NHS
The Princess Alexandra Hospital
NHS Trust

# Annual Report 2018-19


Your future | Our hospital



respectful | caring | responsible | committed

## Contents

# The Performance Report 2018-19

## 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 Chair and the Chief executive officer

### Foreword

This year, 2018-19, started with the fantastic news that The Princess Alexandra Hospital NHS Trust (PAHT) was approved to come out of quality special measures. The trust's Care Quality Commission (CQC) rating improved from inadequate to requires improvement with good ratings in the caring, effective and well-led domains. In March this year (2019) we again welcomed colleagues from the CQC for an inspection of six of our core clinical services. Many of the inspectors for these assessment visits had been part of the team who visited the year before and we were delighted to hear their positive comments about there being a noticeable improvement in the culture of the organisation.

This sense of change is a real reflection of the enormous effort, commitment and dedication shown by all of our people, both our frontline teams and also all those who work behind the scenes to support the clinical teams caring for patients. We are very proud of them and the difference they make to each other and our patients. The results of the recent inspection and our rating will be announced by the CQC in the summer (2019).

A sense of pride and commitment to patient care was also reflected in the results of our annual NHS Staff Survey. Comments from our people placed us in the top 25% of acute trusts across the country. It is well documented that when staff feel positive about their workplace, colleagues and roles they provide better care for patients. The survey also provides us with a valuable insight into the areas where we need to make further improvements and support our people to be able to deliver the very best care and experience for our patients. Taking care of our people is equally as important and this year saw a number of health and wellbeing initiatives implemented including the introduction of Health Assured, a new employee assistance programme that provides help and support for a large range of every day stresses.

In September, we held our second staff Event in a Tent, which brought together a range of events for our people including our annual Amazing People Awards that were a fantastic opportunity to celebrate the passion and commitment of individuals and teams across the trust. During the event we also launched our new staff App My PAHT, which has trust news and information available to access wherever we are and celebrated people who have worked at PAHT for 25 years.

We have continued to offer a variety of work experience opportunities and to grow the number and range of apprenticeships available to both existing staff and people looking for a new opportunity; providing local jobs for local people and future employees.

This year, the NHS has seen an increased demand on services across the country that is very much reflected in the numbers of patients we have seen coming to our hospitals. Despite a marked increase in the number of people attending our emergency department (ED) we have made improvements in meeting the national ED standards. We have also seen further improvements in our cancer, referral to treatment (RTT) and COPD (chronic obstructive pulmonary disease) standards. Our thanks go to all the teams involved from the front door to our wards, clinics and teams supporting the care we provide to our patients.

More of our teams are putting our Quality First improvement methodology and approach into action and introducing changes and efficiencies across the organisation directly benefitting our patients. We were delighted that this was recognised outside the trust when we were awarded, as a result of the whole organisational approach to quality improvement, the national Fab Change Champion Organisation Award for the second year running - a real measure of success for our people and improved care for our patients.

In 2018-19, we invested £11.9m in our places and clinical environments; improving them as places to work and to receive care. This has included a new ward for our orthopaedic surgery patients; a ward refurbishment programme; £2.2m for equipment and £2.1m on IT.

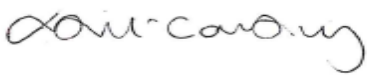
As a result of the hard work and commitment of our people we are pleased that at the end of 2018-19 we have delivered on both our cash and capital investment targets. We have fully spent our £12m capital fund and invested in infrastructure, equipment and IT. Due to good financial management we have halved our financial deficit over the last three years and will continue this focus into 2019-20.

Looking to the future, we are delighted that a preferred way forward for a new hospital was unanimously approved by our trust board in March (2019). We are awaiting approval to proceed and can then begin a public consultation with patients, staff and local people. Our ambition for a new hospital is just one element of our plans for the future and 2019-20 will see us continue to develop and improve all that we do. Underpinning this we will be working together with our people to build a PAHT 2030 strategy outlining a clear direction for them, the trust and our patients.

We would like to thank Alan Burns, our previous chair who completed his term of office and stepped down from the role of chair in November 2018, for his support and commitment to PAHT.

We are immensely proud of everything that PAHT has been able to achieve this year and we know that each achievement and success is only made possible by the hard work, commitment and compassion of all of our clinicians, people and volunteers. We thank them all; for everything that they do each and every day.

**Steve Clarke**
Chair



**Lance McCarthy**
Chief executive officer

## Celebrating our amazing staff

### The purpose and activities of the organisation

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

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

The trust owns the main hospital site in Harlow, and also operates outpatient and diagnostic services out of the Herts and Essex Hospital, Bishops Stortford and St Margaret's Hospital, Epping. The operation of these facilities forms part of the longer term strategy of bringing 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):

| Directory of our services | | | |
|---|---|---|---|
| Ambulatory Care | Diabetic Medicine | Gynaecology | Surgical assessment unit |
| Audiology | Dietetics | High Dependency Unit | Pathology |
| Breast Screening | Early Pregnancy Unit | Critical care unit | Patient Appliances |
| Breast Surgery | Emergency Department | Interventional Radiology | Physiotherapy and Occupational Therapy |
| Cardiology | Endoscopy Services | Maternity | Pre Op Assessments |
| Chemotherapy | Endocrinology | Maxilla-Facial surgery | Radiology |
| Clinical Decision Unit | ENT | Medical Oncology | Respiratory Medicine |
| | Eye Unit | | |
| | 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 and Language Therapy |
| Community Midwifery | Genito-Urinary Medicine | Oral Surgery | Transfusion services |
| Colorectal services | Geriatric Medicine | Paediatrics | Trauma and Orthopaedics |
| Day Surgery | Vascular Services | Paediatric Diabetic Medicine | Urology and Oak unit |
| Dermatology | Gynaecology Ambulatory Service | Paediatric Emergency Department | CSSD<br><br>Operating Theatres |
| Pharmacy | Infection Prevention and Control | End of Life-Palliative Care | |

## 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.

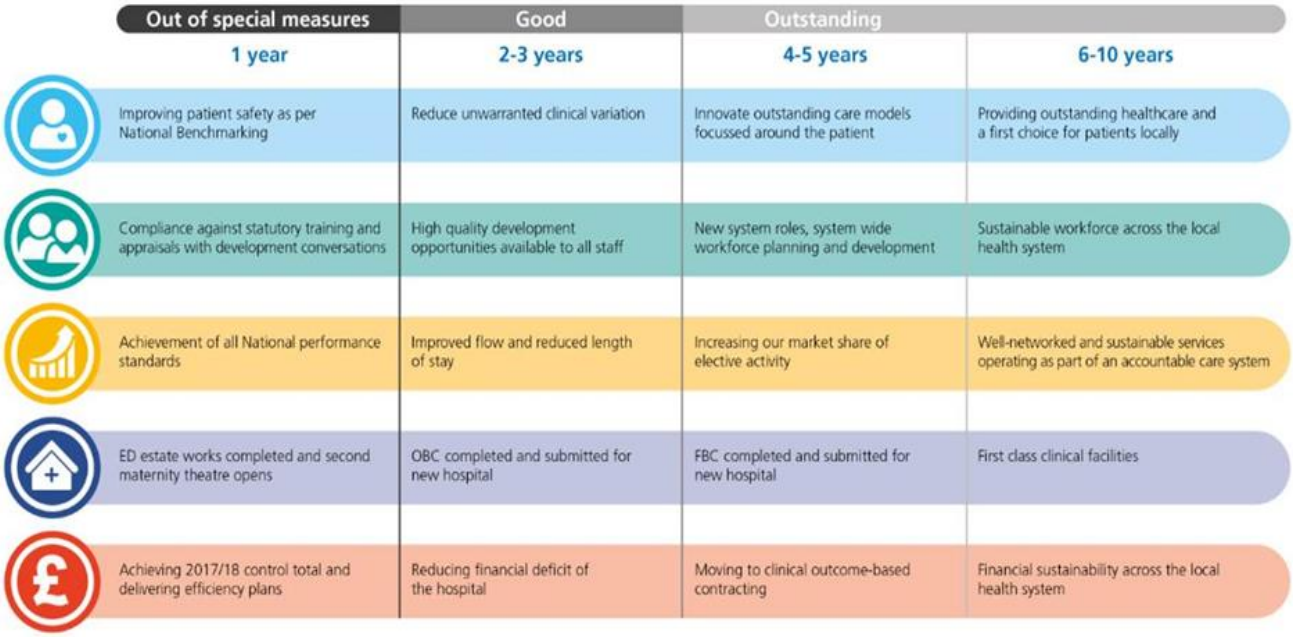
Underpinning the trust's ambition to achieve outstanding healthcare is the Five Ps. The trust Board set 5 strategic objectives for the 2018-19 year focussed on delivering the Five Ps.

| Five Ps | trust objectives |
|---|---|
|  | **Our patients**<br><br>Continue to improve the quality of care we provide **our patients**, improving our CQC rating. |
|  | **Our people**<br><br>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**<br><br>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**<br><br>Meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators. |
|  | **Our pounds**<br><br>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.



| | Out of special measures | Good | Outstanding | |
|---|---|---|---|---|
| | 1 year | 2-3 years | 4-5 years | 6-10 years |
| | Improving patient safety as per National Benchmarking | Reduce unwarranted clinical variation | Innovate outstanding care models focussed around the patient | Providing outstanding healthcare and a first choice for patients locally |
| | Compliance against statutory training and appraisals with development conversations | High quality development opportunities available to all staff | New system roles, system wide workforce planning and development | Sustainable workforce across the local health system |
| | Achievement of all National performance standards | Improved flow and reduced length of stay | Increasing our market share of elective activity | Well-networked and sustainable services operating as part of an accountable care system |
| | ED estate works completed and second maternity theatre opens | OBC completed and submitted for new hospital | FBC completed and submitted for new hospital | First class clinical facilities |
| | Achieving 2017/18 control total and delivering efficiency plans | Reducing financial deficit of the hospital | Moving to clinical outcome-based contracting | Financial sustainability across the local health system |

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.

After feedback from NHS Improvement (NHSI) and a change to the business case process we are revising the Strategic Outline Case (SOC). We held an evaluation event on the 14 February 2019, to discuss and evaluate a long list of options, to identify the preferred way forward for our new hospital. Around 30 different options were considered at the event, with the preferred way forward being a new hospital build, on a greenfield site near the new Junction 7a on the M11. On the 7 March 2019 the trust Board approved this decision at a Public Board meeting.

As the trust proposes moving to a new site a public consultation must take place. Prior to public consultation the local Commissioners are developing, with the trusts assistance, a Pre-Consultation Business Case (PCBC). This presents the need for the new hospital from a wider healthcare perspective. The PCBC will be updated after the public consultation and used to confirm the decision for the new hospital location.

Once the public consultation is complete the trust can then finalise the SOC and begin the development of the Outline Business Case which requires the solution for the hospital to be fully developed prior to approval by NHSI.

The public consultation will be completed by the autumn of 2019 and the SOC submitted in early 2020 with NHSI approval by April of that year with the OBC being approved by the end of 2020.

The trust is part of the Hertfordshire and West Essex STP and during 2018-19 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 and 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 improving 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 is supporting the development of our business cases.

## 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 highest scoring risks on the BAF throughout 2018-19 were variation in clinical outcomes, nurse recruitment, 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:

| Five P | Highest scoring risks on Board Assurance Framework 2018-19 |
|---|---|
|  | **Outcomes**<br>Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality |
|  | **Nurse recruitment**<br>Inability to recruit to critical nursing roles. |
|  | **Estates and infrastructure**<br>Concerns about potential failure of the trust's Estate and Infrastructure and consequences for service delivery |
|  | **4 hour Emergency Department constitutional standard**<br>Failure to achieve ED standard |

## Going concern

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 2019-20 contract with all main Commissioners. This contracts support continued provision of services with no plans for disinvestment

- The trust has submitted a net deficit plan to NHS Improvement (NHSI) totalling £6.2m in 2019-20. The plan is Control Total compliant and includes £5.4m of Provider Sustainability Funding (PSF), £14.8m Financial Recovery Fund (FRF) and £0.6m of centrally funded Marginal Rate Emergency Threshold (MRET) funding. It is supported by the request to receive interim revenue support loans to the value of the gross forecast deficit before PSF and FRF

- The trust has included an estimate of £29.7m of capital requirements in its 2019-20 operating plan. This plan includes £7.5m from Wave 4 STP capital bids for additional capacity, £5m emergency capital, £3.8m STP Interoperability (ICT) bids and £3.3m to continue the progression of a Strategic Outline Business Case (SOC) for Hospital redevelopment

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 2019-20 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 2018-19 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.

## Performance analysis

### Financial performance

The trusts 2018-19 gross Control Total target deficit i.e. excluding Provider Sustainability Fund (PSF) set by NHSI was £28.5m. The trust's outturn was £28m, £0.5m better than plan. After inclusion of Provider Sustainability Funds (PSF) for delivery of the financial target the net financial deficit was £16.5m. This compares to a £28.4m deficit in 2017-18, an £11.9m improvement.

| Breakeven duty and financial performance | | |
|---|---|---|
| | | 2018-19 |
| | | £000's |
| | | |
| Gross control total target deficit (excluding PSF) | | (28,470) |
| | | |
| Gross financial performance deficit (excluding PSF) | | (27,964) |
| | | |
| Net financial performance deficit (including PSF) against breakeven duty | | (16,542) |

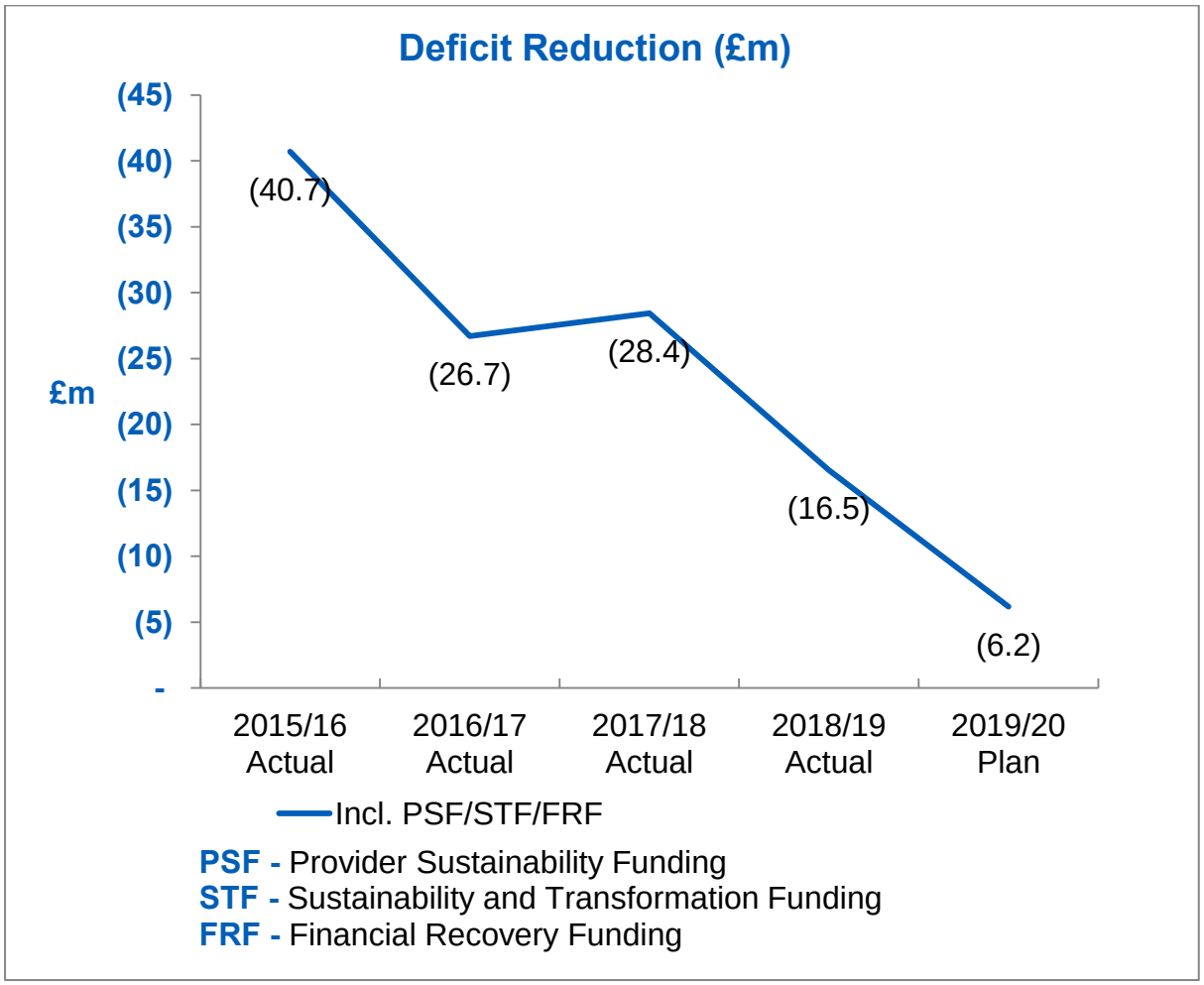
Key drivers of over-delivery against the control total include:

- Delivery of the £10.3m agency target set by NHSI, outturn £9.6m
- Delivery of the trust's annual CIP target of £10m, outturn £12.1m
- Continued cost containment, efficiency and transformational exercises
- Successful resolution to contractual matters and growth in the activity/income base from commissioner contracts
- Eligibility to earn additional provider sustainability funding from delivery of financial performance target

### Deficit reduction

| | 2015/16 Actuals £m | 2016/17 Actuals £m | 2017/18 Actuals £m | 2018/19 Actuals £m | 2019/20 Plan £m |
|---|---|---|---|---|---|
| **Income** | 193.2 | 209.9 | 213.3 | 236.8 | 252.8 |
| **Expenditure** | (233.9) | (236.6) | (241.7) | (253.3) | (259.0) |
| **Performance deficit (Including PSF/STF/FRF)** | **(40.7)** | **(26.7)** | **(28.4)** | **(16.5)** | **(6.2)** |

Since 2015-16 the trust has successfully improved its financial performance by £24.2m, more than halving its financial deficit during this time.




## NHS trust financial duties

The key financial results 2018-19:

- The trust delivered an adjusted retained deficit of £16.5m
- The trust delivered its Capital Investment Plans with an underspent against Capital Resource Limit of £0.2m, £12.1m target an outturn of £11.9m
- The trust made significant capital investments in infrastructure, estate including the purchase of a new modular ward, ICT and medical equipment, a new MRI and new Nuclear medicine scanner
- The trust underspent against its 2018-19 external financial limit by £0.2m
- The trust delivered its agency target of £10.3m with agency spend of £9.6m
- The trust received net revenue support loans of £29.3m to meet its operating costs

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 2018-19 financial year.

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 2018-19 has significantly improved compared to 2017-18 and the trust continues with plans to delivery against 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 processes. The trust will also continue to work closely with its lead commissioner and regulator to manage the cash position.

