setting a deficit budget for the financial year ended 31 March 2019 the Trust had breached its breakeven duty as set out in Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 as interpreted by the Department of Health in its detailed guidance on breakeven duties.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST (continued)

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The Trust reported a deficit of £28.4 million in its financial statements for the year ending 31 March 2018. It also reported deficits in the previous four financial periods. Therefore it continues to breach its duty, under paragraph 2 (1) of Schedule 5 of the National Health Service Act 2006, to break even.

The position in 2017/18, before sustainability and transformation funding, showed a reduction of £5 million in underlying expenditure when compared with the previous year. However, the Trust was not successful in obtaining in full the sustainability and transformation funding planned for 2017/18 due to non delivery of targets which included the impact of national decision suspended elective activity during winter months. As a result the Trust did not meet the planned deficit control total of £29.1million (£21.6 million after STF) agreed with NHS Improvement for 2017/18. The Trust is forecasting a control total compliant deficit of £28.5million in 2018/19 (£20.4 million after STF).

In March 2018, the Care Quality Commission reported on its re-inspection of the Trust undertaken in December 2017 which saw an improved overall rating from 'inadequate' to 'requires improvement'. Following this the Trust was taken out of special measures. The Trust continues to work with other stakeholders to deliver against the Quality Improvement Plan that it has developed in response to the 2016 Care Quality Commission inspection.

The above factors are evidence of weaknesses in proper arrangements for sustainable resource deployment and informed decision making.

Qualified conclusion (Except for)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in August 2017, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 69, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is 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 the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility 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.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST (continued)

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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 August 2017, as to whether 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 2018.

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 form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Certificate

We certify that we have completed the audit of the accounts of The Princess Alexandra NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Debbie Hanson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
10 July 2018

The maintenance and integrity of The Princess Alexandra Hospital NHS Trust's web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	**2017/18 £000's**	2016/17 £000's
Operating income from patient care activities	3	**196,657**	187,056
Other operating income	4	**16,574**	22,686
Operating expenses	5	**(243,473)**	(233,397)
Operating deficit		**(30,242)**	(23,655)
Finance income	10	**31**	161
Finance expenses	11	**(1,234)**	(1,129)
PDC dividends payable		**(205)**	(2,396)
Net finance costs		**(1,408)**	(3,364)
Other gains	13	**8**	0
Deficit for the year		**(31,642)**	(27,019)
Other comprehensive income			
Revaluations	15	**(34,561)**	5,615
Other recognised gains and losses		**(10)**	-
Other reserve movements		**0**	20
Total comprehensive income / (expenditure) for the period		**(66,213)**	(21,384)
Financial performance for the year			
Retained deficit for the year		**(31,642)**	(27,019)
Impairments		**3,175**	252
Adjustments in respect of donated gov't grant asset reserve elimination		**32**	52
Adjusted retained deficit		**(28,435)**	(26,715)

The notes on pages 78 to 113 form part of these Accounts.

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000's	31 March 2017 £000's
Non-current assets :			
Intangible assets	14	**10,578**	12,177
Property, plant and equipment	15	**103,252**	136,668
Trade and other receivables	17	**763**	659
Total non-current assets		**114,593**	149,504
Current assets :			
Inventories	16	**4,161**	4,114
Trade and other receivables	17	**13,694**	15,105
Cash and cash equivalents	20	**1,262**	3,416
Total current assets		**19,117**	22,635
Current liabilities :			
Trade and other payables	22	**(27,113)**	(27,164)
Borrowings	24	**(26,755)**	(177)
Provisions	26	**(888)**	(671)
Other liabilities	23	**(162)**	(229)
Total current liabilities		**(54,918)**	(28,241)
Total assets less current liabilities		**78,792**	143,898
Non-current liabilities :			
Borrowings	24	**(67,945)**	(69,043)
Provisions	26	**(806)**	(840)
Total non-current liabilities		**(68,751)**	(69,883)
Total assets employed		**10,041**	74,015
Financed by :			
Public dividend capital		**128,151**	125,912
Revaluation reserve		**19,015**	53,679
Income and expenditure reserve		**(137,125)**	(105,576)
Total taxpayers equity		**10,041**	74,015

The notes on pages 78 to 113 form part of these Accounts.

The financial statements on pages 74 to 77 were approved by the Board on 24 May 2018 and signed on its behalf by :

Chief Executive

10.07.18

Date

Statement of Changes in Equity for the year ended 31 March 2018

	Public Dividend Capital £000's	Revaluation Reserve £000's	Income and Expenditure Reserve £000's	Total £000's
Taxpayers equity at 1 April 2017	**125,912**	**53,679**	**(105,576)**	**74,015**
Deficit for the year	0	0	(31,642)	**(31,642)**
Other transfers between reserves	0	(93)	93	0
Revaluations	0	(34,561)	0	**(34,561)**
Other recognised gains and losses	0	(10)	0	**(10)**
Public Dividend Capital received	2,239	0	0	**2,239**
Taxpayers equity at 31 March 2018	**128,151**	**19,015**	**(137,125)**	**10,041**

Taxpayers equity at 1 April 2016	122,912	48,110	(78,623)	92,399
Deficit for the year	0	0	(27,019)	(27,019)
Other transfers between reserves	0	(59)	59	0
Revaluations	0	5,615	0	5,615
Public Dividend Capital received	3,000	0	0	3,000
Other reserve movements	0	13	7	20
Taxpayers equity at 31 March 2017	**125,912**	**53,679**	**(105,576)**	**74,015**

Information on reserves

Public Dividend Capital

Public Dividend apital (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.