Performance is summarised as follows:

| | 2018/19 Number | 2018/19 £000's | 2017/18 Number | 2017/18 £000's |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total non-NHS trade invoices paid in the year | 51,665 | 67,947 | 51,727 | 84,375 |
| Total non-NHS trade invoices paid within target | 36,583 | 49,942 | 20,881 | 41,425 |
| Percentage of non-NHS trade invoices paid within target | 70.8% | 73.5% | 40.4% | 49.1% |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 2,553 | 42,033 | 2,267 | 20,740 |
| Total NHS trade invoices paid within target | 1,810 | 36,631 | 1,086 | 10,594 |
| Percentage of NHS trade invoices paid within target | 70.9% | 87.1% | 47.9% | 51.1% |

## Financial plan 2019-2020

The trust has agreed its Operating Plan 2019-20 targeting further improvement of its financial position with plans to reduce the net deficit to £6.2m, in line with the control target set by NHSI. The Trust's PSF and FRF eligibility, subject to delivery of performance criteria, is £20.2m. The plan has aligned income / activity expectations with commissioner contracts and expenditure budgets being set to deliver the baseline activity. Key assumptions which underpin the plan include:

- Delivery of CIP, transformation plans and associated efficiency improvements (£10m). These programmes being developed by reference to Carter, Model Hospital, GIRFT and other STP benchmarking opportunities
- Containing temporary staffing costs including delivery of the agency target of £10.3m
- Delivery of its activity plans and therefore recovery and capture of income.
- Meeting financial performance targets and thereby securing PSF/FRF.
- Managing local and national cost pressures
- Increasing the level of capital investment. The trust has included an estimate of £29.7m of capital requirements in its 2019-20 operating plan. This plan includes £7.5m from wave 4 STP capital bids for additional capacity, £5m emergency capital, £3.8m STP Interoperability (ICT) bids and £3.3m to continue the progression of a Strategic Outline Business Case (SOC) for hospital redevelopment

## Operational performance

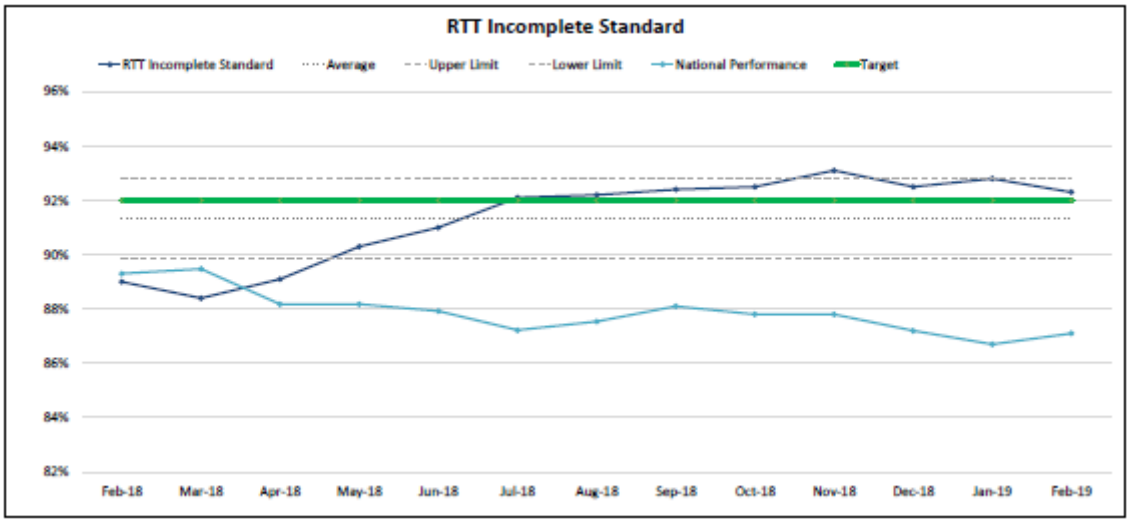
The trust's operational performance against national and local standards is monitored and reviewed at:

- Regular performance review meetings between members of the executive team and each health care group
- The Urgent Care Improvement Board;
- Senior Management Team meetings;
- The Performance and Finance Committee;
- Trust Board meetings.

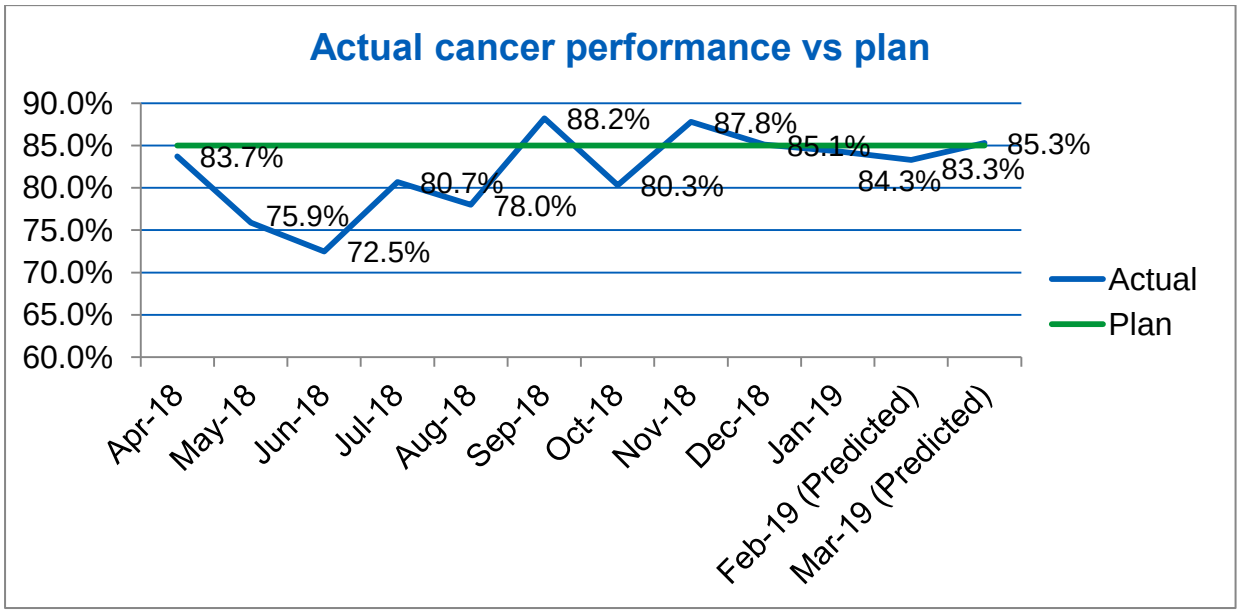
An Integrated Performance Report is presented to the Performance and Finance Committee and Trust Board meetings. Externally, the trust is held to account for its operational performance by NHS Improvement.

## Targets and national standards

The start of 2018-19 was challenging due to the national suspension of the elective operating programme from December 2017 impacting on significantly on the delivery of the Referral to Treatment Standards. The RTT incomplete standard was recovered from July 2018 and has been consistently delivered throughout the remainder of the year.



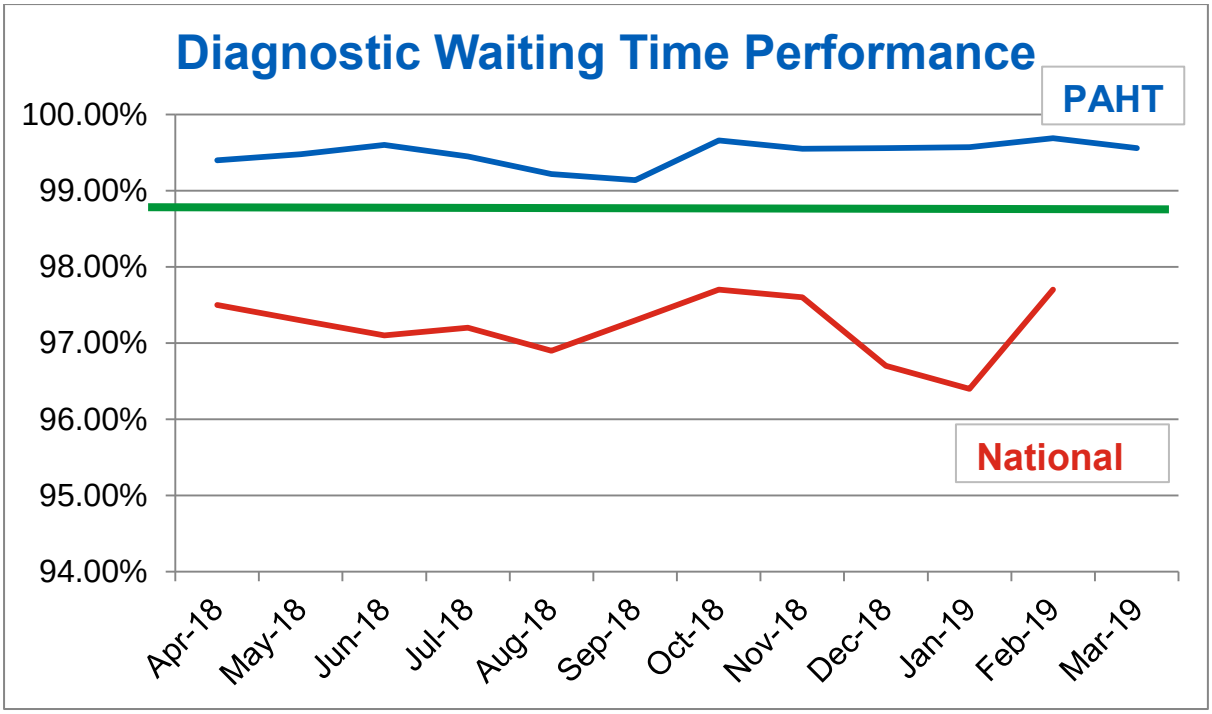

Due to workforce challenges in some of the tumour sites, delivery of the cancer standards has also been challenging. However an improved performance has been seen from November 2018 onwards.




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

## Diagnostic performance

The trust has achieved the standard for Diagnostic Waits every month for the last 4 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 2019-20.




## 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 was incremental improvement in the standard with sustained improvement in the use of assessment facilities to support emergency flow. External capital funding was successfully secured to aid in the refurbishment of the Emergency Department, Paediatric Emergency Department and Urgent Care Centre; as a result assessment areas were successfully realigned to support the management of non-elective patients through the hospital.

A new national Emergency Care Data Set (ECDS) was implemented in December 2017 which has captured 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 across the trust.

Through the West Essex Local Delivery Board, the trust and our commissioners agreed the extra capacity required to better support the non-elective demand across the healthcare system, as well as the process and timescales for reviewing and refreshing our escalation arrangements for managing fluctuations in this demand. As a result, additional 'discharge to assess' and rehabilitation capacity is being established.

In addition, the trust undertook the following internal actions to improve ED performance:

- Completed a comprehensive workforce review to ensure that the clinical workforce meets the emergency department activity, incorporating key

indicators such as staff to patient ratios and skill mix

- Relocation of the Frailty Assessment Unit adjacent to the Emergency Department to enable a more effective transfer of care for frail and elderly patients

- Implemented consultant seven day working across both acute inpatient wards to provide more consistent care for patients

- Developed an action plan with ECIST (Emergency Care Intensive Support Team) to improve our patient flow within the Emergency Department and Medical Assessment Unit

- Implemented primary care streaming to ensure patients receive the most appropriate treatment at the right time

Extensive programmes of work are in place to deliver a trajectory of continuing improvement on the A&E standard, which is monitored via the Urgent Care Improvement Board.

We have co-located social work and community teams with the hospital discharge team to improve discharge systems and processes. This has enabled medically fit patients to be discharged sooner resulting in 30% fewer bed days lost due to delayed discharges.

Working collaboratively with health and social care teams, we have developed a model of care that enables patients to be assessed in their home rather than in hospital.

To support these new models of care, we have an active rolling recruitment programme for nurses and all grades of staff and we are expanding the team within the Emergency Department and our Emergency Assessment Unit (EAU).

Despite the continued level of pressure on the Emergency Department, we have continued to strive to deliver the best possible experience to patients who attend our hospital as an emergency. During the first six months of 2018-19 a gradual increase in performance against the four hour standard can be demonstrated. Since November 2018 we have been unable to sustain this improvement, this has partly been caused by an 8% increase in attendances compared with the same period in 2017-18. However, with the benefit of strong clinical leadership and the dedicated teams described above the trust is planning to deliver the urgent care and ensure sustainable, quality and safe care for all our patients.

### Responding in an emergency

Throughout 2018-19 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 Consultant and Registrar training.

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. Our focus over the last year has been business continuity and cyber security. Along with internal engagement, our resilience team have worked to support a number of external events such as the regional safeguarding conference focusing on how we ensure the psychosocial safety of those responding to emergencies.

As an organisation, we recognise the benefits of multi-agency working, and continue to actively engage in the work of the Local Health Resilience Partnership and the Essex Resilience Forum, as well as the newly developed West Essex Resilience Group, with partners from local authorities and the voluntary sector.

The coming year we see us continue to provide exciting training and development opportunities, along with undertaking a range of events, to enable our staff to have the skills and confidence to respond to the challenges faced by Acute Hospitals, both in emergencies and as part of our usual day to day activities.

## Clinical performance

### Infection Prevention and Control

The prevention and control of healthcare-associated infections (HCAIs) is key to the provision of high-quality, safe healthcare. At PAHT, the wider hospital team, together with the IPC team (IPCT) are proud of the robust infection prevention and control (IP&C) measures that we have in place to reduce healthcare associated infections (HCAIs). These measures include steps to manage antimicrobial resistance and to control outbreaks of infection.

The prevention and control of infection is an integral part of the trust's risk management strategy and reduces the risk of harm from HCAIs for our patients, staff and visitors, as well as reducing trust costs associated with infection. All levels of staff across the organisation are trained and monitored in relation to measures for the prevention and control of infection.

Prevention and control of HCAIs in primary and community care is also supported by the hospital IPCT and trust's Director of Infection prevention and Control (DIPC), ensuring the patient is firmly at the centre of all activities.

### Trust performance

The trust remains in a favourable positon when compared against other trusts nationally; we are in the top performing quartile 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.

## MRSA bacteraemia

There is a trajectory of zero tolerance of MRSA bacteraemia across the NHS. During 2018-19, 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 PAHT since 2014 which is testament to the trust's commitment to IP&C and compliance with our MRSA care pathway.

## Clostridium difficile

The trust has again had a challenging trajectory of just nine cases for 2018/19. Trajectories are set nationally by the Department of Health (DoH) and are based on performance during previous years. Our performance at PAHT remains in the top performing quartile and as such, our trajectory is low. We have managed to achieve this, ending this financial year on a total of 13 cases on the national PHE data base. However, only nine of these are considered to be trust-attributable so far, as four of 13 of the cases were successfully appealed at the West Essex HCAI Scrutiny Panel. This may further reduce to as low as six cases as three (from the 13) are still awaiting appeal. Due to the requirement for a multi-disciplinary team (MDT) to attend the panel, this will not be held until mid-late May. Appeals are successful when there is demonstrable evidence that there were no lapses in care given to patients that contributed to the C difficile infection

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 achievement demonstrates excellent multi-disciplinary team working, with sustained commitment to infection prevention and control procedures, which has spanned a period of over ten years.

## 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). The CQC have commented on our excellence in trust apportioned MSSA bacteraemia control.

## Gram Negative Blood Stream Infections (GNBSI)

From April 2017, there has been an NHS ambition to halve the numbers of healthcare associated Gram-negative blood stream infections (GNBSIs) by 2021. At PAHT we can demonstrate evidence of well-informed leadership, planning and clinical interventions to address this initiative. We have evidence of assessment against the Health and Social Care Act: Code of Practice, we have DIPC / IPCT, senior management and increasing clinical ownership of gram negative Blood Stream Infections and we have a collaborative approach to tackling GNBSIs across the health care economy. We had a reduction in our trust apportioned Pseudomonas aeruginosa BSI case numbers to one case for the whole of 2018-19, which is a significant achievement.

## Outbreaks and incidents

IPC incidences occur sporadically in hospitals; the trust has robust surveillance measures in place to ensure early identification of incidents and outbreaks to ensure

they are managed in in a timely and appropriate way to minimises the risk of transmission to patients, visitors and staff. There is also excellent engagement from other specialist teams in the Trust when required.

### Norovirus

Six norovirus outbreaks have occurred in the trust in 2018-19. These outbreaks resulted in partial or complete closures of wards. Mostly these were isolated incidents; however there were four wards closed at the same time at the height of the norovirus outbreak in January 2019. The trust has robust systems in place for the management of outbreaks with daily meetings for the duration, led by the IPCT and supported by clinicians and senior managers.

### Vancomycin Resistant Enterococci (VRE)

The Trust has had a period of increased incidence (PII) of VRE affecting patients on critical care. This PII was declared as an outbreak and control measures have been ongoing with a comprehensive multi-disciplinary team approach, including members of the trust's Executive team, Public Health England and CCG representation at weekly outbreak control meetings. Five of the patients who were colonised with VRE were treated with Linezolid as a precautionary measure and VRE colonisation has not caused any adverse clinical impact on patients. Control measures have been multi-factorial and the number of new positive cases has reduced significantly.

### MRSA transmissions

A PII of MRSA transmissions affected one medical ward in 2018-19. There were 18 patients affected between March and November. All patients were colonised with MRSA and none of them went on to develop a clinical infection. Outbreak control meetings were held and control measures were multi-factorial. In December, the PII was officially declared as over as there had been no further transmissions in over 28 days which is the approved definition of the end of an outbreak/PII.

### Conclusion

PAHT NHS trust has again maintained another good year in terms of control of HCAIs, despite a VRE outbreak in critical care. This outbreak has not had serious clinical consequences due to immediate and sustained control measures.

We have reduced our trust apportioned HCAI case numbers year on year. This is largely attributable to us having in place a strategy that describes actions over time to support the prevention, recognition and management of infections, a suitably resourced IPCT and good clinical engagement. As an organisation we have developed a board-approved HCAI reduction plan and report progress against this. Antimicrobial stewardship (AMS) is included and we contribute to whole economy decision making on HCAI reduction.

### Learning from incidents

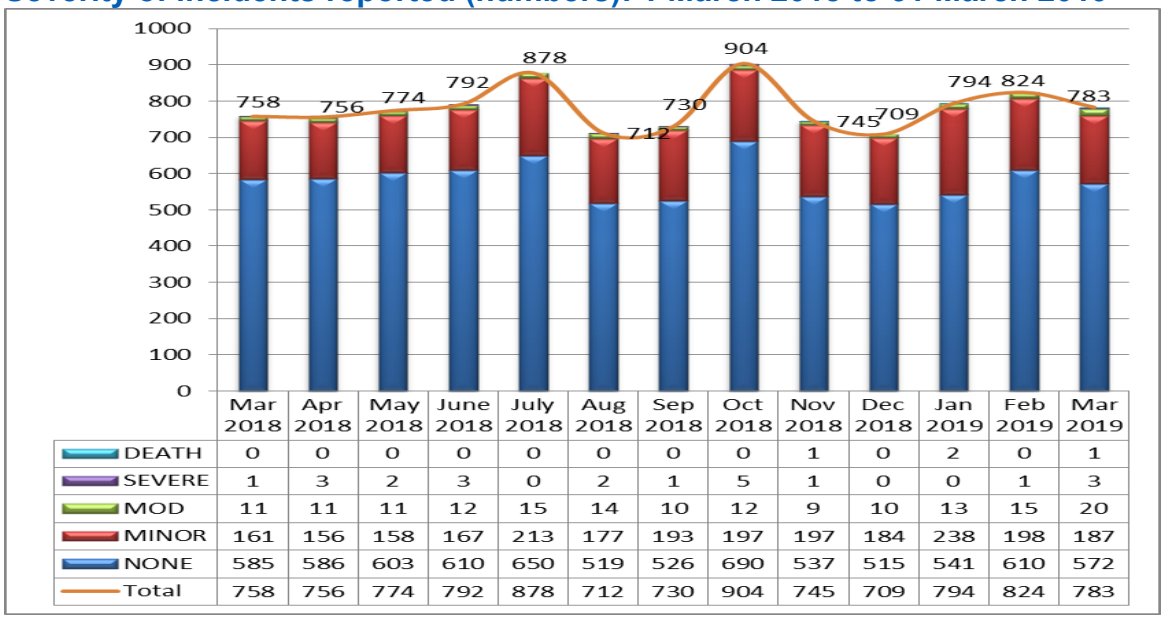
At PAHT, safety is a priority and we continuously work to ensure that incidents are managed effectively and most importantly that we learn and share the improvements from them.

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.

During the year April 2018 to March 2019, a total of 9371 incidents were reported on the trust's Datix incident management system, as having occurred in PAHT. This is a 2.2% reduction when compared with 9580 over the same period last year but is still 781 on average per month. The majority of incidents reported were low or no harm incidents representing 97.99% of the total incidents for this period, with the remaining 2.01% being moderate and severe harms.

All these incidents are reported to the National Reporting and Learning System (NRLS) 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%.

### Severity of incidents reported (numbers): 1 March 2018 to 31 March 2019




| | Mar 2018 | Apr 2018 | May 2018 | June 2018 | July 2018 | Aug 2018 | Sep 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DEATH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 1 |
| SEVERE | 1 | 3 | 2 | 3 | 0 | 2 | 1 | 5 | 1 | 0 | 0 | 1 | 3 |
| MOD | 11 | 11 | 11 | 12 | 15 | 14 | 10 | 12 | 9 | 10 | 13 | 15 | 20 |
| MINOR | 161 | 156 | 158 | 167 | 213 | 177 | 193 | 197 | 197 | 184 | 238 | 198 | 187 |
| NONE | 585 | 586 | 603 | 610 | 650 | 519 | 526 | 690 | 537 | 515 | 541 | 610 | 572 |
| Total | 758 | 756 | 774 | 792 | 878 | 712 | 730 | 904 | 745 | 709 | 794 | 824 | 783 |

### Themes of serious incidents

39 Serious incidents (SIs) have been declared at the trust during 2018-19 and reported externally in year. 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.

The trust ensures that 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 the Director of Nursing and is scheduled every day from Monday to Friday to ensure that there is no delay and initial review is undertaken when events are fresh in the minds of our staff. All potential serious incidents are presented and discussed to identify whether they meet the national SI framework

requirements. The most frequently reported SI topic during this reporting period was for:

- Treatment delay meeting SI criteria (14 incidents)
- Diagnostic delay meeting the SI criteria (4 incidents)
- Maternity/obstetric incident meeting the SI criteria for mother and baby (4 incidents)

### Never events

There were no never events in 2018-19.

### Sharing the learning events

The trust's patient safety and quality teams worked with relevant experts across the trust to organise and facilitate two sharing the learning events during 2018-19:

- **12 April 2018:** Focus on Sepsis and Acute Kidney Injury – presentation on blood cultures in Sepsis, a simulation session and two interactive games to support learning

- **11 July 2018:** Two audit presentations – negative appendectomy rate and clerking standards. A review of mortality by the Chief medical officer and a presentation on consent and legal cases by the trust's Legal services manager

- **12 October 2018:** Presentations from each of our healthcare groups covering: serious incidents, anticoagulation, neutropenic sepsis, gastrointestinal bleeds, morbidity and mortality, CQC musts and should complete actions. The Quality First team presented 'Adopting a quality improvement approach to embedding and sustaining change'

- **10 January 2019:** A journey from a quality Initiative to research to intellectual property with external presenters as well as presentations from Quality First and the Trusts Library team

### Being open and Root Cause Analysis (RCA) investigation skills training

The trust continues to invest in RCA investigation training and training in being open and duty of candour conversations with patients and families. In year the Trust held:

- One Being Open/Duty of Candour training day
- Five days of Root Cause Analysis training

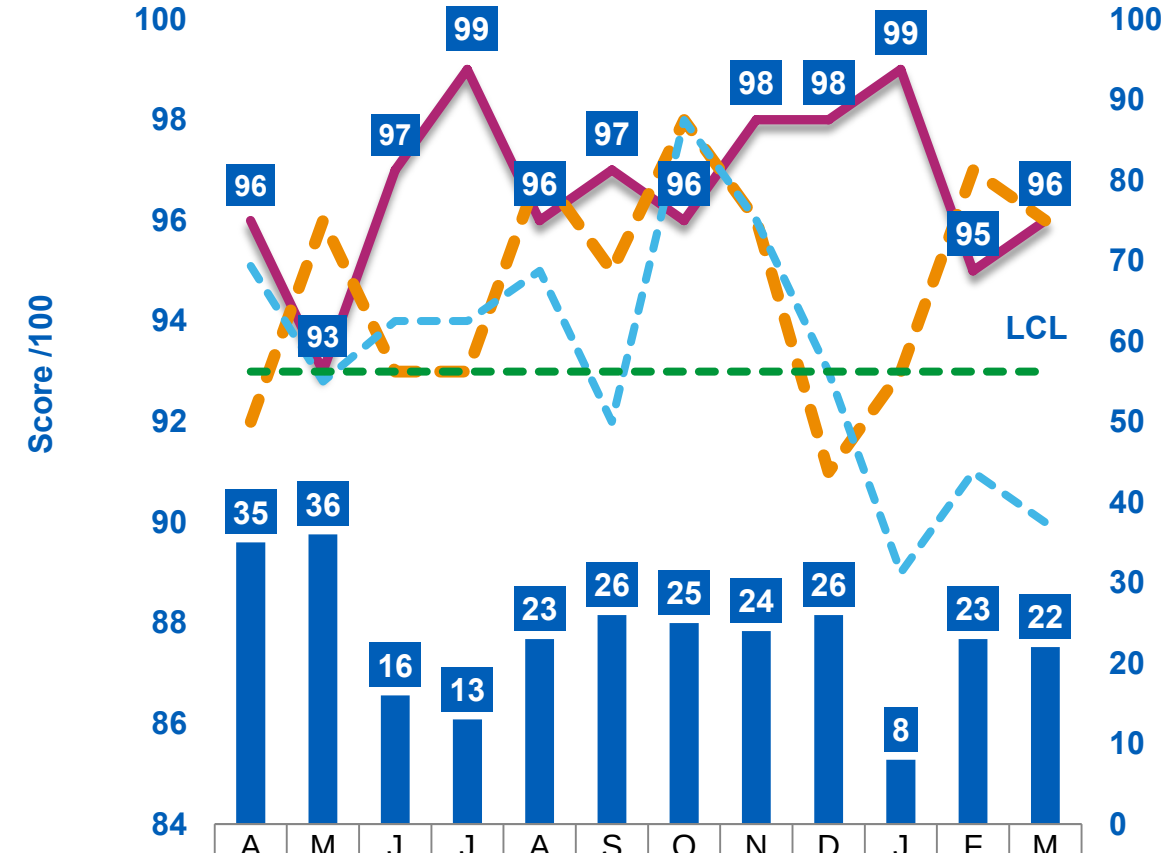
### Friends and Family Test (FFT)

The national average for a composite FFT score is 93%. The trust is above the national average with a composite average score for the year to date of 96.7% consistent with previous CQC findings of the domain of caring being rated 'good'. This is also the highest average annual FFT score since we began recording this data.

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 July 2018 and January 2019

being our best rated months.

### FFT 2016-17 to 2018-19 compared

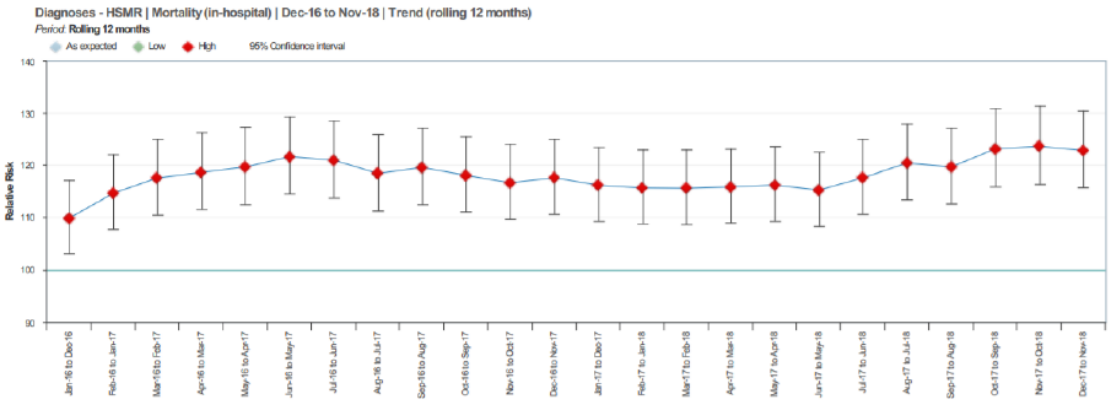



| | A | M | J | J | A | S | O | N | D | J | F | M |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sample | 35 | 36 | 16 | 13 | 23 | 26 | 25 | 24 | 26 | 8 | 23 | 22 |
| 2018-19 | 96 | 93 | 97 | 99 | 96 | 97 | 96 | 98 | 98 | 99 | 95 | 96 |
| 2017-18 | 92 | 96 | 93 | 93 | 97 | 95 | 98 | 96 | 91 | 93 | 97 | 96 |
| 2016-17 | 95.1 | 92.8 | 94 | 94 | 95 | 92 | 98 | 96 | 93 | 89 | 91 | 90 |
| Target | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 |

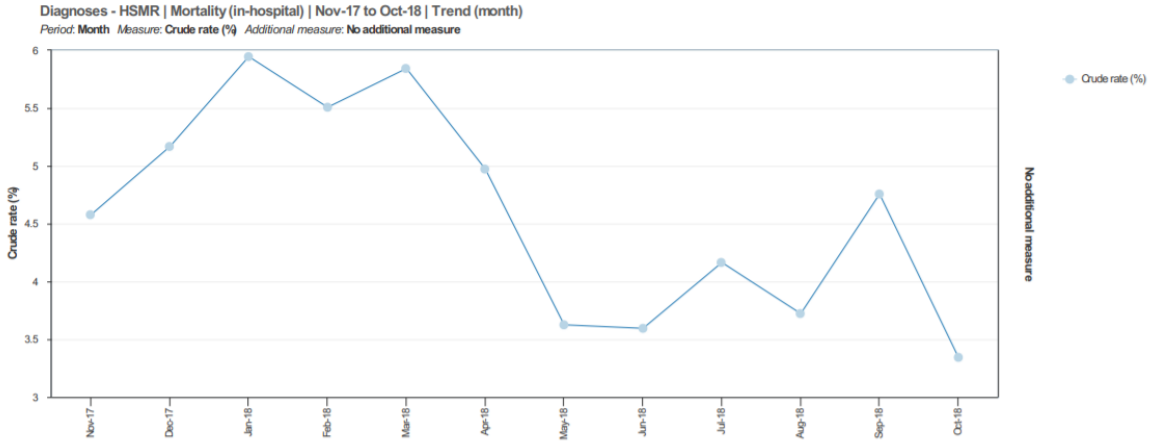
### Mortality

The statistical markers for mortality have been higher than expected for 2018-19.

The rolling Hospital Standardised Mortality Ratio (HSMR) for the last 12 months has been higher than expected:




However, there has been an improvement throughout the second half of the year for the in-month HSMR:




There have been a number of diagnostic alerts for this period. The more significant ones are fractured neck of femur, sepsis, chronic obstructive airways disease, pneumonia, aspiration pneumonitis and gastrointestinal obstruction.

The Mortality Improvement Board, chaired by the Chief executive, has now been set up to oversee four improvement work streams using a recognised quality improvement methodology:

- Hospital at night
- Bundles of care
- Implementation of medical examiners
- Achieving excellence every time (antibiotic stewardship, fluids, sepsis, acute kidney injury and NEWS 2)

## 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.

In December 2017 the CQC undertook a comprehensive inspection of the trust in six 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. The trust was re-inspected by CQC during March and April 2019 and the outcome of those inspections is awaited.

The Trust's current CQC ratings (based on the December 2017 inspection) are reflected below:


| | 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 Quality First team works alongside the patient safety and quality department which is aligned to clinical governance and patient safety. Putting quality first is the underpinning principal to achieving quality improvements. The Quality Improvement Strategy was launched in February 2019. We define quality improvement as 'working together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.'

## Quality First team

One of the signs of quality improvement being embedded across an organisation is the 'presence of a central team that leads the provider's quality improvement approach' (Care Quality Commission). The Quality First team is led by a senior doctor, nurse and manager. The team work alongside our staff, patients and wider partners in health and social care.

This multidisciplinary team's key functions are:

- To centrally coordinate the delivery of quality improvement initiatives that deliver greater efficiency and productivity as well as reducing unwarranted variation

- To support the delivery and realisation of our long term plan (Your future, our hospital (five P's), Clinical Strategy and Quality Improvement Strategy)

- To lead quality improvement and organisational development to prepare the trust for our future health and social care campus

- To support the strategic realisation of the clinical strategy

## The Improvement Partnership

The 'Improvement Partnership' is our program for enrolling, engaging, involving and developing our staff in Quality Improvement. The Quality First Team runs Leading Change and Leading Projects learning and development sessions with the objective of enabling them to deliver successful quality improvement projects. When the staff member completes a quality improvement project (capturing project outcomes in poster), they become PAHT Improvement Partners:


For two consecutive years the trust has won Champion Organisation at the annual Academy of Fabulous Stuff national awards. At the awards in November 2018, the Chief executive of the NHS, Simon Stevens said 'this award is presented to the trust whose energy, leadership and vision has empowered staff to put their ideas into action and have embedded quality improvement as 'the norm' throughout their organisation'.

**2017**


**2018**

The trust has identified the following priorities for quality improvement in 2019-20:

Our priorities are identified in line with the Trust's 5P Strategy and progress will be monitored through the Board committees and reported to Trust Board.

### Our patients

- A reduction in the mortality rate as a result of the work from the Mortality Improvement Board
- A reduction in the length of stay for non-elective patients to support the flow of patients through and out of the hospital
- A greater percentage of patients dying in their preferred place of death
- Ongoing improvements in our patients' experience of care

### Our people

- Introduce a talent management programme and newly appointed consultant development programme by Q3
- Continued improvement in staff survey results of experience being consistent with the Trust's 4 values
- An ambitious programme to significantly reduce the registered nurse vacancy rate to less than 10%
- Unconscious bias training to raise awareness of equality and inclusion issues in attracting, recruiting and retaining our people by Q3
- Implementing a new extranet website for our people by Q4
- Implementation of new PAHT website by Q2

### Our performance

- To achieve all key access standards, including RTT (referral to treatment) and cancer waiting times
- To improve our performance for timeliness of treating patients requiring urgent care
- To commence the redesign of outpatient services to modernise services in primary and secondary care

### Our places

- To work with our partners to complete a pre-consultation business case by July 2019 for the new hospital
- To run a public consultation on the site of the new hospital in the summer of 2019
- To complete a Strategic Outline Business Case for a new hospital by March 2020

## People performance

The trust continues to reduce agency expenditure and delivered against its agency spend target of £10.3m. We have successfully implemented our bank contract and are achieving higher fill rates which are being monitored against the contract KPI's.

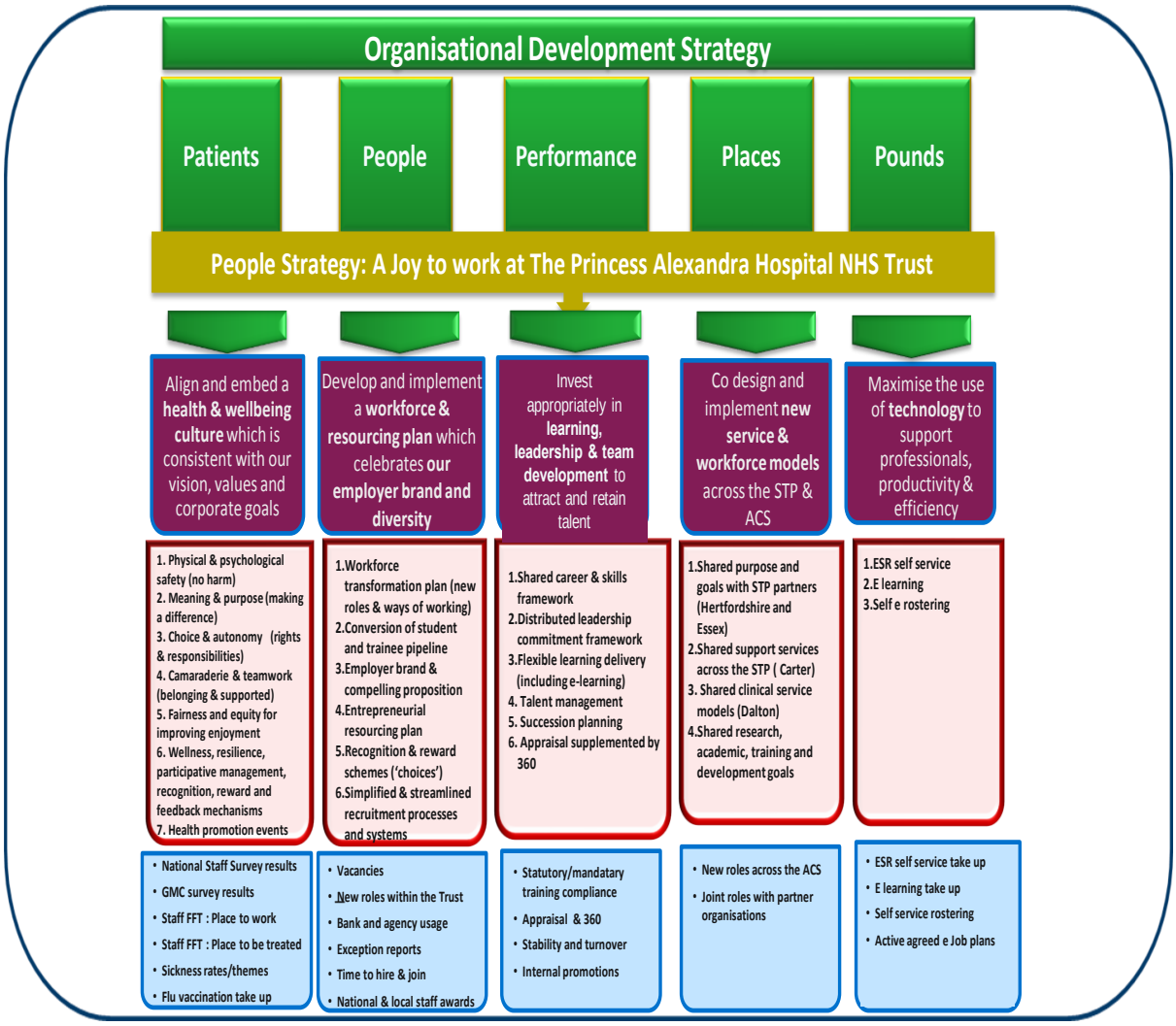
In 2018-19, the trust has seen an improvement in overall vacancy rates and voluntary turnover, with improvements made in recruitment and retention processes. These improvements will continue to be a key area of focus during 2019-20, with our greatest driver being band 5 nurse recruitment. This has been our biggest staffing risk; however the trust has an ambitious plan to reduce the vacancy rate for Band 5 qualified nurses during the forthcoming year.

| People KPI | 19-20 Target |
|---|---|
| Vacancy rate | 8% |
| Sickness absence | 3.5% |
| Voluntary turnover | 12% |
| Statutory and mandatory training | 90% |
| Appraisal | 90% |
| Flu | 75% |
| Time to hire | 31 days |

The trust People Strategy commenced in April 2018 following a series of staff engagement workshop. The five key pillars of the people strategy are:

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

A refreshed People Strategy for 2019-2024 will be launched in early 2019, with its primary focus to have a workforce that is flexible and fully equipped with the appropriate skills, knowledge and resources to deliver highly effective patient centred care across our services.




Throughout 2018-19 the people directorate have aligned work streams to the five pillars and have delivered the following:

- The introduction of a new employee assistance programme – Health Assured, providing expert advice and guidance 24/7, free for all our staff
- An Equality and Inclusion Steering Group has been established with staff champions for each of the nine characteristics with a planned programme of events throughout the year
- Exceeding the flu target for 2018-19 with 77% of our front line staff having the flu immunisation
- Achieving core statutory and mandatory training compliance above 90%
- Providing 170 work experience placements for local young people
- Holding a fantastic three day staff engagement programme, 'Event in a Tent' to celebrate our people
- Achieving non-medical appraisal rates of above 90%

- Achieving our agency target set by NHS Improvement
- Creating the trust Behaviour Charter
- We turned paperless with our payslips, with all staff now accessing their payslip via their individual MyESR account

The above strategy will continue to be delivered through the five people strategy pillars and will be monitored through our annual operating plan.

## Culture, health and wellbeing

During 2018-19 we ran a number of Culture, Health and Wellbeing events across the trust, we trained 11 staff members to become Mental Health First Aiders and plan to increase this number throughout 2019-20.

A mental health awareness day was held across all trust sites in January 2019, providing information about support available and water bottles to all staff to promote hydration.

March 2019 saw PAHT host its own International Women's day with key speakers, celebrating the social, economic, cultural and political achievements of women. We look forward to hosting International Men's day in November 2019.