Income and Expenditure reserve

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

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.

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017/18 £000's	2016/17 £000's
Cash flows from operating activities			
Operating deficit		**(30,242)**	(23,655)
Non-cash income and expense:			
Depreciation and amortisation	5, 15	**8,394**	8,586
Net impairments	7	**3,175**	252
Income recognised in respect of capital donations	4	**(19)**	0
Decrease / (increase) in receivables and other assets		**2,022**	(83)
(Increase) / decrease in inventories		**(47)**	293
Decrease in payables and other liabilities		**(302)**	(3,604)
Increase / (decrease) in provisions		**180**	(872)
Other movements in operating cash flows		**0**	132
Net cash used in operating activities		**(16,839)**	(18,951)
Cash flows from investing activities			
Interest received		**30**	161
Purchase of intangible assets		**(108)**	(434)
Purchase of property, plant, equipment		**(10,934)**	(7,599)
Sales of property, plant, equipment		**10**	0
Net cash generated used in investing activities		**(11,002)**	(7,872)
Cash flows from financing activities			
Public dividend capital received		**2,239**	3,000
Movement on loans from the Department of Health and Social Care		**25,663**	29,665
Movement on other loans		**(95)**	(211)
Capital element of finance lease rental payments		**(88)**	(52)
Interest paid on finance lease liabilities		**(1)**	0
Other interest paid		**(1,112)**	(1,022)
PDC Dividend paid		**(919)**	(2,665)
Net cash generated from financing activities		**25,687**	28,715
(Decrease) /increase in cash and cash equivalents		**(2,154)**	1,892
Cash and cash equivalents at 1 April		**3,416**	1,524
Cash and cash equivalents at 31 March	20	**1,262**	3,416

Notes to the Accounts

Note 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 2017/18 issued by the Department of Health. 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 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.

1.1.2 Going concern

These Accounts have been prepared on a going concern basis.

IAS1 requires management to assess, as part of the Accounts preparation process, the Trust's ability to continue as a going concern. The HM Treasury Financial Reporting Manual directs that in the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without transfer to another entity.

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

- The Board considers the Trust operates a significant portfolio of clinical services. The Trust has signed a 2018/19 contract with main Commissioners. This contract supports continued provision of services with no plans for disinvestment.

- The Trust has submitted a deficit plan to NHS Improvement (NHSI) totalling £28.5m in 2018/19. This plan is Control Total compliant and is supported by the request to receive interim revenue support loans to the value of the forecast deficit. Subject to delivery of performance the Trust is eligible to receive £8.0m of Sustainability and Transformation Funding (STF) in 2018/19. If this is secured the planned deficit would be reduced to £20.4m.

- The Trust has included an estimate of £12.4m of capital requirements in its 2018/19 operating plan. The Trust has submitted a Strategic Outline Business Case (SOC) which is considering a number of site redevelopment options. The Trust is awaiting approval to progress to an Outline Business Case (OBC).

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

The Board of Directors has carefully considered the principle of 'going concern' and recognises 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, interim financial support has continued to be received as planned in the early part of 2018/19 and the Board of Directors concludes the Trust has a reasonable expectation that the Trust will continue to have access to adequate cash financing to meet its liabilities and continue to provide the planned range of clinical services in the foreseeable future. On that basis and for the reasons outlined above the Board of Directors considers it is appropriate to prepare the 2017/18 Accounts on a going concern basis and the financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

1.2 Critical judgements in applying accounting policies

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

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

- Adoption of the going concern basis (see note 1.1.2)

- Classification of leases as finance or operating leases. Leases have been reviewed to determine if they are classified as operating or finance leases in line with IAS17. Critical judgements include whether the ownership transfers at the end of the level term, the level of risk transfer and whether the lease term is for a major part of the economic life of the asset and whether the present value of the minimum lease payment is substantially all of the fair value of the asset.

Department of Health guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

The MEA valuation approach has been adopted for the first time in 2017/18 by the Trust. For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for the Princess Alexandra Hospital would be a multi storey building, which would occupy less land.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

The MEA valuations used by the Trust have been provided to the Trust by the Valuation Office Agency.

The Trust has used component lives based upon contractual information provided by the Valuation Office Agency to depreciate buildings and dwellings on a component basis (see Note 1.7.5 re Useful economic lives of property, plant and equipment).