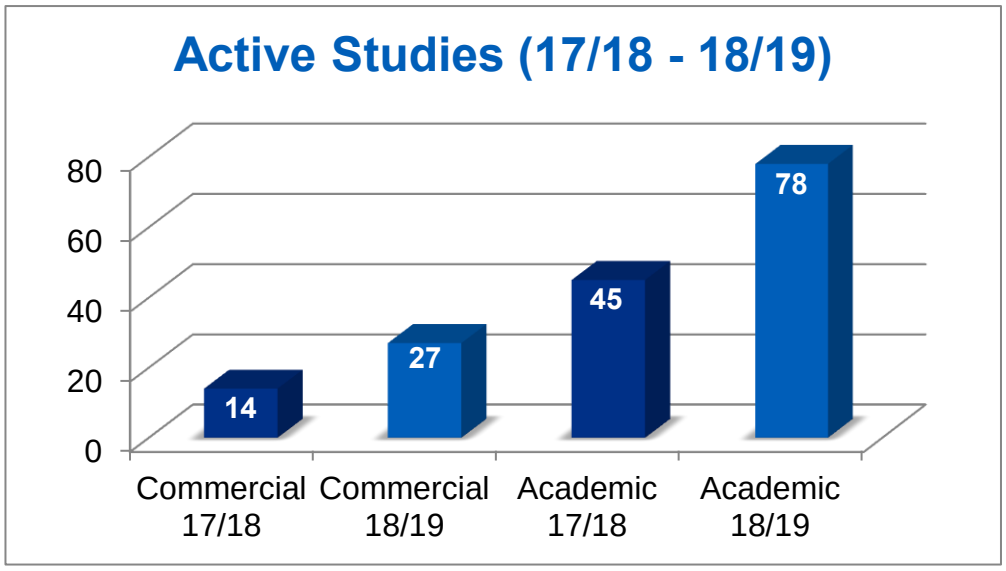
## Staff engagement

In addition to our three-day Event in a Tent outlined above, throughout 2018-19 we introduced a number of initiatives to improve staff engagement:

- Development of a new Behaviour Charter introduced at our Event in a Tent 2018 and embedded within our appraisal process, to be further supported throughout 2019-20 with interactive sessions with teams
- A strengthened approach to using our staff survey results to drive improvement in staff experience, which will continue on an ongoing basis throughout 2019-20 via local staff experience groups actively monitoring progress against action plans
- Our appraisal process has been further improved to provide greater focus on staff health and wellbeing, values and behaviours and talent management
- A new Staff Engagement Steering Group has been introduced, ensuring wide stakeholder involvement across the trust
- We have made a huge improvement in appraisal compliance for non-medical staff (91% at March 2019); meaning many more staff are benefiting from a focused discussion about performance, development and wellbeing every year
- We have revised our processes around pay progression (for non-medical staff) to align to national guidance, and have put support sessions and resources in place to help staff understand how they will be affected

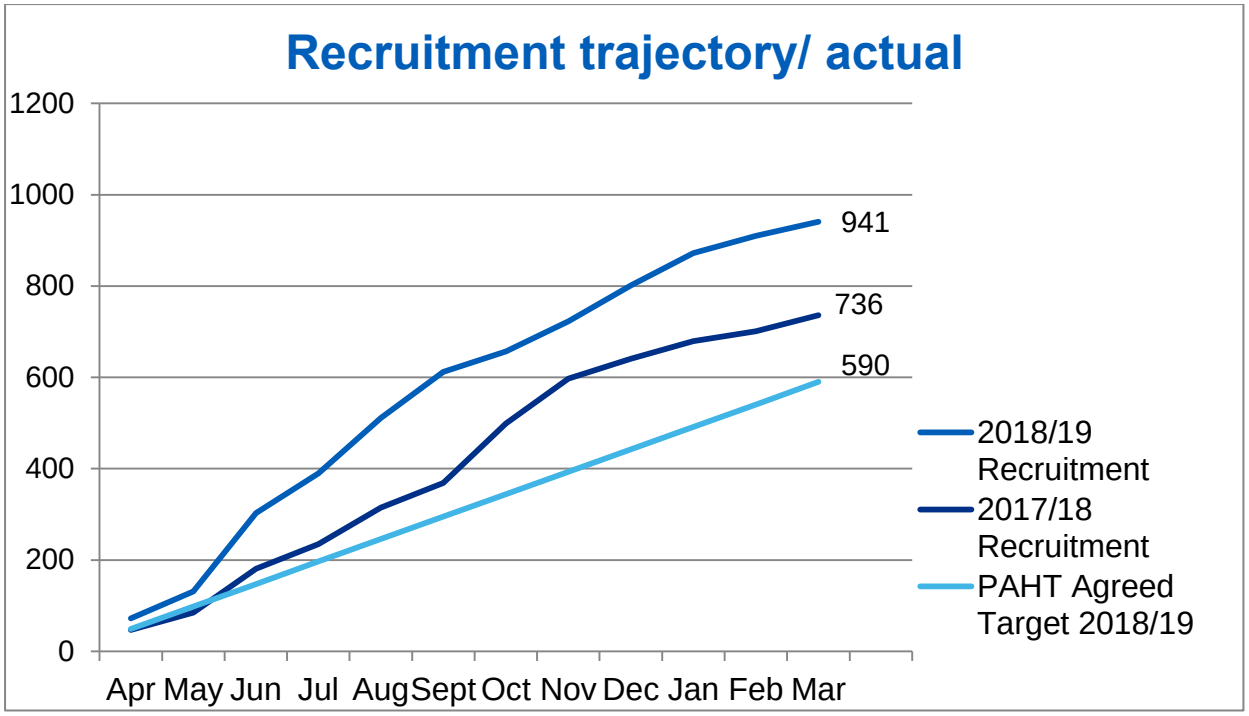
## Research, Development and Innovation

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 2018-19, it was agreed with North Thames Clinical Research Network that PAHT would recruit a target of 590 participants into National Institute for Health Research (NIHR) portfolio adopted trials. Nearing the end of the financial year, the number of participants recruited into research is 941 as of 27 March 2019.




## Recruitment per speciality

| Recruitment Portfolio Activity | Speciality | Directorate | Commercial/Non Commercial |
|---|---|---|---|
| 401 | Cancer | C,C & CSS | Non-Commercial |
| 92 | Surgical | Surgery | Non-Commercial |
| 63 | Gastroenterology | Medical | Non-Commercial |
| 60 | Neurology | Medical | Non-Commercial |
| 23 | Rheumatology | Medical | Non-Commercial |
| 20 | Respiratory | Medical | Non-Commercial |
| 16 | Maternity | F & W,S | Non-Commercial |
| 13 | Cardiology | C, C &CSS | Non-Commercial |
| 4 | Dermatology | Medical | Non-Commercial |
| 2 | Ophthalmology | Medical | Non-Commercial |
| 1 | Musculoskeletal | Medical | Non-Commercial |
| 1 | Diabetes | Medical | Non-Commercial |
| 213 | Emergency | Medical | Commercial |
| 19 | Urology | Surgery | Commercial |
| 5 | Rheumatology | Medical | Commercial |
| 3 | Cancer | C,C & CSS | Commercial |
| 2 | Cardiology | C,C & CSS | Commercial |

| | | | |
|---|---|---|---|
| 2 | Dermatology | Medical | Commercial |
| 1 | Musculoskeletal | Medical | Commercial |

## Good news stories

### Previous FY recruitment overtaken

- PAHT surpassed our 2017-18 recruitment total in September 2018

### qFit study

- PAHT was the second highest overall recruiter to the study

### AZ SPOCS

- PAHT achieved its recruitment target of 5 participants for this Rheumatology study, and has moved to competitive recruitment

### DALES study

- PAHT recruited 87 participants into this study

### SPIT study

- PAHT increased its recruitment rate by 44% between June-July 2018

## National Institute for Health Research (NIHR) funding

Following submission of a business case to North Thames Clinical Research Network, for a trainee research nurse and a clinical trial practitioner, PAHT have been awarded the funding. The recruitment process is now underway.

## Our Amazing People nomination

The Research, Development and Innovation team won a nomination in the Our Amazing People category for the corporate division.

## Research and development health check

A recent research and development health check published by the NIHR shows that PAHT deliver the highest quality of research, based on all trusts in the East of England.

## Patient Panel

Research is developing a relationship with the Patient Panel through regular meetings, events and planning to promote further awareness of Research to the public.

## International clinical trials day

The annual international clinical trials day went ahead on the 17 May 2018, in both the Harvey Shopping Centre, Harlow and outside the Alexandra Restaurant at PAHT. The day was a great success with over 100 interested members of the public attending the stands.

## Estate improvements

Whilst work on developing plans for our new hospital is well underway we still have to ensure we improve the existing hospital site and buildings. During 2018-19 we invested in the following improvements:

**Charnley Ward**: As a result of increased pressures on daily operations and in particular in the winter season influx of patients, the capital team was tasked with increasing the hospital's inpatient bed capacity. A new 27 bed ward was commissioned, built and opened in January 2019 providing a modern new facility. The building is sited on a steel gantry within the main patient/visitor car park, therefore preserving the car parking spaces underneath.

Charnley ward was officially opened on Friday 11 January 2019 by Rt Hon Robert Halfon, MP for Harlow who was joined by the Chair of Harlow Council, Councillor Maggie Hulcoop and guests from partner organisations, patient representatives, including the Patient Panel, and staff.

**Car Parking**: Driven by the need to accommodate the trust's patients and visitors, the Estates directorate was able to increase patients and visitors parking capacity by over 250 spaces. This was achieved by allocating an off site staff parking facility and

redesigning the existing parking spaces on site.

**Lister Ward water ingress:** One of the trust's long standing legacy issues was water ingress into Lister Ward. Following investigation into the cause of the water ingress, all the windows on the east side of Harvey Ward have been replaced and minor refurbishment works have been undertaken in Harvey and Lister Wards to make good on any damages caused by the water ingress.

**New generator:** Due to growing facilities and use of electrical power in the hospital, it has been deemed necessary by the site's Electrical Authorised Engineer (AE), to upgrade the size of our south side generator. Taking the AE's recommendations into consideration a new generator has been installed.

**Ward refurbishment programme:** As part of the trust's ongoing drive to improve standards of care, ensuring safe and suitable environments for our patients and visitors, multiple ward refurbishment projects have been completed notably in John Snow, Main Theatres, HDU and Harold Ward.

**Backlog maintenance schemes:** The trust has made significant strides in addressing a number of backlog maintenance schemes, including:

- Air handling unit repairs and replacement
- Electrical switchgear replacement
- Chiller replacement
- Basement fire stopping
- Medical air emergency reserve manifold
- Medical and surgical air plant replacement
- Theatres 5, 6, 7 environment control replacement

**Ante-Natal and Maternal Foetal Assessment Unit (MFAU)**: Due to Ante-Natal and MFAU being situated in the location of the future fracture clinic, the services had to be relocated to facilitate the fracture clinic build. Ante-Natal services will be relocated to the previous location of the trust's Headquarters. MFAU will be relocated to the ground floor in the maternity reception corridor with both connected via a platform lift. Works are due for completion by mid-April 2019.

## Sustainability

The health and social care carbon footprint makes up between 3 - 6% of the carbon footprint of the whole of England. The legal carbon reduction targets set by the Climate Change Act 2008 in 2014 require a reduction in carbon emissions by 34% by 2020.

The trust has a statutory obligation and duty to contribute to this level of ambition. In order to attain this target, the trust has identified a series of actions which are outlined in our Sustainable Health Care Strategy 2018-2022 which includes the Sustainability Development Management Plan 2018-2020 (SDMP). In line with the Climate Change Act 2008, the SDMP demonstrates a clear commitment for the trust to reduce its carbon emissions.

In order that the responsibility and accountability for sustainable development is clear in our organisation, we are currently establishing a Sustainable Healthcare Committee (SHC).

The Sustainable Development Unit (funded by, and accountable to, the NHS England and Public Health England to work across the NHS, public health and social care system) is emphasising four particular areas of focus for the health and care system.

The four areas identified are:

- Carbon
- Air pollution
- Waste
- Plastics

The above four areas are of particular interest for the SDU and the trust as these are the major contributors to issues such as climate change and resource depletion and also have direct impact on human health and well-being. In the past year, the trust has reviewed its activities in these areas, The findings, outcomes of current activities and proposed endeavours to ensure the trust is working towards achieving the target set by the SDU are:

### Carbon baseline (2013)

- Total trust's energy supply for electricity: 8,508,631 kWh
- Total trust's energy supply for gas: 18,202,407 kWh
- Total CRC emissions: 7945 tCO2

### 2016-17

The electricity supply reported in 2016-17 was 8,855,101 kWh which is equivalent to a 4% increase from the 2013 baseline reporting. Gas supply reduced significantly by 17% to 15,051,075 kWh. Total CRC emissions from gas and electricity were 6718 tCO2; a 15% reduction from the 2013 baseline.

### 2017-18

- Total trust's energy supply for electricity: 8,909,078 kWh
- Total trust's energy supply for gas: 14,320,010 kWh
- Total CRC emissions: 6028 tCO2 (24% reduction from baseline)

### 2018-19 (meeting the target for 28% reduction in carbon emissions)

- Total trust's energy supply for electricity: 9,396, 809 kWh
- Total trust's energy supply for gas: 14,528,876 kWh
- Total CRC emissions: 5742 tCO2

## 100% LED lighting – NHS Energy Efficiency Fund (NEEF)

We secured NHS energy efficiency funds to the value of £475k to pursue our ambition to have 100% LED fitted energy efficient lighting. We have completed the procurement process to appoint a preferred provider. The LED installation will significantly improve our ability to meet the statutory target to reduce our carbon emissions under the Climate Change Act 2008.

In addition, the LED project aspires for significant cost savings in energy from reduced consumption of electricity, equivalent to c£118k per annum. Beyond the financial savings, the LED coverage will ensure positive improvements to our patient's environment and staff satisfaction with energy savings and an education in carbon emissions. With these guaranteed efficiencies, it is expected that the successful implementation will lead to further reduction of carbon emissions from gas and electricity per annum by 30%, exceeding our target of 28% reduction by the year 2020.

## Air pollution

We completed our baseline assessment on air pollution in January 2019. Of the 22 recommendations under this guidance, the trust has demonstrated meeting 21 recommendations, and achieving 95% compliance on standards for preventing air pollution and improving air quality and health.

We are also making progress with our plan to set up a local carbon reduction target for business mileage emissions, which is to be aligned to the Climate Change Act 2020 target and beyond, by implementing reporting mechanisms to monitor and promote sustainable travel, encompassing business travel, fleet, logistics, private user schemes, car parking and transport services. We will then be able to demonstrate reduction in traffic or associated air quality impacts in our local area by implementing use of the SDU validated Health Outcomes of Travel Tool (HOTT).

We are currently preparing a Medium Combustion Plant permit application for our generators in order to comply with the relevant air pollution regulations.

## Waste

Within our SDMP we have identified waste as an area of significant opportunity for improvement. We will reduce our general waste through emphasising in-house opportunities, encouraging training, education and waste hierarchy.

Over the 12 month period from January to December 2018, 560 tonnes of general waste was collected of which 7.7 tonnes was mixed recycling which equates to 1.36%.

The trust will be putting in place an all-encompassing solution to improve our sustainable waste management performance. The new sustainable model will ensure end-to-end management of waste where the focus will be on waste reduction and encouraging reuse. At present we are putting tremendous amount of efforts into the revision of our waste management strategy which includes reducing our food waste and avoidable single-use packaging such as straws, cups, carrier bags etc.,

as these offers the biggest opportunity for change. Once the waste reduction possibilities are fully explored, we will focus on recycling as many items of waste as possible. Subsequently, following the maximisation of material recycling, the final focus is to use the remaining waste to generate low carbon energy and evaluate the impact on carbon reduction targets.

## Plastics

Currently, the amount of plastic waste generated by the NHS is significantly higher (22.7%) than other industries. The SDU is focused on reducing this footprint, targeting the top 15 product groups that are contributing to plastic waste, whilst ensuring continued delivery of health and care in a cost-efficient manner, without compromising patient safety or choice.

Product groups which are also high carbon impact goods and contribute an estimated 69% to overall plastic content are:

- Single-use theatre protective clothing (including drapes) = 9% of total plastic products
- Examination gloves = 8% of total plastic products
- Disposable wipes and cleaning cloth products = 7% of total plastic products
- Catering products, tableware and light equipment = 5% of total plastic products
- Polymer products (aprons and bags) = 5% of total plastic products

The trust will focus on how sustainability measures can be adopted and explore other means to maximise similar opportunities to reduce plastic waste.

## Policies

To further reduce the trust's carbon footprint locally, the trust will continue to embed sustainability through the use of a Sustainable Development Management Plan (SDMP). The trust board adopted the PAHT SDMP in early 2018 and a refreshed version will be considered during the summer of 2019.

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 PAHT sites. This is also presently subject to a comprehensive review, with adoption again scheduled for the coming summer.

Other key documents under development 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 are purchased to provide safe 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
- Any implications for PAHT 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

Tender specifications are being developed which we know will have material implications for improving sustainability. These have included showing a clear preference for low emission vehicles in our transport services, prioritising very high efficiency burners in relation to the boiler house plant upgrade project and in relation to disposable bed-bay curtains, specifically including supplier recycling options within the specification and assessment process.

## Partnership 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 everyone's responsibility and includes 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.

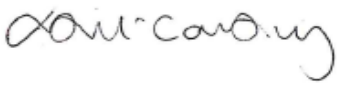
## Looking forward

2019-20 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' initiative whilst continuing to attract contributions 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.

## SDU recognition for best practice

The SDU has recognised our work on specific aspects of the Sustainability Development Assessment Tool (SDAT) and the United Nations (UN) Sustainability Development Goals. The SDU team at the Nottingham Trent University are putting together a case study of our work which will be used in a specific publication that will go on the SDU website, and may also feature in the upcoming report on the progress of the health and care system on the UN Sustainable Development Goals.



**Lance McCarthy**

Chief executive officer

# The Accountability Report 2018-19

## 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 2018-19

| Name | Position | Voting | From | To |
|---|---|---|---|---|
| **Executive Directors:** | | | | |
| Lance McCarthy | Chief executive officer | Y | 03.05.17 | Current |
| Trevor Smith | Chief financial officer | Y | 15.07.13 | Current |
| Dr Andy Morris | Chief medical officer | Y | 01.03.15 | Current |
| Stephanie Lawton | Chief operating officer | Y | 02.03.16 | Current |
| James McLeish | Director of quality improvement | N | 01.04.16 | Current |
| Nancy Fontaine | Chief nurse | Y | 01.11.12 | 26.07.18 |
| Sharon Cullen | Acting chief nurse | Y | 23.07.18 | 30.10.18 |
| Sharon McNally | Director of nursing and midwifery | Y | 01.10.19 | Current |
| Marc Davis | Director of pathways and partnerships | N | 01.10.12 | 03.06.18 |
| Michael Meredith | Director of strategy | N | 04.06.18 | Current |
| Raj Bhamber | Interim director of people | N | 20.11.17 | 31.07.18 |
| Ogechi Emeadi | Director of people | N | 01.08.18 | Current |
| **Non-Executive Directors (NEDs):** | | | | |

| | | | | |
|---|---|---|---|---|
| Alan Burns | Chairman | Y | 01.12.16 | 30.11.18 |
| Steve Clarke | Associate NED<br>NED<br>Chairman | N<br>Y<br>Y | 01.08.17<br>03.10.18<br>03.12.18 | 02.10.18<br>02.12.18<br>02.12.20 |
| Andrew Holden | NED (Chair of Performance and Finance Committee) | Y | 01.01.15 | 31.03.20 |
| Pam Court | NED (Chair of Workforce Committee) | Y | 28.09.15 | 27.09.19 |
| Stephen Bright | NED (Chair of Audit Committee) | Y | 03.10.16 | 02.10.18 |
| John Hogan | NED (Chair of Quality and Safety Committee) | Y | 01.08.17 | 31.07.19 |
| Helen Glenister | Associate NED<br>NED (Chair of Charitable Funds Committee) | N<br>Y | 01.08.17<br>01.04.18 | 31.03.18<br>31.03.20 |
| Helen Howe | Associate NED | N | 11.06.18 | 10.06.20 |

## Attendance at board meetings

Number of Board members present at Board meetings in 2018-19:

| | 3.5.18 | 24.5.18 | 7.6.18 | 5.7.18 | 2.8.18 | 6.9.18 | 4.10.18 | 1.11.18 | 6.12.18 | 3.1.19 | 7.2.19 | 7.3.19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Private | Extraordinary Trust Board | Public and Private | Private | Public and Private | Board Development (no formal meeting) | Public and Private | Board Development (no formal meeting) | Public and Private | Private | Public and Private | Private |
| **Public** | | 13/5 | 14/16 | | 13/16 | | 15/15 | | 13/14 | | 13/14 | 14/14 |
| **Private** | 13/5 | | 14/16 | 11/16 | 13/16 | | 14/15 | | 13/14 | 12/14 | 13/14 | |

## 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.

### Remuneration and Nominations Committee

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

### Performance and Finance Committee

The purpose of the Performance and Finance Committee is:

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

### Quality and Safety Committee

The Quality and Safety Committee (QSC) functions as the trust's umbrella clinical governance committee. It enables the 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 adequate staff with the necessary skills and competencies to meet both the current and future needs of the trust and ensure delivery of efficient services to patients and service users
- Assure the Board that legal and regulatory requirements relating to workforce are met

### 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.

### Statement of board members' interests 2018-19

| Name | Title | Interests/Memberships declared |
|---|---|---|
| Alan Burns | Chairman | • No interests declared |
| Pam Court | Non-Executive Director | • Chief executive officer of Saint Francis Hospice |
| Stephen Bright (left October 2018) | Non-Executive Director | • Chairman Vistem Sarl<br>• Director SDF Consulting Limited – dissolved May 2018<br>• Vale of Aylesbury Housing Association – Non Executive and Chair of Audit committee from June 2017<br>• Audit committee member The Salvation Army<br>• Member of V4T working group to provide intermittent advice |

| | | |
|---|---|---|
| Andrew Holden | Non-Executive Director | • Board director, Liaison Financial Services |
| Helen Glenister | Non-Executive Director | • Chair of Accelerate CIC Limited<br>• Trustee and vice chair of Isabel Hospice |
| Helen Howe | Associate Non-Executive Director | • Honorary professor – University of East Anglia<br>• Associate of the General Pharmaceutical Council<br>• Contractor for Deloitte/Subject Matter Expert on medicine and pharmacy related business (concluded 19/01/2019)<br>• Trustee of Addenbrooke's Charitable trust |
| Steve Clarke | Chairman | • Trustee and honorary treasurer of Dementia UK |
| John Hogan | Non-Executive Director | • Self-employed at private medical practice<br>• Consultant cardiologist at Barts Health NHS trust |
| Lance McCarthy | Chief executive officer | • No interests declared |
| Raj Bhamber (left July 2018) | Interim director of people | • Trustee of Scott's Project trust<br>• Director of Bhamber Estates Ltd<br>• Consultant of Bhamber Consultancy Ltd<br>• Trustee of Staff College |
| Ogechi Emeadi (commenced August 2018) | Director of people | • No interests declared |
| Marc Davis (left November 2018) | Associate director of pathways and partnerships | • Seres GIFTS Limited (Spouse's Company)<br>• Non-Executive Director of Uttlesford Health<br>• Associate of Rethink (consultancy) |
| Michael Meredith (commenced June 2018) | Director of strategy | • No interests declared |
| Nancy Fontaine (left July 2018) | Chief nurse | • Professor of nursing at Anglia Ruskin University and University of Essex |

| | | |
|---|---|---|
| | | • Chair of Adult Safeguarding Performance and Audit Committee for Essex |
| Sharon McNally (commenced October 2018) | Director of nursing and midwifery | • No interests declared |
| Stephanie Lawton | Chief operating officer | • No interests declared |
| James McLeish | Director of quality improvement | • Spouse is a paramedic for East of England Ambulance Service<br>• Daughter employed by Compass Group |
| Andy Morris | Chief medical officer | • No interests declared |
| Trevor Smith | Chief financial officer | • Spouse is a director of Salonica Consulting Limited |

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

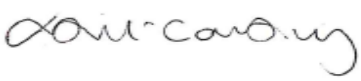
The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS trust Accountable Officer 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

- 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 officer
**Date:** 31 May 2019

## The Princess Alexandra Hospital Annual Governance Statement 2018-19

My Annual Governance Statement (AGS) has been written describing the governance arrangements in place at the trust during 2018-19. 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 Integrated Care Partnership system (ICP). Delivering high quality, timely and cost effective care to our local community are core components of our strategic objectives, and the STP and ICP 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.

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 2018-19 financial year.

The trusts 2018-19 gross Control Total target deficit i.e. excluding Provider Sustainability Fund (PSF) set by NHSI was £28.5m. The trust's outturn was £28m, £0.5m better than plan. After inclusion of Provider Sustainability Funds (PSF) for delivery of the financial target the net financial deficit was £16.5m. This compares to a £28.4m deficit in 2017-18, an £11.9m improvement.

## Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I

am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS trust Accountable Officer Memorandum.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of PAHT, 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 2019 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

As Chief executive cfficer, I am accountable for the overall risk management activity within the trust. Committed leadership in the area of risk management is essential to maintaining sound systems of internal control required to manage risks associated with the achievement of the corporate goals of the trust.

The trust's Risk Management Strategy details my overall accountability to the trust Board for risk management and makes it clear that managing risk is a key responsibility for the trust and all staff employed by it. The trust Board receives regular reports that detail quality, financial and operational performance risk, and, where required, the action being taken to reduce identified high-level risks.

I am responsible for ensuring that the trust is in a position to provide overall assurance that the organisation has in place the necessary controls to manage its risk exposure. In discharging these responsibilities I was assisted by the following Directors during 2018-19:

- The Chief financial officer 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 Chief financial officer also has delegated responsibility that Information Governance arrangements at the trust are suitable and is the trust's Senior Information Risk Owner (SIRO)
- The Director of nursing and midwifery has delegated authority and responsibility for the professional leadership of the Nursing and Allied Health Professions. The role is also the executive lead for infection prevention and control with the Director of Infection Prevention and Control reporting to the Director of nursing and midwifery. 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 includes the establishment and monitoring of assurance mechanisms and provision of associated risk 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 well as managing the Quality First team and implementing the Quality Improvement Strategy.

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

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

## The risk and control framework

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 Board Committee structure with clear reporting lines to the trust Board
- A Risk Management Group reporting to the trust Board via senior management team meetings
- A significant risk register and board assurance framework, both of which are reviewed by the Risk Management Group and trust Board
- 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 Risk Management Group meets on a monthly basis to review risks across all health care groups as well as corporate departments. 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

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 highest scoring risks on the BAF throughout 2018-19 were the risks relating nurse recruitment, our estate/infrastructure, delivery of the ED standard and nurse recruitment. Further detail on these risks and their management is detailed under significant issues.

Following the annual review of the BAF and risk management processes by the trust's internal auditors an overall assessment of substantial assurance was provided.

## Quality governance arrangements

There is clear accountability at Board level for patient safety and clinical quality outcomes along with structured reporting of performance against these objectives. Executive oversight of quality improvement is through the Director of Nursing and Midwifery who, with the Chief Medical Officer Medical Director, ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. They are supported in this work by the Quality First team.

Each of the trust's four Health Care Groups has a Patient Safety and Quality group where themes and trends from reviews of incidents and complaints and learning are reported. Performance is considered at monthly performance review meetings and at the 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. Throughout 2018-19, the Quality & Safety Committee continued to receive updates on progress against the Quality Improvement Plan developed to address concerns raised by CQC during their inspection. Regular 'Sharing the Learning' reports providing an overview of themes, trends and learning arising from incidents, serious incidents and on-going quality improvement initiatives for topics such as falls, dementia and pressure ulcers are also received.

Mortality is monitored by the Quality and Safety Committee as well as the trust Board. The statistical markers for mortality have been higher than expected for 2018-19.

The rolling Hospital Standardised Mortality Ratio (HSMR) for the last 12 months has been "higher than expected". However, there has been an improvement throughout the second half of the year for the in-month HSMR. The trust has launched a Mortality Improvement Programme with workstreams reporting into the newly established Mortality Improvement Board which reports into the Quality and Safety Committee and trust Board.
The Quality and Safety Committee and trust board receive 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 2018-19 and remains a risk on the BAF.

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 2018-19.

## Well led reviews

The Board conducted a self-assessment against the CQC's well-led framework at a Board Development session on 1 November 2018. An overall rating of 'Good' was assigned which aligned with the CQC assessment of the trust when last inspected in December 2017. The outcome of the self-assessment was reported to trust board in December 2018.

## Compliance with NHS provider licence

The trust completed a self-assessment against the following NHS provider licence conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution (Condition G6 (3)
- The provider has complied with required governance arrangements (Condition FT4 (8)

In relation to General Condition 4 (fit and proper persons) of the provider licence the trust has a robust process for monitoring the trust's compliance with the regulations. Annual compliance checks, by way of the annual self-declaration are undertaken and following the review in November 2018 100% compliance was achieved and reported to the Workforce Committee.

## Developing workforce safeguards

We will look to further develop a robust workforce plan that underpins the trust's operational plan which is reviewed annually by the Performance and Finance Committee and trust Board. Through in-depth analysis and interpretation of our workforce metrics we will work in conjunction with our health care groups to implement and support a plan that ensures that the workforce skill mix is used effectively and efficiently and that we are utilising the full potential to work in a more integrated way with our STP partners. Through the use of resources and review of Model Hospital data, we will continue to review our workforce strategies.

The trust remains focussed on increasing and retaining its core nursing workforce, utilising new roles such as nursing associates, paramedics and physician associates whilst continuing to further developing job redesign and embedding new workforce models. This will decrease the reliance on contingent labour and utilise the full range of skills available from the workforce. The 2019-20 workforce strategy looks to recruit internationally specifically at band 5 to decrease our vacancy rate to below 10% by December 2019.

We have a comprehensive statutory and mandatory training programme which is delivered both face to face and via e-learning, our staff are trained and equipped to identify and manage risk in line with their roles and responsibilities. In addition to this, specific training relevant to individual responsibilities is also provided which is supported through individual personal development plans. Our retention strategy will ensure that staff have development plans and that talent is identified and individuals developed, engaged and retained within the organisation. Working with

our STP partners we will continue to look to explore opportunities for joint roles as we identify workforce models that support integrated working.

A people, organisational development and communications governance structure is in place which includes a newly formed People Board attended by staff representing all healthcare groups, is constituted by the senior management team and is the decision making body of the trust for people, organisational development and communications. A Workforce Committee meeting takes place bi-monthly with the purpose of providing the trust Board with assurance in relation to performance on all workforce matters.

### Managing conflicts of interest

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

### Care Quality Commission

The trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Following the inspection in December 2017, the CQC Report, published on 19 March 2018, confirmed the CQC rated the trust as 'Requires Improvement'. The trust was inspected by CQC during March with the well led inspection scheduled to take place in April 2019.

### NHS pension scheme

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

### Equality, diversity and human rights

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

### Carbon reduction

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The trust has a Governance Manual comprising standing orders and standing financial instructions, which provide the framework for ensuring appropriate

authorisation of expenditure commitments in the trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the trust's cost improvement programme on a monthly basis. The trust has a process for the development of business cases for both capital and revenue expenditure and, depending on the level of investment; these are reviewed by the senior management team and/or trust board. The Performance and Finance Committee reviews productivity, operational and financial performance and use of resources both at trust and health care group level. The trust has a scheduled assessment of its use of resources on 26 March 2019. More details of the trust's performance and some specific trust projects aimed at increasing efficiency are included in the performance report. The trust's external auditors are required to consider whether the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee.

## Information governance/data security risks

The trust has reported 11 level 2 Information Governance (IG) data security breaches to the Information Commissioners Office (ICO) during 2018-19; six of these have been closed with no further action, with five still being investigated.

The first breach related to personal identifiable data being sent to external partners in error as part of a conference call, the second to personal identifiable data being uploaded to a webpage in error, and the third to personal identifiable data left in an insecure location outside of the trust. The ICO have investigated and closed all of these incidents with no further action taken.

The fourth breach related to personal identifiable data left unattended in a public place (staff/patient restaurant), the fifth to a patient being sent home with the details of another patient, the sixth to data being handed to the incorrect patient, the seventh to a patient being discharged with another patients summary, the eighth to an IT issue on a virtual server, which resulted in the loss of 10 hours' worth of clinical data - although was available in a dictated format, the ninth to highly sensitive information being discussed in an ward area with relatives and other patients having overheard causing distress to the patient in question, the tenth to maternity data having been handed to an incorrect recipient, and the eleventh to one parent having raised safeguarding concerns about their child against the other, and this having been disclosed to the other parent.

Incidents four to eleven were reported to the ICO for investigation through the new incident reporting tool. However the ICO confirmed that due to having received a high volume of breach reports since the General Data Protection Regulations (GDPR) came into force on the 25 May 2018 cases are still being allocated for further review.

## 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. In the current year, this opinion is being provided in relation to VTE and incidents. The external auditor also undertakes a review of the consistency of the information contained within the quality accounts.

## Elective waiting time data

Patients who have been referred to the trust on a Cancer Waiting Time or Referral to Treatment (RTT) pathway are managed daily by the clinical and operational teams, in line with the hospital's Access Policy. These pathways are reviewed at bi-weekly Patient Tracker List (PTL) meetings, chaired by the Deputy Chief Operating Officer (DCOO) for Planned Care where pathway trigger points are reviewed and remedial actions taken, if required. The PTL 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 Senior Management Team, Performance and Finance Committee and the trust Board.

## 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:

- Non-SLA income (overseas visitors, RTA, private patient and reciprocal payments)
- Cambio system upgrade
- Estates capital plan

- Workforce utilisation – eRostering

The trust's internal auditors undertook a detailed follow up exercise of the recommendations in relation to the five limited assurance reports and concluded that all high priority recommendations had either been implemented by the trust or were not yet due for implementation.

Action plans are in place to address Internal Audit's recommendations for all audits undertaken. The Internal Auditor's provide a progress report to the Executive Management Team, Senior Management Team and 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.

## Head of Internal Audit Opinion (HoIA) on the effectiveness of the system of internal control for the year ended 31 March 2019:

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its Annual Governance Statement (AGS).

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion; and
3. Commentary

**1**. My overall opinion 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.

**2.** The basis for forming my opinion is as follows:
**i.** An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

**ii.** 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.

## 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 2019-20 (and beyond); these issues are also reflected on the Board Assurance Framework:

## Registered nurse vacancy rate

The trust continues to experience a significant vacancy rate amongst registered nursing staff with an overall vacancy rate of 25%. 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.

## Operational performance – A&E standard

The trust has struggled to deliver against this standard throughout the year. Year to date the trust achieved 74.4%, compared with 71.1% for 2017-18. The trust has seen an increase in attendances in 2018-19 compared with 2017-18; in excess of 14 additional patients per day, every day, for the year. The Urgent Care Improvement Board meets on a weekly basis to review actions being taken to improve performance against the standard. Recovery plans remain in place to address performance issues both internally and across the health and social care system. There is also a system wide Local Delivery Board supporting the management of urgent care patients across all parts of the health and care sectors.

## Financial sustainability and strategic options

The trusts 2018-19 gross control total i.e. excluding Provider Sustainability Fund (PSF) set by NHSI was a £28.5m deficit. The trusts outturn was £28m being £0.5m better than plan. After reflecting Provider Sustainability Fund (PSF) allocations the adjusted financial deficit, which the Trusts performance is measured against was £16.5m. This compares to a £28.4m deficit in 2017-18 therefore an £11.9m reduction between the two financial years. Key drivers of the over-achievement of the control total include:

- Over-delivery against the £10.3m agency target set by NHSI with an outturn of £9.6m
- Over-delivery of the trust's annual CIP target of £10m (£12.1m actuals)
- Continued costs containment, efficiency and transformational exercises
- Successful resolution to contractual matters and growth in the activity/income base from Commissioner contracts
- Eligibility to earn additional Provider Sustainability funding from delivery of financial performance standards

The Trust has agreed the 2019-20 Operating Plan which further improves the financial position and plans to reduce the deficit to £6.2m. This is consistent with the

2019-20 Control Target set by NHSI. The trust's PSF and FRF eligibility, subject to delivery of performance criteria, is £20.8m. The plan has aligned income / activity expectations with Commissioner contracts and expenditure budgets being set to deliver the baseline activity. Jointly work with STP partners will refresh Medium Term Financial Models (MTFM); this work will recognise the national requirement to be in breakeven position by 2020-21.

At a strategic level we continue to work actively with our commissioners, regulators, and independent advisers and STP with plans to develop an ICP. At the trust Board of the 7 March 2019 the Board gave unanimous support to the preferred way forward for a new hospital. This means the trust can now move to the next stage and progress a Pre Consultation Business Case (PCBC) and a Strategic Outline Business Case (SOC) which will include detailed work to assess options and seek authority to approve to proceed with the case. Whilst a new hospital solution is developed we recognise that sustainability will require investment in existing infrastructure, estate, ICT and medical equipment. The trust has therefore included an estimate of £29.7m of capital requirements in its 2019-20 operating plan. This plan includes £7.5m from Wave 4 STP capital bids for additional capacity, £5m emergency capital, £3.8m STP Interoperability (ICT) bids and £3.3m to continue the progression of the aforementioned SOC. These investments will add to the £11.9m of capital expenditure the trust invested in 2018-19.

With transformational plans to readdress financial and clinical sustainability clearly progressing we expect that beyond 2019-20 the trust will plan to deliver a breakeven position. Notwithstanding this progress and, in 2017-18 our External auditors improved their value for money conclusion which moved from an inadequate opinion (2016-17) to an 'except for' opinion in (2017-18) as the trust has not achieved its statutory financial duty of cumulative break-even over a three year period and in line with their duties as auditors, the trust's external auditors have reported the trusts is position to the Secretary of State for Health and Social Care 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

## 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. However we still need 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 2018-19 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.

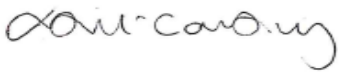
In year improvements to the estate include:

- New 27 bedded ward
- Two new maternity theatres
- New antenatal scanning department
- New MRI scanner
- Secured additional and improved car parking for patients and visitors
- Refurbished two wards
- Agreed and approved a preferred contractor to build a new fracture clinic on PAH site with work underway and to complete during 2019

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

## Conclusion

As Accountable Officer, I receive information and assurance from a wide range of sources about the trust's internal control systems and structures in place to ensure the effective operation of the trust. These facilitate the identification of strengths and areas in need of attention enabling appropriate action plans to be established and acted on. Although 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 officer
(31 May 2019)

## 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 2018-19. The Remuneration Report set out below is subject to audit by our external auditors.

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

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

### Staff report

### Pay multiples

Reporting bodies are required to disclose 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 PAHT in the financial year 2018-19 was £235k-£240k (2017-18, £250k-£255k). This was 10.9 times (2017-18, 12.1 times) the median remuneration of the workforce, which was £22k (2017-18, £21k)
- In 2018-19, no employees received remuneration in excess of the highest paid director (this was the same in 2017-18). Remuneration ranged from the bands £0k-£5k to £235k-£240k (2017-18 £0k-£5k to £250k-£255k)
- 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

2018-19 total expenditure on consultancy and professional services was £1,912k (2017-18 £2,158k).