1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions
Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date where the liability meets the recognition criteria of IAS37. These are based on judgements and estimates of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

Public liability claims are based on information received from the NHS Resolution (NHSR, previously NHS Litigation Authority) which handles claims on behalf of the Trust. For cases not yet concluded, provision, or contingent liability is made according to NHSR assessment of expected outcomes.

Pensions provisions are based on information received from NHS Pension Agency (previously NHS Business Service Authority).

Other provisions for legal and constructive obligations (including employment) are made by management informed by professional opinion. Provisions are made where past events are known and settlement by the Trust is probable and a reliable estimate can be made. As actual settlement is not known at the reporting date provisions are calculated on the best information available on likely settlement at the date the Accounts are approved. Note 26 provides more detail on provisions.

Accruals
At the end of each accounting period management review expenditure items that are outstanding and estimate the amount to be accrued in financial statements. Accruals are generally based on estimates and judgements of historical trends and outcomes. Any variation in prior periods has not been material to the Accounts.

Note 1.3 Charitable funds
Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. IAS 1 states that specific disclosure requirements as set out in individual standards or interpretations need not be satisfied if the information is not material, and on that basis the Trust has not consolidated its Charitable Funds.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme. The scheme is designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it is receives notification from the Department of Work and Pensions Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision of 22.84% for unsuccessful compensation claims and doubtful debts.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 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 Trust's policy prohibits the carry forward of annual leave and therefore no costs are recognised in the financial statements.

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. There, the schemes are accounted for as though they are defined contribution schemes.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

1.7.1 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 economic lives.

1.7.2 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. An item of property, plant and equipment 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts 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 basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Property, plant and equipment which have been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

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.

1.7.3 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 i.e.
- management are 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 dropped or significant changes made to it.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.4 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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7.5 Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Minimum Life Years	Maximum Life Years
Buildings and dwellings	0	29
Plant & machinery	2	15
Transport equipment	0	7
Information technology	0	5
Furniture & fittings	0	8
Development expenditure	0	8

Finance leased assets (including land) are depreciated over the shorter of the useful economic 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.

1.8 Intangible assets

1.8.1 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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

1.8.2 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

1.8.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Minimum Life Years	Maximum Life Years
Intangible assets - internally generated		
Information technology	0	5
Development expenditure	0	8
Websites	0	5
Intangible assets - purchased		
Software	0	5
Licences & trademarks	0	5
Patents	0	5
Other	0	5
Goodwill	0	5

Note 1.9 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.10 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 three 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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)
The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.12 Financial instruments and financial liabilities

1.12.1 Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, i.e, when receipt or delivery of the goods or services is made.

1.12.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.12.3 Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and

Financial liabilities are classified as fair value through income and expenditure or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

Note 1.13 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.

Note 1.13.1 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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

The annual rental 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.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The Trust as Lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 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 as below :

Early Retirement - Positive 0.1% (previously positive 0.24%)

All other provisions are subject to three discount rates according to expected timing of cashflows from the Statement of Financial Position date :

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Rate	*Term*	*Real rate*
Short Term	0 and up to, and including 5 years	Minus 2.42% (previously minus 2.70%)
Medium Term	5 and up to, and including 10 years	Minus 1.85% (previously minus 1.95%)
Long Term	exceeding 10 years	Minus 1.56% (previously minus 0.80%)

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 27 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as :

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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 (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.

Note 1.17 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.19 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* .

Note 1.20 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.

Note 1.21 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or
The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

It is not expected that implementation of these standards will materially impact on the accounts of the Trust

Note 2. Operating Segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across locations, since all policies, procedures and governance arrangements are Trust wide. As a Trust, all services are subject to the same regulatory environment and standards set out by our external performance managers. Accordingly the Trust operates one segment.

Note 3. Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000's	2016/17 £000's
Acute services		
Elective income	27,106	31,041
Non elective income	71,550	62,246
First outpatient income	16,327	16,050
Follow up outpatient income	14,273	16,238
A & E income	14,253	12,630
High cost drugs (pass-through costs)	14,134	14,174
Other NHS clinical income	38,006	33,709
Private patient income	296	335
Other clinical income	712	633
Total income from activities	**196,657**	**187,056**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000's	2016/17 £000's
NHS England	21,890	15,214
Clinical commissioning groups	170,974	167,815
Other NHS providers	2,534	2,002
NHS other	100	718
Local authorities	151	339
Non-NHS: private patients	296	335
Non-NHS: overseas patients (chargeable to patient)	149	12
NHS injury scheme	563	566
Non NHS: other	0	55
Total income from activities	**196,657**	**187,056**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000's	2016/17 £000's
Income recognised this year	149	12
Cash payments received in-year	38	46
Amounts added to provision for impairment of receivables	109	17
Amounts written off in-year	3	22

Note 4. Other operating income

	2017/18 £000's	2016/17 £000 's
Research and development	796	651
Education and training	6,071	5,766
Receipt of capital grants and donations	19	5
Non-patient care services to other bodies	3,451	3,535
Sustainability and transformation fund income	3,229	9,998
Rental revenue from operating leases	155	132
Other income [1]	2,853	2,599
Total other operating income	**16,574**	**22,686**

[1] Other income includes catering and car parking receipts.