## Employee benefits and staff numbers (subject to audit)

### Employee benefits

| Gross expenditure | Permanently employed | Other | 2018-19 Total | 2017-18 Total |
|---|---|---|---|---|
| | £000's | £000's | £000's | £000's |
| Salaries and wages | 114,308 | 293 | **114,601** | 109,608 |
| Social security costs | 12,045 | 0 | **12,045** | 10,907 |
| Apprenticeship levy | 566 | 0 | **566** | 490 |
| Employer's contributions to NHS pensions | 13,467 | 0 | **13,467** | 12,856 |
| Pension costs - other | 21 | 0 | **21** | 0 |
| Temporary staff | 0 | 29,182 | **29,182** | 26,024 |
| **Total employee benefits** | **140,407** | **29,475** | **169,882** | **159,885** |
| Less: Employee costs capitalised | 656 | 594 | **1,250** | 1,471 |
| **Gross employee benefits excluding capitalised costs** | **139,751** | **28,881** | **168,632** | **158,414** |

### Average staff numbers

| | Permanent Number | Other Number | 2018-19 Total | 2017-18 Total |
|---|---|---|---|---|
| Medical and dental | 428 | 73 | **501** | 521 |
| Ambulance staff | 4 | 0 | 4 | 0 |
| Administration and estates | 497 | 31 | 528 | 583 |
| Healthcare assistants and other support staff | 764 | 23 | 787 | 257 |
| Nursing, midwifery and health visiting staff | 748 | 162 | 910 | 926 |
| Nursing, midwifery and health visiting learners | 368 | 93 | 461 | 423 |
| Scientific, therapeutic and technical staff | 65 | 15 | 80 | 266 |

| | | | | |
|---|---|---|---|---|
| Healthcare science staff | 14 | 0 | 14 | 158 |
| Other | 108 | 0 | 108 | 126 |
| **Total** | 2,996 | 398 | 3,394 | 3,260 |
| Staff engaged on capital projects (included in above) | 13 | 9 | 22 | 35 |

Note: In 2018/19 the Trust reviewed classifications and this has resulted in some movements between staff categories.

### Staff sickness and ill health retirements

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

| | 2018-19 | 2017-18 |
|---|---|---|
| | **Number** | **Number** |
| Total days lost | 26,182 | 23,688 |
| Total staff years | 3,000 | 2,904 |
| Average working days lost | 8.7 | 8.2 |

| | 2018-19 | 2017-18 |
|---|---|---|
| | **Number** | **Number** |
| Number of persons retired early due to ill health grounds | 0 | 1 |
| | **£000s** | **£000s** |
| Total additional pensions liabilities accrued in the year | 0 | 0 |

## Reporting of compensation schemes - exit packages 2018-19 (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 | 1 | 0 | **1** |
| £100,001- £150,000 | 0 | 0 | **0** |
| £150,001 - £200,000 | 0 | 0 | **0** |
| > £200,000 | 0 | 0 | **0** |
| **Total** | **2** | **0** | **2** |
| Total resource cost (£) | £119,000 | £0 | **£119,000** |

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 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** |

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

| | 2018-19 | | 2017-18 | |
|---|---|---|---|---|
| | **Agreements** | **Total value of agreements** | Agreements | Total value of agreements |
| | **Number** | **£000's** | Number | £000's |
| Contractual payments in lieu of notice | - | - | 5 | 104 |
| Exit payments following Employment Tribunals or court orders | - | - | 1 | 62 |
| **Total** | **-** | **-** | 6 | 166 |

## Off payroll arrangements

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

During 2018-19 there were no executive posts covered by off-payroll arrangements.

The trust had no off-payroll engagements as of 31 March 2019, and there were no new engagements during the period 1 April 2018 to 31 March 2019.

## Table of salaries - Non-Executive Directors (subject to audit)

| | | 2018/19 | | | | 2017/18 | | | |
|---|---|---|---|---|---|---|---|---|---|
| Name | Title | Period | Salary (bands of £5,000) | Expense payments (taxable to nearest £100) | Total (bands of £5,000) | Period | Salary (bands of £5,000) | Expense payments (taxable to nearest £100) | Total (bands of £5,000) |
| | | | £000's | £'s | £000's | | £000's | £'s | £000's |
| Alan Burns | Chairman | 01.04.18 - 30.11.18 | 20 - 25 | 800 | 20 - 25 | All Year | 35 - 40 | 2,600 | 35 - 40 |
| Steve Clark[1] | Chairman | 03.12.18 - 31.03.19 | 15 - 20 | 2,500 | 15 - 20 | 01.08.17 - 31.03.18 | 0 - 5 | 100 | 0 - 5 |
| Andrew Holden | Non-Executive Director | All Year | 5 - 10 | 1,600 | 5 - 10 | All Year | 5 - 10 | 0 | 5 - 10 |
| James Anderson | Non-Executive Director | - | - | 200 | 0 - 5 | All Year | 5 - 10 | 100 | 5 - 10 |
| Pam Court | Non-Executive Director | All Year | 5 - 10 | - | 5 - 10 | All Year | 5 - 10 | 0 | 5 - 10 |
| Stephen Bright | Non-Executive Director | 01.04.18 - 02.10.18 | 0 - 5 | 200 | 0 - 5 | All Year | 5 - 10 | 0 | 5 - 10 |
| Dr John Hogan | Non-Executive Director | All Year | 5 - 10 | - | 5 - 10 | 01.08.17 - 31.03.18 | 0 - 5 | 0 | 0 - 5 |
| Helen Howe | Associate Non-Executive Director | 11.06.18 - 31.03.19 | 0 - 5 | 300 | 5 - 10 | - | - | - | - |
| Dr Helen Glenister | Non-Executive Director | All Year | 5 - 10 | 1,400 | 5 - 10 | 01.08.17 - 31.03.18 | 0 - 5 | 100 | 0 - 5 |

1. Associate NED and NED roles held prior to being appointed as Chairman. Appointed as Associate NED on 1.08.18 and then as NED on 3.10.18.

## Table of salaries - Executive Directors (subject to audit)

| | | 2018/19 | | | | 2017/18 | | | |
|---|---|---|---|---|---|---|---|---|---|
| Name | Title | Period | Salary (bands of £5,000) | All pension related benefits (bands of £2,500) | Total (bands of £5,000) | Period | Salary (bands of £5,000) | All pension related benefits (bands of £2,500) | Total (bands of £5,000) |
| | | | £000's | £000's | £000's | | £000's | £000's | £000's |
| Lance McCarthy | Chief Executive | All Year | 180 - 185 | 90 - 92.5 | 270 - 275 | 03.05.17 - 31.03.18 | 160 - 165 | 115 - 117.5 | 275 - 280 |
| Phil Morley | Chief Executive | - | - | - | - | 01.04.17 - 14.04.17 | 5 - 10 | 0 | 5 - 10 |
| Sharon McNally | Director of Nursing and Midwifery | 01.10.18 - 31.03.19 | 55 - 60 | 87.5 - 90 | 145 - 150 | - | - | - | - |
| Sharon Cullen | Interim Chief Nurse | 23.07.18 - 30.10.18 | 25 - 30 | - | 25 - 30 | - | - | - | - |
| Prof. Nancy Fontaine | Chief Nurse | 01.04.18 - 26.07.18 | 40 - 45 | 10 - 12.5 | 50 - 55 | All Year | 130 - 135 | 30 - 32.5 | 160 - 165 |
| Dr. Andy Morris[1] | Chief Medical Officer | All Year | 235 - 240 | 5 - 7.5 | 245 - 250 | All Year | 250 - 255 | 45 - 47.5 | 295 - 300 |
| Trevor Smith | Chief Financial Officer | All Year | 140 - 145 | - | 140 - 145 | All Year | 145 - 150 | 97.5 - 100 | 245 - 250 |
| Stephanie Lawton | Chief Operating Officer | All Year | 130 - 135 | 20 - 22.5 | 150 - 155 | All Year | 130 - 135 | 30 - 32.5 | 160 - 165 |
| James McLeish | Director of Quality Improvement | All Year | 105 - 110 | 10 - 12.5 | 115 - 120 | All Year | 100 - 105 | 15 - 17.5 | 115 - 120 |
| Michael Meredith | Director of Strategy | 04.06.18 - 31.03.19 | 95 - 100 | 17.5 - 20 | 110 - 115 | - | - | - | - |
| Marc Davis | Director of Pathways and Partnerships | 01.04.18 - 03.06.18 | 25 - 30 | 0 - 2.5 | 25 - 30 | All Year | 100 - 105 | 25 - 27.5 | 125 - 130 |

| | | 2018/19 | | | | 2017/18 | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Title** | **Period** | **Salary (bands of £5,000)** | **All pension related benefits (bands of £2,500)** | **Total (bands of £5,000)** | **Period** | **Salary (bands of £5,000)** | **All pension related benefits (bands of £2,500)** | **Total (bands of £5,000)** |
| | | | **£000's** | **£000's** | **£000's** | | **£000's** | **£000's** | **£000's** |
| Simon Covill | Acting Chief Financial Officer | - | - | - | - | 01.04.17 - 03.05.17 | 20 - 25 | 5 - 5.5 | 25 - 30 |
| Elizabeth Booth | Director of Human Resources | - | - | - | - | 01.04.17 - 11.12.17 | 65 - 70 | 35 - 37.5 | 100 - 105 |
| Ogechi Emeadi | Director of People, Comms & OD | 01.08.18 - 31.03.19 | 75 - 80 | 50 - 52.5 | 130 - 135 | - | - | - | - |
| Raj Bhamber | Director of People | 01.04.18 - 31.07.18 | 40 - 45 | 10 - 12.5 | 50 - 55 | 20.11.17 - 31.03.18 | 40 - 45 | - | 40 - 45 |

**1.** £128k of the salary within the total £235k-240k salary banding disclosed for Dr Andrew Morris, Chief Medical Officer, is for their clinical role. (2017-18 £156k of the total £250k-£255k salary of Dr Andrew Morris was for their clinical role).

## Salary pension entitlement of senior managers (subject to audit)

| Name and 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 2019 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2018 | Real increase in Cash Equivalent Transfer Value (CETV) | Cash Equivalent Transfer Value at 31 March 2019 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| Lance McCarthy[1] | 5 - 7.5 | 5 - 7.5 | 55 - 60 | 130 - 135 | 750 | 177 | 927 | 0 |
| Prof Nancy Fontaine[1] | 0 - 2.5 | (2.5) - 0 | 50 - 55 | 120 - 125 | 864 | 42 | 989 | 0 |
| Sharon Cullen[2] | (2.5) - 0 | (2.5) - 0 | 45 - 50 | 140 - 145 | 1023 | -1023 | 0 | 0 |
| Dr. Andy Morris[1] | 2.5 - 5 | (7.5) - (5) | 95-100 | 245 - 250 | 1756 | 219 | 1,975 | 0 |
| Trevor Smith[1,3] | (2.5) - 0 | (10) - (7.5) | 60 - 65 | 150 - 155 | 1071 | 108 | 1,179 | 0 |
| Stephanie Lawton[1] | 0 - 2.5 | (2.5) - 0 | 45 - 50 | 105 -110 | 649 | 119 | 768 | 0 |
| James McLeish | 0 - 2.5 | 2.5 - 5 | 20 - 25 | 70 - 75 | 475 | 74 | 549 | 0 |
| Michael Meredith[1,4] | 0 - 2.5 | (2.5) - 0 | 0 - 5 | 5 - 10 | 47 | 23 | 70 | 0 |
| Ogechi Emeadi[1] | 2.5 - 5 | 2.5 - 5 | 35 - 40 | 90 - 95 | 584 | 95 | 727 | 0 |
| Sharon McNally | 2.5 - 5 | 10 - 12.5 | 40 - 45 | 125 - 130 | 637 | 122 | 881 | 0 |
| Rajwant Bhamber[1] | 0 - 2.5 | 0 - 2.5 | 25 - 30 | 75 - 80 | 509 | 34 | 596 | 0 |
| Marc Davis[1] | 0 - 2.5 | (2.5) - 0 | 25 - 30 | 55 - 60 | 431 | 57 | 488 | 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. Member over Normal Retirement Age (NRA) in scheme - therefore CETV calculation no longer applicable
3. Real increase may be low or negative due to reduced pensionable pay this year as acting up ceased 4.6.2017
4. Part year calculation not done as employee has no other membership in this Pension Year prior to joining PAHT

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 experience of people working here and I am committed to doing exactly that.

### We are now amongst the best performing trusts in the country for:

- The quality of staff appraisals
- Support given to staff by immediate managers
- Our safety culture

### What staff have told us has improved:

- Staff are more satisfied with the recognition they receive for good work and feel more valued
- Staff are more satisfied with their level of pay
- Many staff agree that the trust acts on concerns raised by our patients/service users and uses feedback from patients/service users to make informed decisions
- Most staff feel that they have been supported to receive training, learning or development identified in their appraisal
- More staff continue to positively rate their experience of their appraisal, including discussion of our trust values and how valued they felt
- Over half of our staff feel that they have opportunities for flexible working patterns
- Many staff see care of patients being the trust's top priority
- More staff would recommend the trust as a place to work and a place to receive treatment
- More staff feel that communications between senior managers and staff is effective
- More staff feel that they are treated fairly when involved in an error, that the trust takes action to learn from incidents and makes changes

### What we need to improve

- Availability of adequate materials, supplies and equipment to support staff in their roles
- Having enough staff at the trust
- Staff working additional hours
- Some staff experience violence, harassment and abuse from staff, patients and visitors which is unacceptable

- Continue to focus on improving staff health and wellbeing, in particular around stress management, and feeling pressure to come into work when not well enough

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.

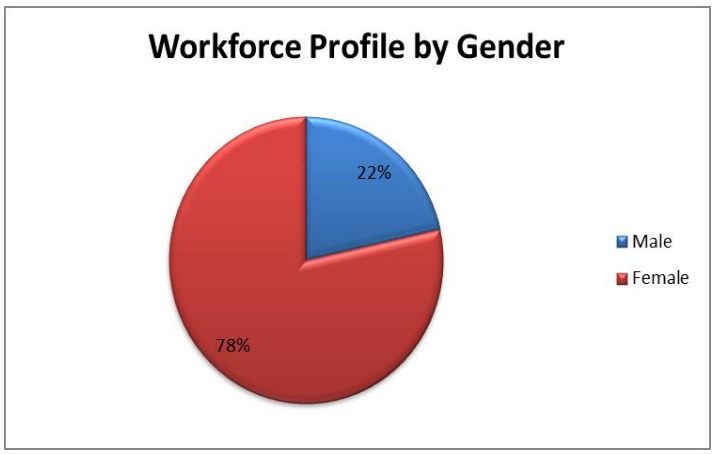
## Our staff breakdown

| 2017-18 Staff Composition | Male | Female |
|---|---|---|
| Executive Directors | 5 | 3 |
| Other employees | 747 | 2729 |
| **Total** | **750** | **2733** |

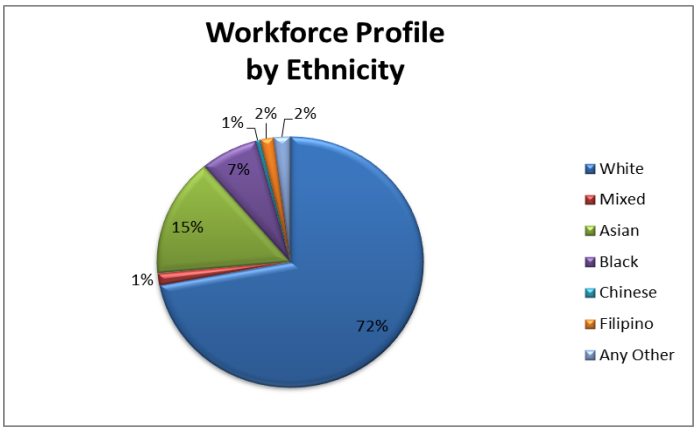
## Turnover rate

| Turnover Rate | 2017-18 | 2018-19 |
|---|---|---|
| Overall staff turnover | 19.57% | 16.82% |
| Voluntary turnover | 13.2% | 13.61% |

## Our workforce – gender profile



## Our workforce – ethnic profile




## Equality and diversity

## Significant achievements during 2018-19

## Equality and Inclusion Steering Group

The trust established an equality and inclusion steering group in April 2017 which has gone from strength to strength throughout 2018 with champions for each of the 9 protected characteristics. The EISG has worked to agreed terms of reference and has contributed to a number of successes including:

- New trust policy on equality and inclusion
- Production of a new equality and inclusion statement
- Launch of equality and inclusion charter
- Co-ordination of Black History Month celebration (2x)
- Production of an equality and Inclusion calendar – to make reference and observer were necessary religious and diversity events to represent our diverse workforce
- Contribution and support equality and includion action in relation to the staff survey
- Appointed equality and inclusion champions against for all nine protected characteristics
- Launch of the Lesbian, Gay Bisexual and Transgender, Queer or Questioning) plus (LGBTQ+) network
- Launch of the Black, Asian and Minority Ethnic (BAME) network
- Several of the equality and inclusion champions and other EISG members have completed Managing Equality and Diversity ILM Level 4 Award Accredited Programme

## Accessible Information Standard (AIS)

The Accessible Information Standard was introduced by NHS England and stipulates the legal requirement that NHS providers identify patient's communication needs, record the need, flag the need, share information about the need (with and between services), and meet the need by taking steps to ensure

the individual receives information in a format they understand (e.g. easy read, large print, BSL, email, braille).

The Standard relates to patients who have communication support needs related to a disability, sensory impairment and/or sensory loss (Protected Characteristics as described in the Equality Act 2010) and does not apply to the communication needs of non-English speakers or BAME groups.

The national deadline set for achievement of the Standard by NHSE was July 2016 and we have made progress in achieving manual compliance across a wide range of areas, information including:

- Developing easy read information in response to the standard
- Offering reasonable adjustments across all protected characteristics through internal information campaigns on digital screens
- Patient and stakeholder group involvement in the development of an action plan and in scoping the range of needs and adjustments
- Policy developed and approved by patient groups including the Patient Panel and learning disabilities groups
- Contributing to information governance toolkit compliance as a result of the development of an AIS action plan and progress in meeting objectives
- Changes to the COSMIC patient administration system to achieve compliance with the standard
- Recorded adjustments being shared through a shared secure folder with our pay per mailing provider Synertec and associated testing on the supplier side completed
- A stakeholder event and preparation of an action plan with LD groups and the establishment of an Eye Unit working group

### 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
- 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 a learning disability
- 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 officer 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 2019-20. 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 2019-20

2019-20 will see improvements in our workforce processes as we continue to recruit and retain the best possible talent to deliver safe, effective patient care, with particular focus on band 5 registered nurses.

We will continue our focus to “grow our own” ensuring that apprenticeships and graduate programmes are available to both internal and new recruits.

The equality and inclusion group will continue to develop its programme of work and will report into our Workforce Committee, as a committee of the Board, to ensure visibility and scrutiny of all interventions.

Feedback from patients and staff is important to us and, through our annual surveys, we will continue to learn from the outcomes is useful and where possible will respond to those who submit views and comments with what action we have been able to take.

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 be an employer of choice. We will continue to focus on inclusive leadership throughout 2019-20.

EDS2 goals will continue to be monitored to ensure we maintain our performance, seeking stakeholder feedback on our progress.

We will continue to learn from the feedback that our patients and 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.

We are very proud of the achievements we have been made during 2018-19 and are committed and looking forward to building on these in 2019-20.

## Looking forward

As we look to 2019-20 and beyond, we will continue to develop and improve all that we do; putting quality first and making a difference to the people we care for.

PAHT continues to play an active role, along with our local health and social care partners, in the ongoing development of the Sustainability and Transformation Partnership (STP) as it evolves to be a collaborative Integrated Care System that aims to ensure that no part of the system works in isolation and that it works together to improve health, wellbeing and services and to make the best use of the available resources.

We will continue on our improvement journey with a clear direction to meet our ambition of delivering outstanding healthcare. To underpin this we are currently developing our Your future, our hospital focus across the trust and a 5P spotlight on our patients; people; performance; places and pounds, into a clear 10-year strategy - PAHT 2030. At the heart of this will be:

- ✓ a trust-wide clinical strategy
- ✓ local 5P plans, with patients at the centre of all we do and putting quality first
- ✓ modernisation programme for all of our non-clinical services
- ✓ a new hospital
- ✓ use of technology and digital resources
- ✓ quality improvement approach that will continue to put quality first

In partnership with our people, and in-line with our 5P organisational objectives, we have agreed our focus and aims for 2019-20 are:

### Our patients

- a reduction in the mortality rate as a result of the work from the mortality improvement board
- a reduction in the length of stay for non-elective patients to support the flow of patients through and out of the hospital
- a greater percentage of patients dying in their preferred place of death
- ongoing improvements in our patients' experience of care

### Our people

- introducing a talent management programme and newly appointed consultant development programme
- proactive recruitment of additional nurses
- career conversations to identify career pathways and the appropriate development required
- introduction of paperless payslips
- unconscious bias training to raise awareness of equality and inclusion issues in attracting, recruiting and retaining our people
- implementing a new extranet website for our people

### Our performance

- achieving all key access standards, including RTT (referral to treatment) and cancer
- Improvement in performance of timeliness of patients requiring urgent care and treatment
- redesign of outpatients to modernise service delivery

### Our places

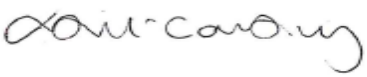
- full public consultation on a new hospital and the development of an outline business case
- improvements to acute assessment and frailty to support urgent care
- relocation of the fracture clinic on to the Princess Alexandra Hospital site
- improved cancer and training and education facilities

### Our pounds

- new contracts for MSK (musculoskeletal), COPD (chronic obstructive pulmonary disease) and urgent care services
- achievement of financial targets, on our way to ensuring a consistent surplus is generated annually

- maximising the capital investment in the hospital infrastructure, use of technology and improvements in medical equipment

**"Every day I see the hard work and absolute commitment to the people we care for from everyone at The Princess Alexandra Hospital NHS trust. I am proud to know the difference they make to each other and the people we care for and I thank them all."**



**Lance McCarthy**
Chief executive officer

The Princess Alexandra Hospital
NHS Trust

# The Princess Alexandra Hospital NHS Trust

## Annual Accounts for year ended 31 March 2019

## Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the Trust;

- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and,

- annual statutory Accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

**Chief Executive** _____ **Date** 23.5.19

## Statement of Directors' responsibilities in respect of the Accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the Accounts.

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

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

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

By order of the Board

**Chief Executive** _____ **Date** 23.5.19

**Chief Financial Officer** _____ **Date** 23/5/2019

## 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 2019 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 42. 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 2018/19 HM Treasury's Financial Reporting Manual (the 2018/19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 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 2019 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.

### Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust has reported a deficit in year and is budgeting for a further deficit in the next financial year. The Trust is reliant on 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.

### 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.

## Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust (continued)

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; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in these respects.

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

- Referral to the Secretary of State

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(1)(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)

### 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 82, 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.

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 November 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 2019.

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.

## Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust (continued)

### Certificate

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

### Use of our report

This report is made solely to the 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.

Debbie Hanson

Ernst + Young LLP

Debbie Hanson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
23-May-19

The maintenance and integrity of The Princess Alexandra Hospital NHS Trust 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

| | Note | 2018/19 £000's | 2017/18 £000's |
|---|---|---|---|
| Operating income from patient care activities | 3 | **211,910** | 196,657 |
| Other operating income | 4 | **24,790** | 16,574 |
| Operating expenses | 6 | **(251,680)** | (243,473) |
| **Operating deficit from continuing operations** | | **(14,980)** | (30,242) |
| Finance income | 12 | **75** | 31 |
| Finance expenses | 13 | **(1,654)** | (1,234) |
| PDC dividends payable | | **0** | (205) |
| **Net finance costs** | | **(1,579)** | (1,408) |
| Other gains | 15 | **0** | 8 |
| **Deficit for the year from continuing operations** | | **(16,559)** | (31,642) |
| **Other comprehensive income** | | | |
| Revaluations | 17 | **(284)** | (34,561) |
| Other recognised gains and losses | | **(37)** | (10) |
| **Total comprehensive expenditure for the period** | | **(16,880)** | (66,213) |
| **Adjusted financial performance (control total basis):** | | | |
| Deficit for the period | | **(16,559)** | (31,642) |
| Impairments | | **0** | 3,175 |
| Adjustment in respect of capital grants and donations | | **17** | 32 |
| **Adjusted financial performance deficit** | | **(16,542)** | (28,435) |

## Statement of Financial Position

| | Note | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 16 | **9,021** | 10,578 |
| Property, plant and equipment | 17 | **107,377** | 103,252 |
| Trade and other receivables | 19 | **912** | 763 |
| **Total non-current assets** | | **117,310** | 114,593 |
| **Current assets** | | | |
| Inventories | 18 | **4,515** | 4,161 |
| Trade and other receivables | 19 | **18,871** | 13,694 |
| Cash and cash equivalents | 20 | **1,197** | 1,262 |
| **Total current assets** | | **24,583** | 19,117 |
| **Current liabilities** | | | |
| Trade and other payables | 22 | **(20,038)** | (27,113) |
| Borrowings | 25 | **(57,952)** | (26,755) |
| Provisions | 28 | **(151)** | (888) |
| Other liabilities | 24 | **(656)** | (162) |
| **Total current liabilities** | | **(78,797)** | (54,918) |
| **Total assets less current liabilities** | | **63,096** | 78,792 |
| **Non-current liabilities** | | | |
| Borrowings | 25 | **(66,383)** | (67,945) |
| Provisions | 28 | **(785)** | (806) |
| **Total non-current liabilities** | | **(67,168)** | (68,751) |
| **Total assets employed** | | **(4,072)** | 10,041 |
| **Financed by** | | | |
| Public dividend capital | | **130,918** | 128,151 |
| Revaluation reserve | | **18,626** | 19,015 |
| Income and expenditure reserve | | **(153,616)** | (137,125) |
| **Total taxpayers equity** | | **(4,072)** | 10,041 |

The notes on pages 91 to 127 form part of these Accounts.

The financial statements on pages 87 to 90 were approved by the Board on 23 May 2019 and signed on its behalf by :

Dave Carney — **Chief Executive**

23.5.19 — **Date**

## Statement of Changes in Equity for the year ended 31 March 2019

| | Public Dividend Capital £000's | Revaluation Reserve £000's | Income and Expenditure Reserve £000's | Total £000's |
|---|---|---|---|---|
| **Taxpayers equity at 1 April 2018** | **128,151** | **19,015** | **(137,125)** | **10,041** |
| Deficit for the year | 0 | 0 | (16,559) | **(16,559)** |
| Other transfers between reserves | 0 | (68) | 68 | **0** |
| Revaluations | 0 | (284) | 0 | **(284)** |
| Other recognised gains and losses | 0 | (37) | 0 | **(37)** |
| Public dividend capital received | 2,767 | 0 | 0 | **2,767** |
| **Taxpayers equity at 31 March 2019** | **130,918** | **18,626** | **(153,616)** | **(4,072)** |
| | | | | |
| **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** |

### Information on Reserves :

**Public Dividend Capital**

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

| | Note | 2018/19 £000's | 2017/18 £000's |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating deficit | | **(14,980)** | (30,242) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6,17 | **9,082** | 8,394 |
| Net impairments | 8 | **0** | 3,175 |
| Income recognised in respect of capital donations | 4 | **(17)** | (19) |
| (Increase) / decrease in receivables and other assets | | **(6,189)** | 2,022 |
| Increase in inventories | 18 | **(354)** | (47) |
| Decrease in payables and other liabilties | | **(4,495)** | (302) |
| (Decrease) / increase in provisions | | **(759)** | 180 |
| **Net cash used in operating activities** | | **(17,712)** | (16,839) |
| **Cash flows from investing activities** | | | |
| Interest received | | **75** | 30 |
| Purchase of intangible assets | | **(365)** | (108) |
| Purchase of property, plant, equipment and investment property | | **(13,407)** | (10,934) |
| Sales of property, plant, equipment and investment property | | **0** | 10 |
| **Net cash used in investing activities** | | **(13,697)** | (11,002) |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | **2,767** | 2,239 |
| Movement on loans from the Department of Health and Social Care | | **29,274** | 25,663 |
| Movement on other loans | | **0** | (95) |
| Capital element of finance lease rental payments | | **(18)** | (88) |
| Interest on loans | | **(1,532)** | (1,112) |
| Interest paid on finance lease liabilities | | **0** | (1) |
| PDC dividend refunded / (paid) | | **863** | (919) |
| Cash flows in from other financing activities | | **(10)** | 0 |
| **Net cash generated from financing activities** | | **31,344** | 25,687 |
| **Decrease in cash and cash equivalents** | | **(65)** | (2,154) |
| **Cash and cash equivalents at 1 April** | | **1,262** | 3,416 |
| **Cash and cash equivalents at 31 March** | 20 | **1,197** | 1,262 |

## Notes to the Accounts

### Note 1. Accounting policies and other information

#### Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the Accounts.

#### Note 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.

#### Note 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 2019/20 contract with all main Commissioners. This contracts support continued provision of services with no plans for disinvestment.

- The Trust has submitted a deficit plan to NHS Improvement (NHSI) totalling £6.2m in 2019/20. The 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 £20.8m. This value is comprised of £5.4m Provider Sustainability Fund (PSF), £14.8m Financial Recovery Fund (FRF) and £0.6m of centrally funded Marginal Rate Emergency Threshold (MRET) funding in 2019/20. If these are secured the planned deficit would be £6.2m.

- The Trust has included an estimate of £29.7m of capital requirements in its 2019/20 operating plan. This plan includes £7.5m from Wave 4 Sustainability and Transformation Partnerships (STP) capital bids for additional capacity, £5m emergency capital, £3.8m STP Interoperability (ICT) and £3.3m to continue the progression of a Strategic Outline Business Case (SOC) to consider site redevelopment options.

## 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 2019/20 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 2018/19 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.

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

**Note 1.2.1 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:

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

***Provisions***

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date where the liability meets the recognition criteria of IAS 37. These are based on judgements and estimates of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

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

Pensions provisions are based on information received from NHS Pension Agency (part of NHS Business 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 28 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.

**Note 1.4 Revenue**

**Note 1.4.1 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

***Revenue from NHS contracts***

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

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

Commissioners are entitled not to pay for patient care where it is deemed the patient represented to the Trust within 30 days of the initial admission and such a readmission is judged to have been avoidable if this was within control of the Trust. At the start of the financial year the Trust agreed a percentage deduction to be applied to the total cohort of patients who were readmitted. This agreement represented the basis of a performance obligation which was satisfied by reduction in transaction price. During the year the Commissioners and the Trust agreed an audit to inform future levels of contractual deductions. This audit concluded that readmissions deductions being applied to the Trust should be negligible.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

***Revenue from research contracts***

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

***NHS injury cost recovery scheme***
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

**Note 1.4.2 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 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 1.4.3 Other income**
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.

Other operating income includes Provider Sustainability Fund (PSF) and Sustainability and Transformation Fund (STF).

**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 cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**
*NHS Pension Scheme*
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

**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**

**Note 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 costs at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually cost more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

***Subsequent expenditure***
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

***Depreciation***
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

***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.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

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.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

**Note 1.7.3 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 abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

#### Note 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 met.

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

#### Note 1.7.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Buildings, excluding dwellings | 0 | 29 |
| Dwellings | 2 | 15 |
| Plant & machinery | 0 | 7 |
| Transport equipment | 0 | 5 |
| Information technology | 0 | 8 |
| Furniture & fittings | 0 | 8 |

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

#### Note 1.8 Intangible assets

#### Note 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.

***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;

## Notes to the Accounts

**Note 1. Accounting policies and other information (continued)**

- how the intangible asset will generate probable future economic or service delivery benefits, e.g., 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.

**Note 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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

***Amortisation***

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

**Note 1.8.3 Useful economic life of intangible assets**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Information technology | 0 | 5 |
| Development expenditure | 0 | 8 |
| Websites | 0 | 5 |
| Software licences | 0 | 5 |
| Licences & trademarks | 0 | 5 |
| Patents | 0 | 5 |
| Other (purchased) | 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.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

#### 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 the 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.

Allowances acquired under the scheme are recognised as intangible assets.

#### Note 1.12 Financial assets and financial liabilities

##### Note 1.12.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

##### Note 1.12.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below:

- Financial assets are classified as fair value through income and expenditure.
- Financial liabilities classified as fair value through income and expenditure.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

***Financial assets and financial liabilities at amortised cost***
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

***Financial assets measured at fair value through other comprehensive income***
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

***Financial assets and financial liabilities at fair value through income and expenditure***
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive Income.

***Impairment of financial assets***
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to a 12 month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit loss if the credit risk assessed for the financial asset significantly increases (stage 2).

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

All outstanding non-NHS receivables over one year old are included in the credit loss allowance. Any receivable relating to prescription charges that are over six months old plus any receivable where the Trust considers there to be a high risk of being uncollectable are included. The amount included for Injury Cost Recovery receivables follows the DHSC GAM guidance (an allowance of 21.89% of outstanding receivables is included).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

**Note 1.12.3 Derecognition**
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

**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.

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

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

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

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

***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.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

#### 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's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

***Operating lease***
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. The discounted rate used by the Trust for Early Retirements is positive 0.29% (2017/18 positive 0.1%).

***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 29 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 30 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

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

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the Annual Accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the Annual Accounts.

**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.

## Notes to the Accounts

### Note 1. Accounting policies and other information (continued)

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

- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

**Note 1.19 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).

**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 2018/19.

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2018/19. These Standards are still subject to HM Treasury FReM interpretation and are subject to HM Treasury consideration. The assessment of the impact of these Standards on the Trusts Accounts are therefore yet to be determined.

- 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.

## 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

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

| Note 3.1 Income from patient care activities (by nature) | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Acute services** | | |
| Elective income | 27,977 | 27,106 |
| Non elective income | 79,807 | 71,550 |
| First outpatient income | 19,329 | 16,327 |
| Follow up outpatient income | 15,083 | 14,273 |
| A & E income | 15,147 | 14,253 |
| High cost drugs (pass-through) income from commissioners | 14,927 | 14,134 |
| Other NHS clinical income | 35,758 | 38,006 |
| **All services** | | |
| Private patient income | 277 | 296 |
| Agenda for Change pay award central funding | 2,606 | 0 |
| Other clinical income | 999 | 712 |
| **Total income from activities** | **211,910** | **196,657** |

### Note 3.2 Income from patient care activities (by source)

| Income from patient care activities received from: | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| NHS England | 21,785 | 21,890 |
| Clinical commissioning groups | 185,544 | 170,974 |
| Department of Health and Social Care* | 2,606 | 0 |
| Other NHS providers | 525 | 2,534 |
| NHS other | 110 | 100 |
| Local authorities | 64 | 151 |
| Non-NHS: private patients | 277 | 296 |
| Non-NHS: overseas patients | 81 | 149 |
| Injury cost recovery scheme | 918 | 563 |
| **Total income from activities** | **211,910** | **196,657** |

* Department of Health and Social Care funding received in 2018/19 relates to centrally funded impact of Agenda for Change pay award funding.

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

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| Income recognised this year | 81 | 149 |
| Cash payments received in-year | 16 | 38 |
| Amounts added to provision for impairment of receivables | 7 | 109 |
| Amounts written off in-year | 4 | 3 |

### Note 4. Other operating income

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Other operating income from contracts with customers** | | |
| Research and development | 713 | 796 |
| Education and training (excluding notional apprenticeship levy | 6,602 | 6,071 |
| Non-patient care services to other bodies | 2,675 | 3,451 |
| Provider Sustainability Fund (PSF) / Sustainability and Transformation Fund (STF) income | 11,422 | 3,229 |
| Other contract income | 3,024 | 2,853 |
| **Other non-contract operating income** | | |
| Receipt of capital grants and donations | 17 | 19 |
| Rental revenue from operating leases | 337 | 155 |
| **Total other operating income** | **24,790** | **16,574** |

### Note 5. Additional information on revenue from contracts

### Note 5.1 Additional information on revenue from contracts with customers recognised in the period

| | 2018/19 £000's |
|---|---|
| Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end. | 162 |

## Note 6. Operating expenses

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| Purchase of healthcare from NHS and DHSC bodies | 1,990 | 3,575 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 1,950 | 1,728 |
| Staff and executive directors costs | 168,513 | 158,414 |
| Remuneration of non-executive directors | 75 | 76 |
| Supplies and services - clinical (excluding drugs costs) | 17,572 | 16,813 |
| Supplies and services - general | 3,190 | 3,223 |
| Drug costs | 20,550 | 19,433 |
| Inventories written down | 18 | 0 |
| Consultancy and professional services | 1,912 | 2,158 |
| Establishment | 1,601 | 1,462 |
| Premises | 9,122 | 8,357 |
| Transport (including patient travel) | 826 | 707 |
| Depreciation on property, plant and equipment | 7,242 | 6,585 |
| Amortisation on intangible assets | 1,840 | 1,809 |
| Net impairments | 0 | 3,175 |
| Movement in credit loss allowances: | | |
| Contract receivables / contract assets | 15 | 0 |
| All other receivables / investments | 0 | 400 |
| Change in provisions discount rate(s) | (2) | 1 |
| Audit fees payable to the external auditor | | |
| audit services- statutory audit | 73 | 73 |
| other auditor remuneration (external auditor only) | 12 | 10 |
| Internal audit costs | 99 | 82 |
| Clinical negligence | 11,115 | 11,884 |
| Legal fees | 110 | 167 |
| Insurance | 141 | 118 |
| Education and training | 796 | 803 |
| Rentals under operating leases | 1,674 | 1,663 |
| Redundancy | 119 | 0 |
| Car parking & security | 408 | 375 |
| Hospitality | 12 | 1 |
| Losses, ex gratia & special payments | 76 | 77 |
| Other external services | 267 | 261 |
| Other | 364 | 43 |
| **Total** | **251,680** | **243,473** |

## Note 7. Other auditor remuneration

### Note 7.1 Other auditor remuneration

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Other auditor remuneration paid to the external auditor:** | | |
| Other assurance services | 12 | 10 |
| **Total** | **12** | **10** |

### Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5m (2017/18: £5m).

## Note 8. Impairment of assets

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Net impairments charged to operating deficit resulting from:** | | |
| Unforeseen obsolescence | 0 | 320 |
| Changes in market price | 0 | 2,855 |
| **Total net impairments charged to operating deficit** | **0** | **3,175** |

## Note 9. Employee benefits

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| Salaries and wages | 114,601 | 109,608 |
| Social security costs | 12,045 | 10,907 |
| Apprenticeship levy | 566 | 490 |
| Employer's contributions to NHS pensions | 13,467 | 12,856 |
| Pension cost - other | 21 | 0 |
| Temporary staff (including agency)* | 29,182 | 26,024 |
| **Total staff costs** | **169,882** | **159,885** |
| **Of which** | | |
| Costs capitalised as part of assets | 1,250 | 1,471 |

* Agency revenue costs totalled £9.6m (£13.0m 2017/18) being £0.7m better than the agency target set by NHSI of £10.3m.

### Note 9.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the Trust agreed on the grounds of ill-health. There was one in the year ended 31 March 2018 with an estimated additional pension liabilities of £113k.