Note 5. Operating expenses

	2017/18 £000's	2016/17 £000's
Purchase of healthcare from NHS and DHSC bodies	3,575	3,559
Purchase of healthcare from non-NHS and non-DHSC bodies	1,728	5,680
Staff and executive directors costs	158,414	149,977
Remuneration of non-executive directors	76	55
Supplies and services - clinical (excluding drugs costs)	16,813	18,256
Supplies and services - general	3,223	3,092
Drug costs	19,433	17,500
Inventories written down	0	147
Consultancy and professional services	2,158	2,139
Establishment	1,462	1,509
Premises	8,357	8,278
Transport (including patient travel)	707	401
Depreciation on property, plant and equipment	6,585	6,809
Amortisation on intangible assets	1,809	1,777
Net impairments	3,175	252
Increase/(decrease) in provision for impairment of receivables	400	(172)
Change in provisions discount rates	1	11
Audit fees payable to the external auditor		
audit services- statutory audit	73	64
other auditor remuneration (external auditor only)	10	11
Internal audit costs	82	99
Clinical negligence	11,884	10,804
Legal fees	167	272
Insurance	118	125
Education and training	803	509
Rentals under operating leases	1,663	1,313
Early retirements	0	0
Redundancy	0	0
Car parking & security	375	394
Hospitality	1	6
Losses, ex gratia & special payments	77	187
Other services	261	253
Other	43	90
Total	**243,473**	**233,397**

Prior year comparators have been restated in accordance with the revised disclosure details issued by NHS Improvement (NHSI).

Note 6. Other auditor remuneration

	2017/18 £000's	2016/17 £000's
Other auditor remuneration paid to the external auditor		
Other assurance services	10	11
Total	**10**	**11**

Note 6.1 Limitation on auditor's liability

There is a £5m professional indemnity placed on external audit work.

Note 7. Impairment of assets

	2017/18 £000's	2016/17 £000's
Net impairments charged to operating surplus / deficit		
Unforeseen obsolescence	320	120
Changes in market price	2,855	132
Total net impairments charged to operating deficit	**3,175**	**252**

Note 8. Employee benefits

Note 8.1 Employee benefits

	2017/18 Total £000 's	2016/17 Total £000 's
Salaries and wages	109,608	103,773
Social security costs	10,907	10,035
Apprenticeship levy	490	0
Employer's contributions to NHS pensions	12,856	12,082
Termination benefits	0	13
Temporary staff (including agency)	26,024	25,360
Total staff costs	**159,885**	**151,263**
Of which		
Costs capitalised as part of assets	1,471	1,286

Note 8.2 Retirements due to ill-health

During 2017/18 there was one early retirement from the trust agreed on the grounds of ill-health (three in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £113k (£86k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Pension Agency (previously NHS Business Services Authority).

Note 8.3

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9. Operating leases

Note 9.1 The Trust as Lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

	2017/18 £000's	2016/17 £000's
Operating lease revenue		
Minimum lease receipts	155	132
Total	**155**	**132**

	31 March 2018 £000's	31 March 2017 £000's
Future minimum lease receipts due:		
- not later than one year;	53	132
- later than one year and not later than five years;	53	527
- later than five years.	0	791
Total	**106**	**1,450**

Note 9.2 The Trust as Lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

	2017/18 £000's	2016/17 £000's
Operating lease expense		
Minimum lease payments	1,663	1,313
Total	**1,663**	**1,313**

	31 March 2018 £000's	31 March 2017 £000's
Future minimum lease payments due:		
- not later than one year;	1,275	861
- later than one year and not later than five years;	4,132	2,508
- later than five years.	4,956	2,123
Total	**10,363**	**5,492**

Note 10. Finance income

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

	2017/18 £000's	2016/17 £000's
Interest on bank accounts	31	24
Other finance income	0	137
Total	**31**	**161**

Note 11. Finance expenditure

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

	2017/18 £000's	2016/17 £000's
Interest expense:		
Loans from the Department of Health and Social Care	1,220	1,130
Finance leases	1	0
Interest on late payment of commercial debt	5	0
Total interest expense	**1,226**	**1,130**
Unwinding of discount on provisions	2	(1)
Other finance costs	6	0
Total finance costs	**1,234**	**1,129**

Note 12. The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18 £000's	2016/17 £000's
Amounts included within interest payable arising from claims made under this legislation	**5**	**0**

Note 13. Other gains

	2017/18 £000's	2016/17 £000's
Gains on disposal of assets	8	0
Total gains on disposal of assets	**8**	**0**

Note 14. Intangible non-current assets

Note 14.1 Intangible non-current assets - current year

2017/18	IT - in house & third party software	Development expenditure	Total
	£000's	£000's	**£000's**
Valuation / gross cost at 1 April 2017 - brought forward	43	14,389	**14,432**
Additions	5	205	**210**
Gross cost at 31 March 2018	**48**	**14,594**	**14,642**
Amortisation at 1 April 2017 - brought forward	27	2,228	**2,255**
Provided during the year	5	1,804	**1,809**
Amortisation at 31 March 2018	**32**	**4,032**	**4,064**
Net book value at 31 March 2018	16	10,562	**10,578**
Net book value at 1 April 2017	16	12,161	**12,177**

Note 14.2 Intangible non-current assets - prior year

2016/17	IT - in house & third party software	Development expenditure	Total
	£000's	**£000's**	**£000's**
Valuation / gross cost at 1 April 2016 - as previously stated	43	14,084	**14,127**
Additions	0	305	**305**
Valuation / gross cost at 31 March 2017	**43**	**14,389**	**14,432**
Amortisation at 1 April 2016 - as previously	18	460	**478**
Provided during the year	9	1,768	**1,777**
Amortisation at 31 March 2017	**27**	**2,228**	**2,255**
Net book value at 31 March 2017	16	12,161	**12,177**
Net book value at 1 April 2016	25	13,624	**13,649**

Note 15. Property, plant and equipment

Note 15.1 Property, plant and equipment - current year

2017/18	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Valuation/gross cost at 1 April 2017 - brought forward	**18,575**	**100,048**	**1,033**	**27,699**	**190**	**18,702**	**1,435**	**167,682**
Additions	0	6,040	300	1,863	0	2,679	25	**10,907**
Impairments	(2,855)	0	0	(23)	0	(297)	0	**(3,175)**
Revaluations	(7,570)	(29,421)	0	0	0	0	0	**(36,991)**
Reclassifications	0	0	(892)	0	0	892	0	**0**
Disposals / de-recognition	0	0	0	(1,816)	0	(5,053)	(150)	**(7,019)**
Valuation/gross cost at 31 March 2018	**8,150**	**76,667**	**441**	**27,723**	**190**	**16,923**	**1,310**	**131,404**
Accumulated depreciation at 1 April 2017 - brought forward	0	0	0	**18,447**	**161**	**11,021**	**1,385**	**31,014**
Provided during the year	0	2,430	0	2,337	5	1,803	10	**6,585**
Revaluations	0	(2,430)	0	0	0	0	0	**(2,430)**
Disposals / derecognition	0	0	0	(1,814)	0	(5,053)	(150)	**(7,017)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**18,970**	**166**	**7,771**	**1,245**	**28,152**
Net book value at 31 March 2018	**8,150**	**76,667**	**441**	**8,753**	**24**	**9,152**	**65**	**103,252**
Net book value at 1 April 2017	**18,575**	**100,048**	**1,033**	**9,252**	**29**	**7,681**	**50**	**136,668**

Note 15.2 Property, plant and equipment - prior year

2016/17	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Valuation / gross cost at 1 April 2016	**15,568**	**96,924**	**110**	**25,186**	**170**	**18,808**	**1,488**	**158,254**
Additions	0	3,590	1,038	3,177	20	2,373	0	**10,198**
Impairments	0	(132)	0	(4)	0	(116)	0	**(252)**
Revaluations	3,007	(449)	0	0	0	0	0	**2,558**
Reclassifications	0	115	(115)	0	0	0	0	0
Disposals / de-recognition	0	0	0	(660)	0	(2,363)	(53)	**(3,076)**
Valuation/gross cost at 31 March 2017	**18,575**	**100,048**	**1,033**	**27,699**	**190**	**18,702**	**1,435**	**167,682**
Accumulated depreciation at 1 April 2016	**0**	**0**	**0**	**16,968**	**158**	**11,787**	**1,425**	**30,338**
Provided during the year	0	3,057	0	2,139	3	1,597	13	**6,809**
Revaluations	0	(3,057)	0	0	0	0	0	**(3,057)**
Disposals/ derecognition	0	0	0	(660)	0	(2,363)	(53)	**(3,076)**
Accumulated depreciation at 31 March 2017	**0**	**0**	**0**	**18,447**	**161**	**11,021**	**1,385**	**31,014**
Net book value at 31 March 2017	**18,575**	**100,048**	**1,033**	**9,252**	**29**	**7,681**	**50**	**136,668**
Net book value at 1 April 2016	**15,568**	**96,924**	**110**	**8,218**	**12**	**7,021**	**63**	**127,916**

Note 15.3 Property, plant and equipment financing - current year

2017/18	Land £000's	Buildings excl. dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Net book value at 31 March 2018								
Owned - purchased	8,150	76,667	441	8,645	24	9,152	65	**103,144**
Finance leased	0	0	0	35	0	0	0	**35**
Owned - donated	0	0	0	73	0	0	0	**73**
NBV total at 31 March 2018	**8,150**	**76,667**	**441**	**8,753**	**24**	**9,152**	**65**	**103,252**