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

## Note 10. Pension costs

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

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

**a) Accounting valuation**
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

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

## Note 11. Operating leases

### Note 11.1 The Trust as a lessor

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

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Operating lease revenue** | | |
| Minimum lease receipts | 337 | 155 |
| **Total** | **337** | **155** |

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Future minimum lease receipts due:** | | |
| - not later than one year; | 101 | 53 |
| - later than one year and not later than five years; | 247 | 53 |
| - later than five years. | 194 | 0 |
| **Total** | **542** | **106** |

### Note 11.2 The Trust as a lessee

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

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Operating lease expense** | | |
| Minimum lease payments | 1,674 | 1,663 |
| **Total** | **1,674** | **1,663** |

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Future minimum lease payments due:** | | |
| - not later than one year; | 1,291 | 1,275 |
| - later than one year and not later than five years; | 3,702 | 4,132 |
| - later than five years. | 4,955 | 4,956 |
| **Total** | **9,948** | **10,363** |

## Note 12. Finance income

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

| | 2018/19 £000 's | 2017/18 £000 's |
|---|---|---|
| Interest on bank accounts | 75 | 31 |
| **Total finance income** | **75** | **31** |

## Note 13. Finance expenditure

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

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **Interest expense:** | | |
| Loans from the Department of Health and Social Care | 1,643 | 1,220 |
| Finance leases | 0 | 1 |
| Interest on late payment of commercial debt | 0 | 5 |
| **Total interest expense** | **1,643** | **1,226** |
| Unwinding of discount on provisions | 1 | 2 |
| Other finance costs | 10 | 6 |
| **Total finance costs** | **1,654** | **1,234** |

## Note 14. The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| Amounts included within interest payable arising from claims under this legislation | 0 | 5 |

## Note 15. Other gains

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| Gains on disposal of assets | 0 | 8 |
| **Total gains on disposal of assets** | 0 | **8** |

## Note 16. Intangible assets - 2018/19

| | IT - in-house & third party software £000's | Development expenditure £000's | Total £000's |
|---|---|---|---|
| **Valuation / gross cost at 1 April 2018** | **48** | **14,594** | **14,642** |
| Additions | 17 | 266 | **283** |
| Disposals / derecognition | (17) | 0 | **(17)** |
| **Valuation / gross cost at 31 March 2019** | **48** | **14,860** | **14,908** |
| **Amortisation at 1 April 2018** | **32** | **4,032** | **4,064** |
| Provided during the year | 6 | 1,834 | **1,840** |
| Disposals / derecognition | (17) | 0 | **(17)** |
| **Amortisation at 31 March 2019** | **21** | **5,866** | **5,887** |
| **Net book value at 31 March 2019** | **27** | **8,994** | **9,021** |
| **Net book value at 1 April 2018** | **16** | **10,562** | **10,578** |

## Note 16.1 Intangible assets - 2017/18

| | IT - in-house & third party software £000's | Development expenditure £000's | Total £000's |
|---|---|---|---|
| **Valuation / gross cost at 1 April 2017** | **43** | **14,389** | **14,432** |
| Additions | 5 | 205 | **210** |
| **Valuation / gross cost at 31 March 2018** | **48** | **14,594** | **14,642** |
| **Amortisation at 1 April 17** | **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 17. Property, plant and equipment - 2018/19 | 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 2018** | **8,150** | **76,667** | **441** | **27,723** | **190** | **16,923** | **1,310** | **131,404** |
| Additions | 0 | 6,061 | 1,531 | 2,258 | 29 | 1,772 | 0 | **11,651** |
| Revaluations | 0 | (2,406) | 0 | 0 | 0 | 0 | 0 | **(2,406)** |
| Reclassifications | 0 | 123 | (123) | 0 | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | (3,461) | (143) | (627) | (141) | **(4,372)** |
| **Valuation/gross cost at 31 March 2019** | **8,150** | **80,445** | **1,849** | **26,520** | **76** | **18,068** | **1,169** | **136,277** |
| **Accumulated depreciation at 1 April 2018** | **0** | **0** | **0** | **18,970** | **166** | **7,771** | **1,245** | **28,152** |
| Provided during the year | 0 | 2,657 | 0 | 2,274 | 5 | 2,296 | 10 | **7,242** |
| Revaluations | 0 | (2,122) | 0 | 0 | 0 | 0 | 0 | **(2,122)** |
| Disposals / derecognition | 0 | 0 | 0 | (3,461) | (143) | (627) | (141) | **(4,372)** |
| **Accumulated depreciation at 31 March 2019** | **0** | **535** | **0** | **17,783** | **28** | **9,440** | **1,114** | **28,900** |
| **Net book value at 31 March 2019** | **8,150** | **79,910** | **1,849** | **8,737** | **48** | **8,628** | **55** | **107,377** |
| **Net book value at 1 April 2018** | **8,150** | **76,667** | **441** | **8,753** | **24** | **9,152** | **65** | **103,252** |

| Note 17.1 Property, plant and equipment - 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** | **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 / derecognition | 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** | **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 17.2 Property, plant and equipment financing - 2018/19

| | 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 |
| **Net book value at 31 March 2019** | | | | | | | | |
| Owned - purchased | 8,150 | 79,910 | 1,849 | 8,681 | 48 | 8,628 | 55 | **107,321** |
| Owned - donated | 0 | 0 | 0 | 56 | 0 | 0 | 0 | **56** |
| **NBV total at 31 March 2019** | **8,150** | **79,910** | **1,849** | **8,737** | **48** | **8,628** | **55** | **107,377** |

### Note 17.3 Property, plant and equipment financing - 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 |
| **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 17.4 Donations of property, plant and equipment

The Trust has received capital asset donations from The PAH NHS Trust Charitable Fund (Registered Charity No 10547745) totalling £21k (2107/18 £19k).

### Note 17.5 Revaluations of property, plant and equipment

The Trust has undertaken a revaluation of land and buildings as at 31 March 2019. This work was performed by Mr Giles Awford BSc (Hons) MRICS, Principal Surveyor, District Valuer Services (DVS), the specialist property arm of the Valution Office Agency (VOA). The valuation has been undertaken in accordance with International Finance Reporting Standard (IFRS) as interpreted by the HM Financial Reporting Manual (FREM) compliant with the DHSC Group Manual for Accounts (DHSC GAM). The valuation approach continues to adopt the Modern Equivalent Asset (MEA) concept. DHSC guidance specifies that land and buildings should be valued on the basis of depreciated replacement cost, applying the MEA concept. MEA is defined as 'the cost of a modern replacement asset that has the same productive capacity as the property being valued'. Therefore MEA is not a valuation of the existing land and buildings that the Trust holds but a thoeretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

**Note 17.5 Revaluations of property, plant and equipment (continued)**

There has been an overall reduction of £284k (£34,561k reduction in 2017/18 being the the first year the Trust adopted MEA) in the valuation of Property, Plant and Equipment. The range of minimum and maximum useful lives applied to buildings and dwellings remains between 0 to 29 years (Note 1.7.5).

**Note 18. Inventories**

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| Drugs | 1,395 | 1,140 |
| Consumables | 3,004 | 2,901 |
| Energy | 80 | 85 |
| Other | 36 | 35 |
| **Total inventories** | **4,515** | **4,161** |

Inventories recognised in expenses for the year were £30,816k (2017/18: £28,801k). There were write-down of inventories recognised as expenses in 2018/19 of £18k (2017/18: £0k).

**Note 19. Trade receivables and other receivables**

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Current** | | |
| Contract receivables* | 17,365 | - |
| Trade receivables* | - | 5,188 |
| Accrued income* | - | 5,539 |
| Allowance for impaired contract receivables / assets* | (1,066) | - |
| Allowance for other impaired receivables * | - | (1,058) |
| Prepayments (non-PFI) | 1,514 | 1,432 |
| Interest receivable | 4 | 4 |
| PDC dividend receivable | 0 | 863 |
| VAT receivable | 882 | 1,566 |
| Other receivables | 172 | 160 |
| **Total current trade and other receivables** | **18,871** | **13,694** |
| **Non-current** | | |
| Contract receivables* | 912 | - |
| Accrued income* | - | 763 |
| **Total non-current trade and other receivables** | **912** | **763** |
| **Of which receivables from NHS and DHSC group bodies:** | | |
| Current | 14,300 | 9,189 |
| Non-current | 0 | 0 |

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

### Note 19.1 Allowances for credit losses - 2018/19

| | £000's |
|---|---|
| **Allowance for all other receivables - as at 1 April 2018** | **(1,058)** |
| Impact of implementing IFRS 9 and 15 on 1 April 2018 : | |
| Allowance for contract receivables and contract assets (previously reported as all other receivable) | (1,058) |
| Changes to allowances from 1 April 2018 : | |
| New allowances arising | (211) |
| Changes in existing allowances | 9 |
| Reversals of allowances | 187 |
| Utilisation of allowances (write offs) | 7 |
| **Allowances as at 31 March 2019** | **(1,066)** |

### 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.

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| **At 1 April** | **1,262** | **3,416** |
| Net change in year | (65) | (2,154) |
| **At 31 March** | **1,197** | **1,262** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 46 | 47 |
| Cash with the Government Banking Service | 1,151 | 1,215 |
| **Total cash and cash equivalents as in SoFP** | **1,197** | **1,262** |

### Note 21. Third party assets held by the Trust

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

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| Bank balances | 15 | 13 |
| **Total third party assets** | **15** | **13** |

## Note 22. Trade and other payables

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Current** | | |
| Trade payables | 4,434 | 587 |
| Capital payables | 3,214 | 5,032 |
| Accruals | 9,140 | 19,143 |
| Social security costs | 1,661 | 1,594 |
| Other taxes payable | 1,487 | 401 |
| Accrued interest on loans* | 0 | 268 |
| Other payables | 102 | 88 |
| **Total current trade and other payables** | **20,038** | **27,113** |
| **Of which payables from NHS and DHSC group bodies:** | | |
| Current | 2,447 | 7,455 |
| Non-current | 0 | 0 |

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

## Note 23. Early retirements in NHS payables above

There were no early retirements due to ill heath (one during 2017/18).

## Note 24. Other liabilities

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Current** | | |
| Deferred income: contract liabilities | 656 | 162 |
| **Total other current liabilities** | **656** | **162** |

## Note 25. Borrowings

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Current** | | |
| Loans from the Department of Health and Social Care | 57,952 | 26,737 |
| Obligations under finance leases | 0 | 18 |
| **Total current borrowings** | **57,952** | **26,755** |
| **Non-current** | | |
| Loans from the Department of Health and Social Care | 66,383 | 67,945 |
| **Total non-current borrowings** | **66,383** | **67,945** |
| **Total borrowings** | **124,335** | **94,700** |

## Note 26. Reconciliation of liabilities arising from financing activities

| | Loans from DHSC | Finance leases | Total |
|---|---|---|---|
| | £000's | £000's | £000's |
| **Carrying value at 1 April 2018** | **94,682** | **18** | **94,700** |
| **Cash movements:** | | | |
| receipts of principal | 29,274 | (18) | **29,256** |
| interest | (1,532) | 0 | **(1,532)** |
| **Non-cash movements:** | | | |
| Impact of implementing IFRS 9 on 1 April 2018 | 268 | 0 | **268** |
| Application of effective interest rate | 1,643 | 0 | **1,643** |
| **Carrying value at 31 March 2019** | **124,335** | **0** | **124,335** |

## Note 27. Finance leases

### Note 27.1 The Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Gross lease liabilities** | 0 | **18** |
| of which liabilities are due not later than one year | 0 | 18 |
| **Net lease liabilities** | **0** | **18** |
| of which payable not later than one year | 0 | 18 |

## Note 28. Provisions for liabilities and charges analysis

| | Pensions: £000's | Legal £000's | Other £000's | Total £000's |
|---|---|---|---|---|
| **At 1 April 2018** | **878** | **88** | **728** | **1,694** |
| Change in the discount rate | (2) | 0 | 0 | **(2)** |
| Arising during the year | 72 | 23 | 0 | **95** |
| Utilised during the year | (73) | 0 | (173) | **(246)** |
| Reversed unused | (18) | (33) | (555) | **(606)** |
| Unwinding of discount | 1 | 0 | 0 | **1** |
| **At 31 March 2019** | **858** | **78** | **0** | **936** |
| **Expected timing of cash flows:** | | | | |
| not later than one year; | 73 | 78 | 0 | **151** |
| later than one year and not later than five years; | 293 | 0 | 0 | **293** |
| later than five years. | 492 | 0 | 0 | **492** |
| **Total** | **858** | **78** | **0** | **936** |

The Trust has no provisions for injury benefit liabilities.

## Note 29. Clinical negligence liabilities

At 31 March 2019 £125.389m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2018: £105.384m).

## Note 30. Contingent assets and liabilities

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (16) | (28) |
| Employment tribunal and other employee related litigation | (127) | (46) |
| **Total contingent liabilities** | **(143)** | **(74)** |

## Note 31. Contractual capital commitments

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| Property, plant and equipment | 3,766 | 681 |
| **Total Capital Commitments** | **3,766** | **681** |

## Note 32. Financial instruments

### Note 32.1 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.

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 and Social Care) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

## Note 32.1 Financial risk management (continued)

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

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

## Note 32.2 Carrying values of financial assets

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

| Carrying values of financial assets as at 31 March 2019 under IFRS 9 | Held at amortised cost | Total book value |
|---|---|---|
| | £000's | £000's |
| Trade and other receivables excluding non financial assets | 17,387 | **17,387** |
| Cash and cash equivalents at bank and in hand | 1,197 | **1,197** |
| **Total at 31 March 2019** | **18,584** | **18,584** |

| Carrying values of financial assets as at 31 March 2018 under IAS 39 | Loans and receivables | Total book value |
|---|---|---|
| | £000's | £000's |
| 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** |

## Note 32.3 Carrying value of financial liabilities

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

| Carrying values of financial liabilities as at 31 March 2019 under IFRS 9 | Held at amortised cost | Total book value |
|---|---|---|
| | £000's | £000's |
| Loans from the Department of Health and Social Care | 124,335 | **124,335** |
| Trade and other payables excluding non financial liabilities | 16,890 | **16,890** |
| **Total at 31 March 2019** | **141,225** | **141,225** |

**Note 32.3 Carrying value of financial liabilities (continued)**

| Carrying values of financial liabilities as at 31 March 2018 under IAS 39 | Total other financial liabilities £000's |
|---|---|
| Loans from the Department of Health and Social Care | 94,682 |
| Obligations under finance leases | 18 |
| Trade and other payables excluding non financial liabilities | 25,118 |
| **Total at 31 March 2018** | **119,818** |

**Note 32.4 Fair values of financial assets and liabilities**

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 33. Maturity of financial liabilities**

| | 31 March 2019 £000's | 31 March 2018 £000's |
|---|---|---|
| In one year or less | 74,842 | 51,873 |
| In more than one year but not more than two years | 25,663 | 30,836 |
| In more than two years but not more than five years | 40,720 | 37,109 |
| **Total** | **141,225** | **119,818** |

**Note 34. Losses and special payments**

| | 2018/19 | | 2017/18 | |
|---|---|---|---|---|
| | Total number of cases | Total value of cases £000's | Total number of cases | Total value of cases £000's |
| **Losses** | | | | |
| Cash losses | 2 | 4 | 6 | 1 |
| Bad debts and claims abandoned | 4 | 6 | 8 | 16 |
| Stores losses and damage to property | 9 | 64 | 10 | 58 |
| **Total losses** | **15** | **74** | **24** | **75** |
| **Special payments** | | | | |
| Compensation under court order or legally binding arbitration award | 5 | 31 | 5 | 15 |
| Ex-gratia payments | 10 | 1 | 11 | 3 |
| **Total special payments** | **15** | **32** | **16** | **18** |
| **Total losses and special payments** | **30** | **106** | **40** | **93** |

**Note 35. Initial application of IFRS 9**

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

**Note 35. Initial application of IFRS 9 (continued)**

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

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £268k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a movement of £1,058k between receivable categories.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,612k.

**Note 35.1 Initial application of IFRS 15**

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

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

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

The standard has had no material impact on the financial statements of the Trust.

**Note 36. Related parties**

In accordance with IAS 24 and paragraphs 5.184-5.188 of the GAM the Trust is required to disclose the main entities within the public sector that the Trust has had dealings with. The Department of Health and Social Care are regarded as a parent department. Related parties include :-

| | |
|---|---|
| The Department of Health and Social Care | HM Revenue and Customs |
| Other NHS Providers | NHS Blood and Transplant Service |
| CCGs and NHS England | NHS Professionals |
| NHS West Essex | NHS Pensions Agency |
| NHS East and North Hertfordshire | NHS Improvement |
| NHS England | Health Education England |
| NHS Resolution | NHS Property Services |
| NHS Business Service Authority | Local Authorities |

Other Health Bodies and Government Departments e.g. HMRC

## Note 36. Related parties (continued)

All Board members and the most senior managers of the Trust with key controlling influence 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 of Related Party | Name of Trust Employee | Title of Trust Employee | Relationship with Related Party | Expenditure with related party £000's | Income from related party £000's | Amounts owed to related party £000's | Amounts due from related party £000's |
|---|---|---|---|---|---|---|---|
| Liaison Financial Services | Andrew Holden | Non-Executive Director | Board Director | 3,762 | 0 | 0 | 0 |
| Addenbrooke's Charitable Trust | Helen Howe | Associate Non-Executive Director | Trustee | 2 | 0 | 0 | 0 |
| University of East Anglia | Helen Howe | Associate Non-Executive Director | Honorary Professor | 2 | 0 | 0 | 0 |
| Anglia Ruskin University | Nancy Fontaine | Chief Nurse (left July 2018 | Professor of Nursing | 56 | 29 | 6 | 0 |
| University of Essex | Nancy Fontaine | Chief Nurse (left July 2018 | Professor of Nursing | 11 | 0 | 0 | 0 |
| The Staff College | Raj Bhamber | Interim Director of People (left July 2018) | Trustee | 5 | 0 | 0 | 0 |
| Compass Group | James McLeish | Director of Quality Improvement | Family member an employee | 0 | 245 | 0 | 102 |
| Ramsay Healthcare | Marcelle Michail | Deputy Chief Medical Officer | Private Practice | 0 | 82 | 0 | 11 |
| Barts Health NHS Trust | John Hogan | Non-Executive Director | Consultant Cardiologist | 273 | 486 | 137 | 235 |

PAH NHS Trust Charitable funds (Registered Charity 10547745). The Trust receives revenue and capital payments from this charity and certain trustees are also members of the Trust Board. The charity's objective is to provide support both generally and in certain areas of the Trust's activities. During the year the charity contributed £278k (unaudited) to the Trust (2017/18 £440k).

## Note 37. Prior Period Adjustments

There have been no prior period adjustments with IAS8 that has required restatement of comparative information due to either changes in accounting policy or material prior period error.

## Note 38. 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 23 May 2019.

## Note 39. Better Payment Practice Code

| | 2018/19 Number | 2018/19 £000's | 2017/18 Number | 2017/18 £000's |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total non-NHS trade invoices paid in the year | 51,665 | 67,947 | 51,727 | 84,375 |
| Total non-NHS trade invoices paid within target | 36,583 | 49,942 | 20,881 | 41,425 |
| Percentage of non-NHS trade invoices paid in target | **70.8%** | **73.5%** | **40.4%** | **49.1%** |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 2,553 | 42,033 | 2,267 | 20,740 |
| Total NHS trade invoices paid within target | 1,810 | 36,631 | 1,086 | 10,594 |
| Percentage of NHS trade invoices paid in target | **70.9%** | **87.1%** | **47.9%** | **51.1%** |

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.

Reclassification between the NHS and Non-NHS categories has resulted in some movement between 2017/18 and 2018/19 across those categories.

## Note 40. External financing

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

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| External financing limit (EFL) | 32,286 | 30,203 |
| Cashflow financing | 32,088 | 29,873 |
| Underspend against EFL | **198** | **330** |

## Note 41. Capital Resource Limit (CRL)

| | 2018/19 £000's | 2017/18 £000's |
|---|---|---|
| Gross capital expenditure | 11,934 | 11,117 |
| Less: Disposals | 0 | (2) |
| Less: Donated and granted capital additions | (17) | (19) |
| **Charge against Capital Resource Limit** | **11,917** | **11,096** |
| Capital Resource Limit | 12,102 | 11,642 |
| **Underspend against CRL** | **185** | **546** |

## Note 42. Breakeven duty and financial performance

| | Control Target £000's | 2018/19 Actual Outturn £000's | Under-spend £000's |
|---|---|---|---|
| Gross Control Total | (28,471) | (27,964) | **507** |
| Net Control Total | (20,436) | (16,542) | **3,894** |

## Note 42 Breakeven duty rolling assessment

| | 1997/98 to 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 | 2018/19 £000's |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | | 511 | 415 | 461 | 122 | (16,403) | (21,998) | (37,714) | (26,715) | (28,435) | (16,542) |
| Breakeven duty cumulative position | 1,536 | 2,047 | 2,462 | 2,923 | 3,045 | (13,358) | (35,356) | (73,070) | (99,785) | (128,220) | (144,762) |
| Operating income | | 172,171 | 179,388 | 180,790 | 184,568 | 177,739 | 190,478 | 196,124 | 209,742 | 213,231 | 236,700 |
| Cumulative breakeven position as a percentage of operating income | | **1.19%** | **1.37%** | **1.62%** | **1.65%** | **-7.52%** | **-18.56%** | **-37.26%** | **-47.58%** | **-60.13%** | **-61.16%** |

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.