Note 15.4 Property, plant and equipment financing - prior year

2016/17	Land £000's	Buildings excl. dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Net book value at 31 March 2017								
Owned - purchased	18,575	100,048	1,033	9,028	29	7,681	50	**136,444**
Finance leased	0	0	0	119	0	0	0	**119**
Owned - donated	0	0	0	105	0	0	0	**105**
NBV total at 31 March 2017	**18,575**	**100,048**	**1,033**	**9,252**	**29**	**7,681**	**50**	**136,668**

Note 15.4 Donations of property, plant and equipment

The Trust has received capital asset donations from The PAH NHS Trust Charitable Fund (Registered Charity No 10547745) totalled £19k, (2016/17 £5k).

Note 15.5 Revaluations of property, plant and equipment

The Trust has undertaken a revaluation of its Land and Buildings as at 31 March 2018. This work was carried out by Giles Awford BSc (Hons) MRICS, Principal Surveyor,District Valuer Services (DVS), the specialist property arm of the Valuation Office Agency (VOA)

The valuation has been undertaken in accordance with International Finance Reporting Standards (IFRS) as interpreted and applied by the HM Treasury Financial Reporting Manual (FREM) compliant DH Group Manual for Accounts (DH GAM).

Department of Health guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

The MEA valuation approach has been adopted for the first time in 2017/18 by the Trust. This has resulted in an overall reduction in the Trust PPE of £34,561k through the revaluation reserve. In addition, the range of minimum and maximum useful lives applied to "Building and Dwellings" has been revised to "0 to 29 years" (Non-MEA in 2016/17 "0 to 63" years).

Note 16. Inventories

	31 March 2018 £000's	31 March 2017 £000's
Drugs	1,140	1,115
Consumables	2,901	2,866
Energy	85	111
Other	35	22
Total inventories	**4,161**	**4,114**

Inventories recognised in expenses for the year were £28,801k (2016/17: £19,061k). There were no write-down of inventories recognised as expenses for 2017/18 (2016/17: £147k).

Note 17. Trade receivables and other receivables

	Current		Non-current	
	31 March 2018 £000's	31 March 2017 £000's	31 March 2018 £000's	31 March 2017 £000's
Current				
Trade receivables	5,188	3,961	0	0
Accrued income	5,539	9,765	763	659
Provision for impaired receivables	(1,058)	(925)	0	0
Prepayments	1,432	1,331	0	0
Interest receivable	4	3	0	0
PDC dividend receivable	863	149	0	0
VAT receivable	1,566	821	0	0
Other receivables	160	0	0	0
Total trade & other receivables	**13,694**	**15,105**	**763**	**659**

Of which receivables from NHS and DHSC group bodies:		
Current	9,189	11,447
Non-current	0	0

Prior year comparators have been restated in accordance with the revised disclosure details issued by NHS Improvement (NHSI).

Note 18. Provision for impairment of receivables

	2017/18 £000's	2016/17 £000's
At 1 April as previously stated	**925**	**1,625**
Increase in provision	491	(802)
Amounts utilised	(267)	(528)
Unused amounts reversed	(91)	630
At 31 March	**1,058**	**925**

Note 19. Credit quality of financial assets

	Trade and other receivables	
Ageing of impaired financial assets	**31 March 2018 £000's**	**31 March 2017 £000's**
0 to 30 days	3	9
30 to 60 Days	37	17
60 to 90 days	18	16
90 to 180 days	183	357
Over 180 days	2,038	1,820
Total	**2,279**	**2,219**
Ageing of non-impaired financial assets past their due date		
0 to 30 days	1,463	460
30 to 60 Days	889	374
60 to 90 days	260	445
90 to 180 days	1,180	1,047
Over 180 days	729	1,074
Total	**4,521**	**3,400**

Note 20. 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.

	2017/18 £000's	**2016/17 £000's**
At 1 April	**3,416**	**1,524**
Net change in year	(2,154)	1,892
At 31 March	**1,262**	3,416
Broken down into:		
Cash at commercial banks and in hand	47	34
Cash with the Government Banking Service	1,215	3,382
Total cash and cash equivalents as in SoFP	**1,262**	3,416

Note 21. Third party assets held by the Trust

The Trust held £13k of cash and cash equivalents which relate to monies held by Trust on behalf of patients or other parties (nil in 2016/17). This has been excluded from the cash and cash equivalents figure reported in the Accounts (note 20).

Note 22. Trade and other payables

	Current		Non-current	
	31 March 2018 £000's	31 March 2017 £000's	31 March 2018 £000's	31 March 2017 £000's
Trade payables	**587**	1,244	**0**	0
Capital payables	**5,032**	4,966	**0**	0
Accruals	**19,143**	19,165	**0**	0
Social security costs	**1,594**	1,467	**0**	0
Other taxes payable	**401**	134	**0**	0
Accrued interest on loans	**268**	150	**0**	0
Other payables	**88**	38	**0**	0
Total trade and other payables	**27,113**	**27,164**	**0**	0
Of which payables from NHS and DHSC group bodies:				
Current	7,455	4,319		
Non-current	0	0		

There are no early retirements in NHS payables above (nil in 2016/17)

Prior year comparators have been restated in accordance with the revised disclosure details issued by NHS Improvement (NHSI).

Note 23. Other liabilities

	Current		Non-current	
	31 March 2018 £000's	31 March 2017 £000's	31 March 2018 £000's	31 March 2017 £000's
Current				
Deferred income	162	229	**0**	0
Total other current liabilities	**162**	**229**	**0**	0

Note 24. Borrowings

	Current		Non-current	
	31 March 2018 £000's	31 March 2017 £000's	31 March 2018 £000's	31 March 2017 £000's
Current				
Loans from the Department of Health and Social Care	26,737	0	67,945	69,019
Other loans	0	95	0	0
Obligations under finance leases	18	82	0	24
Total current borrowings	**26,755**	**177**	**67,945**	**69,043**

Note 25. Finance lease

	31 March 2018 £000's	31 March 2017 £000's
Gross lease liabilities	**18**	**107**
of which liabilities are due:		
not later than one year;	18	83
later than one year and not later than five years;	0	24
Finance charges allocated to future periods	0	(1)
Net lease liabilities	**18**	**106**
of which payable:		
not later than one year;	18	82
later than one year and not later than five years;	0	24

Note 26. Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000's	£000's	£000's	£000's
At 1 April 2017	**912**	**267**	**332**	**1,511**
Change in the discount rate	1	0	0	**1**
Arising during the year	36	61	727	**824**
Utilised during the year	(73)	(62)	(184)	**(319)**
Reversed unused	0	(178)	(147)	**(325)**
Unwinding of discount	2	0	0	**2**
At 31 March 2018	**878**	**88**	**728**	**1,694**
Expected timing of cash				
not later than one year;	72	88	728	**888**
later than one year and not later than five years;	292	0	0	**292**
later than five years.	514	0	0	**514**
Total	**878**	**88**	**728**	**1,694**

Note 27. Clinical negligence liabilities

At 31 March 2018, £105,384k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2017: £76,021k).

Note 28. Contingent assets and liabilities

	31 March 2018 £000's	31 March 2017 £000's
Value of contingent liabilities		
NHS Resolution legal claims	(28)	(22)
Employment tribunal and other employee related litigation	(46)	0
Gross value of contingent liabilities	**(74)**	**(22)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(74)**	**(22)**
Net value of contingent assets	0	0

Note 29. Contractual capital commitments

	31 March 2018 £000's	31 March 2017 £000's
Property, plant and equipment	681	670
Intangible assets	0	8
Total	**681**	**678**

Note 30. Financial instruments

30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking activities. Because of the continuing service provider relationship that the Trust has with Commissioners and the way Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which financial reporting standards mainly apply.

The Trust's cash management operations are undertaken by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust can borrow from the government for capital expenditure, subject to approval from NHS Improvement. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest charges at the national loans fund rate, fixed for the life of the loan.

Note 30. Financial instruments

The Trust can also borrow from the government for revenue support funding, subject to approval form NHS Improvement. Interest rates are confirmed by the lender (Department of Health) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

A majority of the Trusts revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Liquidity risk

The Trusts operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust mainly funds its capital from internally generated funds. The Trust is therefore not to significant liquidity risks.

30.2 Carrying values of financial assets

	Loans and receivables £000's	Total book value £000's
2018		
Trade and other receivables excluding non financial assets	10,596	**10,596**
Cash and cash equivalents at bank and in hand	1,262	**1,262**
Total at 31 March 2018	**11,858**	**11,858**

	Loans and receivables £000's	Available-for-sale £000's	Total book value £000's
2017			
Trade and other receivables excluding non financial assets	13,463	0	**13,463**
Other investments / financial assets	0	1,679	**1,679**
Cash and cash equivalents at bank and in hand	3,416	0	**3,416**
Total at 31 March 2017	**16,879**	**1,679**	**18,558**

	Other financial liabilities £000's	Total book value £000's
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance leases	94,682	**94,682**
Obligations under finance leases	18	**18**
Trade and other payables excluding non financial liabilities	25,118	**25,118**
Total at 31 March 2018	**119,818**	**119,818**

30.3 Carrying value of financial liabilities

	Other financial £000's	Total book value £000's
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	69,114	**69,114**
Obligations under finance leases	106	**106**
Trade and other payables excluding non financial liabilities	25,563	**25,563**
Total at 31 March 2017	**94,783**	**94,783**

The carrying value of financial liabilities is at book value (carrying value) as it is considered that this is a reasonable approximation of fair value

Note 31. Maturity of financial liabilities

	31 March 2018 £000's	31 March 2017 £000's
In one year or less	51,873	25,724
In more than one year but not more than two years	30,836	26,777
In more than two years but not more than five years	37,109	42,282
Total	**119,818**	**94,783**

Note 32. Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000's	Number	£000's
Losses				
Cash losses	6	1	6	0
Bad debts and claims abandoned	8	16	0	0
Stores losses and damage to property	10	58	8	127
Total losses	**24**	**75**	14	127
Special payments				
Compensation under court order or legally binding arbitration award	5	15	17	56
Ex-gratia payments	11	3	9	3
Total special payments	**16**	**18**	26	59
Total	**40**	**93**	40	186

Note 33. Related parties

All Board members and most senior managers with key controlling influence in the Trust have been requested to confirm any material related party transactions, including any transactions of close family members. The Trust also maintains a hospitality and declaration of interest register.

Name, Trust role, Related Party	Expenditure with Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000's	£000's	£000's	£000's
Lance McCarthy, Trust Chief Executive - Anglia Ruskin Health Partnership	50	0	0	0
James Anderson, Trust Non-executive director - IQVIA	42	0	11	0
Steve Clarke, Trust Non-executive director - Health Education England	4	5,968	3	73
John Hogan, Trust Non-executive director, Barts Health NHS Trust	292	453	167	93
Nancy Fontaine, Trust Chief Nurse, Anglia Ruskin University		33		2
Andrew Holden -Non Executive Director - Liaison	3,718	0	0	0

The DH is regarded as a related party. During the year the 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. For example :

- NHS West Essex
- NHS East and North Hertfordshire
- NHS England
- NHS Litigation Authority
- NHS Business Services Authority
- NHS Blood and Transplant
- NHS Property Services
- Health Education England
- NHS Professionals
- NHS Pensions Agency
- NHS Improvement

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HM Revenue and Customs

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board. The members of the Trust Board are also Trustees of the PAH NHS Trust Charitable Funds (Registered Charity No 10547745) The charity's objective is to provide support both generally and in certain areas of the Trusts activities. During the Year the Charity contributed £440k (unaudited) to the Trust (2016/17 £389k)

Note 34. Prior period adjustments

There have been no Prior Period adjustments within IAS8 (Accounting Policies, Changes in Accounting Estimates and Errors) that has required restatement of comparative information due to either a change in accounting policy or material prior period error.

Note 35. Events after the reporting date

The Trust has no adjusting events after the end of the reporting period. The Accounts were approved by the Board of Directors on 24 May 2018.

Note 36. Better Payment Practice code

	2017/18 Number	2017/18 £000's	2016/17 Number	2016/17 £000's
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	51,727	84,375	48,282	85,479
Total non-NHS trade invoices paid within target	20,881	41,425	16,043	38,525
Percentage of non-NHS trade invoices paid within target	**40.37%**	**49.10%**	33.23%	45.07%
NHS Payables				
Total NHS trade invoices paid in the year	2,267	20,740	2,130	16,654
Total NHS trade invoices paid within target	1,086	10,594	486	5,710
Percentage of NHS trade invoices paid within target	**47.90%**	**51.08%**	22.82%	34.29%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 37. External financing

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

	2017/18 £000's	2016/17 £000's
External financing limit (EFL)	30,203	30,794
Cash flow financing	29,873	30,510
Underspend against EFL	**330**	284

Note 38. Capital Resource Limit

	2017/18 £000's	2016/17 £000's
Gross capital expenditure	11,117	10,507
Less: Disposals	(2)	0
Less: Donated and granted capital additions	(19)	(5)
Charge against Capital Resource Limit	**11,096**	10,502
Capital Resource Limit	11,642	11,500
Underspend against CRL	**546**	998

Note 39. Breakeven duty financial performance - current year

	2017/18 £000's
Adjusted financial performance deficit	**(28,435)**

A Trust's reported NHS financial performance position is derived from its retained surplus / (deficit), but adjusted for the following:
a) Impairments to non-current assets.
b) Incremental revenue expenditure relating to the change in the treatment of donated assets and government granted assets following the accounting policy change outlined in the Treasury FREM for 2011/12.

39.1 Breakeven duty rolling assessment

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's	2013/14 £000's	2014/15 £000's	2015/16 £000's	2016/17 £000's	2017/18 £000's
Breakeven duty in-year financial performance	3,222	511	415	461	122	(16,403)	(21,998)	(37,714)	(26,715)	(28,435)
Breakeven duty cumulative position	1,536	2,047	2,462	2,923	3,045	(13,358)	(35,356)	(73,070)	(99,785)	(128,220)
Operating income	161,295	172,171	179,388	180,790	184,568	177,739	190,478	196,124	209,742	213,231
Cumulative breakeven position as a percentage of operating income	**0.95%**	**1.19%**	**1.37%**	**1.62%**	**1.65%**	**-7.52%**	**-18.56%**	**-37.26%**	**-47.58%**	**-60.13%**

The amounts in the above tables in respect of 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.